AN EVALUATION OF THE COMMUNICATION STRATEGIES OF THE CATHOLIC RELIEF SERVICES (CRS) IN MITIGATING THE IMPACT OF HIV AND AIDS AND POVERTY IN ZAMBIA

BY

KALYONDO STANISLAUS

A dissertation submitted to the University of Zambia in partial fulfillment of the requirements for the degree of **Master of Communication for Development**

THE UNIVERSITY OF ZAMBIA
LUSAKA

DECLARATION

I declare that this report has not been previously submitted for a degree in this or any other University

FULL NAME: KALYONDO STANISLAUS

Signature: 

Date: 14. 12. 09

SUPERVISOR: MR. KENNY MAKUNGU

Signature: 

Date: 14 - 12 - 09

ABSTRACT

This study is based on the attachment of the researcher with Catholic Relief Services (CRS) Zambia in Kasama and Lusaka. CRS is an international, humanitarian and development based organization, indirectly implementing through its partners, who include the Catholic Church, faith-based and community-based organizations. CRS operates in this way in order to empower local communities to take ownership of their programmes, thereby being more fully involved in influencing their future.

The aim of this study is to establish the extent to which CRS' communication strategies are influencing people's attitudes, beliefs and behaviour towards the HIV and AIDS pandemic as well as the ravaging poverty. It is for this reason that the researcher tried to evaluate the effectiveness of the communication strategies in use by CRS in mitigating the impact of the HIV and AIDS pandemic and poverty in Zambia.

In order to achieve the above main objective of the study, the researcher employed both the qualitative and the quantitative research methods. The use of multiple methodologies to acquire data ensured triangulation and validation of the findings. The data gathering methods employed included audience surveys, four FGDs, four in-depth interviews, and participatory methods such as transect walks, community mapping and timelines.

These methods revealed that CRS has tended mostly to use meetings, workshops, seminars, print materials, drama and printed T-shirts and citenge materials as approaches in communicating its messages. According to the available data from the study sites, these methods have been able to change people's beliefs, attitudes and behaviour especially with regard to HIV and AIDS.

However, the study also established that although CRS had made such tremendous contributions towards the fight against HIV and AIDS and poverty, it had failed to explore other effective communication tools such as radio which are widely used and favored by most people in the study sites. Moreover, it was also observed that CRS had not done much in translating print materials, such as posters, brochures and pamphlets, and printed messages on T-shirts and citenge and the instructions on medicines into local languages.

This study recommends among other things that materials be designed specifically for the target audience within their particular culture. Much of information passing in rural areas of Zambia is still based on oral tradition, so the use of non-print materials is likely to be more effective. Consistent, unambiguous messages are the cornerstone of effective communication. The study further recommends that CRS should also explore other communication tools apart from the ones currently in use in order to be more effective in disseminating its messages.

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I dedicate this work to my late Father, Mr. Joseph Chisha Kalyondo, and my Mother, Mrs. Fidelia Mulenga, who mentored and taught me life skills that have seen me to what I am today. I will always remain grateful to you my parents.

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ACRONYMS

ADRA	Adventist Development and Relief Agency
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral Therapy
ARVs	Anti-retroviral
AS	Audience Survey
ASP	Agricultural Support Programme
BET	Black Entertainment Television
CBO	Community-based Organization
CCP	Center for Communication Programme
CHAMP-OVC	Community HIV and AIDS Mitigation Project – Orphans and Vulnerable Children
CHAZ	Churches Health Association of Zambia
CHEP	Copperbelt Health Education Programme
CIDA	Canadian International Development Agency
CRS	Catholic Relief Services
C-SAFE	Consortium of Southern Africa Food Security Emergency
CSO	Central Statistics Office
FAO	Food and Agricultural Programme
FBOs	Faith-based Organizations
FGD	Focus Group Discussion

FHH-O	Female-headed household fostering orphans
FHH-PLWA	Female-headed household with people living with AIDS
FHI	Family Health International
FSP	Food Security Pack
GRZ	Government of the Republic of Zambia
HBC	Home Based Care
HBT	Health Behavior Theory
HEART	Helping Each other Act Responsibly Together
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
IGA	Income-generating Activity
IMF	International Monetary Fund
KDHMB	Kasama District Health Management Board
LCMS	Living Conditions Monitoring Survey
LISAR	Livelihood Initiative in Support of Agricultural Recovery
MACO	Ministry of Agriculture and Cooperatives
MDG	Millennium Development Goal
MHH-O	Male-headed household fostering orphans
MHH-PLWA	Male-headed household with people living with AIDS
MMD	Movement for Multiparty Democracy
MoH	Ministry of Health
NAACZ	National AIDS Advisory Council of Zambia

NAC	National HIV/AIDS/STD/TB Council
NAMBOARD	National Agricultural Marketing Board
NAPCP	National AIDS Prevention and Control Programme
NASC	National AIDS Surveillance Committee
NCU	Northern Cooperative Union
NGO	Non-governmental Organization
NMF	Nelson Mandela Foundation
OVCs	Orphans and Vulnerable Children
PAM	Programme Against Malnutrition
PEPFAR	President's Emergency Plan for AIDS Relief
PLWA	People Living With AIDS
PRSP	Poverty Reduction Strategy Paper
PTA	Parent–teacher Association
PUSH	Project Urban Self-Help
RAPIDS	Reaching HIV Affected People with Integrated Development and Support
RDC	Rural Development Committee
SAP	Structural Adjustment Programme
SLA	Sustainable Livelihoods Approach
SPSS	Statistical Package for Social Sciences
SUCCESS	Scaling Up Community Care to Enhance Social Safety nets
TAZARA	Tanzania Zambia Railway Authority
TB	Tuberculosis

TCA	Theatre for Community Action
TNDP	Transitional National Development Plan
TV	Television
UNAIDS	United Nations programme on HIV/AIDS
UNDP	United Nations Development Programme
UNZA	University of Zambia
USA	United States of America
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
ZBC	Zambia Business Coalition
ZNBC	Zambia National Broadcasting Corporation

CHAPTER I

1.0. INTRODUCTION AND BACKGROUND

Humankind has experienced few crises that have presented such a threat to social development and economic progress as the Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS) pandemic. Almost three decades after the first evidence of the virus was reported, AIDS has become the most devastating disease humankind has ever faced. HIV and AIDS is now the leading cause of death in sub-Saharan Africa (WHO, 2006).

About twenty seven years into the pandemic, there is still no cure for AIDS. Information remains the most crucial weapon in the war against the AIDS virus. But is the provision of information successful in combating this terrible disease? The results are mixed. There have been some successes, most notably in Uganda, where the prevalence of HIV and AIDS has dropped from estimates as high as 30 percent in some areas to as low as 5 percent. While a few other countries show some small gain in the fight against the disease, most continue to report increasing rates of new infections and deaths, despite the targeted efforts of information and communication campaigns.

Zambia, in Southern Africa, has one of the world's most devastating HIV and AIDS pandemic. According to a Ministry of Health report more than one in every seven adults in Zambia is living with HIV and life expectancy at birth has fallen to just 37 years

(Ministry of Health, 2007). This has compounded Zambia's existing economic problems. In four decades of independence, Zambia has found peace but not prosperity and today it is one of the poorest and least developed nations on earth.

In this chapter, the researcher gives the background to the study and the general information about Zambia. The chapter also presents the statement of the problem, rationale, objectives of the study and the research questions.

1.1. Background to the Study

This study is entitled **"An Evaluation of the Communication Strategies of the Catholic Relief Services (CRS) in Mitigating the Impact of HIV and AIDS and Poverty in Zambia."** The study was based on the attachment of the researcher with CRS in partial fulfillment of the degree of Master of Communication for Development, offered by the University of Zambia. This programme focuses on the effective use of communication as a tool to further the development agenda. As Agunga (1997) observes, if development concerns, such as poverty, food insecurity, the HIV and AIDS pandemic and gender inequality, and the need to promote democracies worldwide are to become a reality, then the centrality of communication in development must be considered. In this regard, the attachment was aimed at finding out how CRS communicates with its partners and also to identify their communication strategies in mitigating the impact of poverty and HIV and AIDS in Zambia. Therefore, poverty and HIV and AIDS information dissemination has been deeply explored by the researcher. In order to achieve this objective, the researcher undertook an evaluation of CRS' poverty reduction and HIV and

AIDS programmes from the rural and urban setups. The rural evaluation was done in Kasama district and the urban evaluation in Lusaka district.

After an evaluation of the study findings, the report outlines the observations made and makes recommendations that the researcher think may help to enhance efforts of CRS in its quest to uplift the living standards of the people of Zambia.

1.2. Background Information on Zambia

1.2.1. Location

Zambia is a landlocked country situated in South Central Africa. It covers an area of 752,618 square kilometers. The country is located between 10 and 18 degrees latitude south of the Equator and longitudes 22 degrees and 33 degrees east (Zambia Basic Education Atlas, 1994). Zambia sits on a gently undulating plateau which is between 900 and 1500 meters above sea level.

Zambia shares a border with eight other countries including Botswana and Zimbabwe to the south; Angola and Namibia to the west; the Democratic Republic of Congo and Tanzania to the north; Malawi and Mozambique to the east.

The location of Zambia makes it vulnerable to high mobility which gives rise to high HIV prevalence rates. Mobile people are those who move from one place to another temporarily, seasonally or permanently for a host of voluntary or involuntary reasons. They include truck drivers, seafarers, transport workers, agricultural workers, business

people, traders, employees of large industries, miners, government officials, uniformed service officers, construction workers and sex workers. Internal migrants move within their country of birth and include rural-urban movements and resettlement, whereas external migrants cross country borders. While being mobile itself is not a risk factor for HIV, the situations encountered and the behaviours adopted during the mobility process may increase a person's vulnerability to the disease. People are also affected by mobility through interaction with others who are mobile even if they are not mobile themselves and so become vulnerable to the risk of HIV transmission. They include spouses, children and the elderly (UNDP, 2001).

For example, mobility is high in the Northern Province, which is crossed by the Great North Road and the Tanzania Zambia Railways (TAZARA), both going to the United Republic of Tanzania. Mobility is also very high in Lusaka which is the capital city of Zambia and is interconnected by major routes from all parts of the country, and this makes it highly vulnerable to high HIV prevalence rates.

Poverty and mobility are critical dimensions of vulnerability to HIV transmission. The driving force behind migratory movements is poverty, in addition to the lack of livelihood opportunities in rural areas. Migrant workers who are away from home for extended periods of time are more likely to engage in casual, unprotected sex, thus increasing their risk of exposure to HIV transmission.

Figure 1: Map of Zambia (Source: *www.googlemaps.com*)

1.2.2. Climate and Vegetation

Zambia has three distinct seasons. These are the hot, dry season which runs from August to October with temperatures ranging form 27 degrees to 33 degrees Celsius; the warm wet season runs from November to April with temperatures relatively lower ranging from

20 degrees to 27 degrees Celsius; and the cool dry season which runs from May to July with temperatures ranging from 10 degrees to 20 degrees Celsius.

The country has three types of rainfall namely relief, convectional and convergence. The rainfall pattern over the country is similar throughout the country, but the northern parts of the country receive much high annual rainfall. The average annual rainfall ranges from 700 millimeters to 1500 millimeters.

The predominant type of vegetation is the savannah woodlands and grasslands which covers the largest parts of the country. The savannah woodlands and grasslands are interspaced with lakes, rivers, falls, swamps and lush plains. The main lakes include Tanganyika, Mweru, Bangweulu, Kariba and Mweru Wa Ntipa. The major rivers include Zambezi, Kafue, Luapula, and Chambeshi. The most stunning feature is the Victoria Falls, on the southern border shared with Zimbabwe, and is one of the natural wonders of the world.

From the above mentioned major lakes and rivers, Northern Province occupies three lakes and one river; and thus has four major fisheries and two game reserves. Female traders coming from towns to buy grains, fish, game meat and potatoes offer sex in order to obtain these commodities at lower prices, especially when demand is greater than supply and prices shoot up. Traders in the fisheries areas exchange sex for fish and this makes these areas highly vulnerable to HIV and AIDS.

1.2.3. Demographic Characteristics and Distribution

The country's population growth rate of 3.2 percent is among the highest in Africa. According to a report posted on the website by Zambia Press, Media, Television, Radio and Newspaper forum (2007), the population of Zambia as of 2005 stood at approximately 11.7 million.

About 62 percent of the population resides in rural areas while 38 percent are in urban areas. Most of the population is concentrated along the line of rail, that is, from Livingstone in the Southern province through up to Chililabombwe in the Copperbelt province. The country has a relatively young population with about 45 percent aged between 0 and 14 years.

The United States of America State Department website (2008) reported that the literacy levels in Zambia for men and women stood at 60.6 percent and 81.6 percent respectively. The report further said that the infant mortality rate for Zambia was at 95 per 1000 births. Life expectancy was estimated to be at 37.6 years. In Zambia, HIV and AIDS is erasing decades of progress made in improving mortality conditions and extending life expectancies. The reduction in the life expectancy has been attributed to the high prevalence of the HIV and AIDS which by last year stood at 17 percent and by mid 2008 it reduced to 14.7 percent (Ministry of Health, 2008).

Demographic projections of the impact of HIV and AIDS on population structures reveal dramatic changes in the size, age and sex compositions. Not only will the total population

be reduced, but the projected age and sex structure will change, resulting in a population dominated by the elderly and the youth.

The languages spoken in the country include English (U.K) as the national official language, Bemba, Nyanja, Tonga, Lozi, Kaonde, Lunda, Luvale and 66 others. The religions present in Zambia include Christianity, Indigenous beliefs, Islam and Hinduism.

1.2.4. Political and Economic Background

Zambia before independence was under the British rule from 1924 to 1964 and during this period it was called Northern Rhodesia. Zambia gained its independence on 24th October 1964 under Kenneth Kaunda as its first Republican President.

Since independence, Zambia has passed through three distinct political phases called republics. The first and second republics were generally characterized by a centrally managed and subsidized economy. In the agricultural sector, which is the main livelihood strategy in Northern Province, inputs such as maize seed and fertilizer were heavily subsidized and uniformly priced throughout the country. This, coupled with subsidized and guaranteed produce marketing, encouraged widespread maize cultivation in the province, inline with the government policy of food self-sufficiency. In the early 1970s, institutional reforms established provincial cooperative unions that replaced and strengthened the role of the then National Agricultural Marketing Board (NAMBOARD) in carrying out subsidized input and output marketing. The era following this saw tremendous progress regarding the contribution of the small-scale farming sector to the

rural economy. According to Howard and others (1993), the area under maize increased by 70 percent between 1983 and 1991, and the proportion of land planted with maize was around 57 percent to 70 percent. Several authors (Bangwe and others, 1996) point out that this historical increase in maize performance was achieved at a high cost to the economy owing to marketing and distribution subsidies. By 1991, the maize subsidy was costing the government 90 million pounds (Foster, 1993). This contributed to the government's fiscal and budgetary problems in the late 1980s, and efforts to liberalize the economy gradually started to be made, marking the start of the Structural Adjustment Programme (SAP). Attempts to liberalize the economy fully were, however, half-hearted and marked by inertia that led to acrimonious relations between populist politicians on one hand and reform-minded politicians, the International Monetary Fund (IMF) and the World Bank on the additional (Bangwe and others, 1996). The Movement for Multiparty Democracy (MMD) government in the third republic accelerated the pace of economic reforms with its policy document of 1992, which outlined the strategies of market liberalization, the removal of input and food subsidies, crop diversification and service provision for smallholders, and the expansion of opportunities for outlying regions. Government was to play a regulatory and facilitating role in these changes (GRZ, 1992).

One of the expected results of agricultural market liberalization was the realignment to crop production by comparative advantage. This means that areas that are not suitable for maize production would witness reduced production levels (Chuzu, 1993). A lack of subsidized inputs in Northern Province has encouraged farmers to revert to the cultivation of traditional staples *(cassava and finger millet)* under the slash-and-burn system of

cultivation *(chitemene)*. The demise of the Northern Cooperative Union (NCU) in the province has meant that farmers no longer have guaranteed markets for their produce. The private sector has taken over the marketing functions of quasi-government organizations in only the most accessible areas of the country, and the transaction costs in remote areas such as those of Northern Province are prohibitive. Under this scenario, farmers are increasingly relying on barter for marketing their produce. In spite of this, agricultural development has the potential to enhance Zambia's economic performance and reduce poverty. This is very important because the majority of Zambians (more than 70 percent) depend on agriculture-related activities for their livelihoods. The agricultural sector's failure to provide secure livelihoods to the rural population is a major contributing factor to rural poverty (TNDP, 2003).

A significant proportion of the populations of Zambia most affected by HIV and AIDS depend on agriculture for their subsistence and food security. The agricultural sector therefore, has an important role to play to ensure availability and access to food, as well as to reduce rural households' vulnerability to the long-term effects of the pandemic. A successful mitigation strategy must address the diverse impacts of the HIV and AIDS pandemic ranging from illness to food insecurity. HIV and AIDS are having a dramatic impact on agricultural production and rural livelihoods. All dimensions of food security, availability, stability, access to, and utilization of food are affected, particularly where the prevalence of HIV is high. Accumulated evidence has demonstrated the impact of HIV and AIDS on agriculture, rural development, nutrition, food security and rural poverty.

Therefore, there is a need to recognize and integrate the expertise and knowledge of the food security and agricultural sectors into the mainstream AIDS discourse and response, not only to assist in addressing the impacts of HIV and AIDS on the lives of people, but also to contribute towards the prevention of further transmission and future AIDS-related impacts.

1.2.5. Poverty Levels

Poverty in Zambia, as elsewhere, is multidimensional and caused by complex factors. Rural poverty is largely attributed to poorly functioning markets for agricultural outputs and low agricultural productivity owing to a reliance on very basic implements combined with low utilization of agricultural inputs, and more recently with the presence of HIV and AIDS. The majority of the rural and urban poor earn their livelihoods from small-scale agriculture and a variety of informal income-generating activities, which tend to be short-term, seasonal and poorly rewarding. This phenomenon has generally resulted in severe food insecurity and the attendant high levels of malnutrition among both children and adults (PRSP, 2002).

Poverty continues to be an endemic problem. According to the Living Conditions Monitoring Survey (LCMS, 1998), 78 percent of the population in Zambia is classified as living in poverty. Furthermore, poverty is more prevalent in rural areas (where it affects 78 percent of the population than urban ones of 53 percent). Poverty has existed in Zambia, but it is clear that disease, including HIV and AIDS, have exacerbated it by

contributing to decreased agricultural productivity and increased household food insecurity.

High levels of poverty directly or indirectly promote behaviors which create vulnerability to HIV and AIDS. In turn, the consequences of HIV and AIDS can lead to poverty resulting in a complex and mutually re-enforcing interrelationship between HIV and AIDS and poverty. As a result, preventable and treatable diseases have taken an enormous toll on the poorest people in Zambia who do not have access to professional care, health information, education, and secure employment.

HIV and AIDS prevalence, in both urban and rural areas of Zambia, is generally attributed to high poverty levels and factors related to mobility, culture and tradition. High poverty levels increase the likelihood of survival sex to secure access to food and income, as well as commercial sex. For example, young girls increasingly resort to survival sex in order to obtain cash for clothes, school fees and hair dos. In addition, poverty-linked malnutrition contributes to an earlier onset of AIDS and increases the likelihood of opportunistic infection. Following the removal of the regulated market system, and owing to the low levels of financial capital in the communities, households rely heavily on bartering with traders. This often involves sexual favors during negotiations. The Ministry of Health (2000) report on HIV and AIDS mentioned that road constructors and truck drivers give young girls and women small sums of money in exchange for sex. Other factors include cultural and traditional practices such as sexual

cleansing, wife inheritance, multiple sex partners, the low use of condoms and excessive beer drinking.

The CSO (2000) report further says poverty is perceived differently by different people. The term is limited to such definitions as lack of material well being, civil rights and nutrition. The CSO report solely uses the term poverty to mean lack of material well being. According to this report (ibid.), the countrywide poverty levels had declined from 73 percent to 68 percent from 1984 to 2004. Urban areas accounted for 53 percent while rural areas accounted for 78 percent. Table 1 presents statistics on the poverty situation in Zambia.

Indicator	**Indicator**	**1996**	**1998**	**2002**
National incidence	%	78.0	73.0	67.0
Incidence of Extreme Poverty	%	66.0	58.0	46.0
Rural Poverty (% of Rural Population)	%	89.0	83.0	72.0
Urban Poor (% of Urban Population)	%	60.0	56.0	28.0
Income Distribution	_	0.61	0.66	0.57

Table 1: Poverty Situation in Zambia, 1996 – 2002. ***(Source: Ministry of Finance and National Planning, Economic Report, 2004)***

Zambia's PRSP has incorporated the fight against HIV and AIDS, which is a critical intervention against poverty (PRSP, 2002).

1.2.6. Background to the HIV and AIDS Policy in Zambia

According to the Ministry of Health (1990), Zambia's first HIV and AIDS case was reported in 1984. Within two years of the first report of HIV and AIDS in the country, the

National AIDS Surveillance Committee (NASC) and National AIDS Prevention and Control Programme (NAPCP) were established to coordinate the HIV and AIDS.

In the early 1990s, the World Health Organization (WHO, 1992) estimated that as many as 1 in 5 adults had been infected with HIV and this resulted in the formation of the National AIDS Advisory Council in Zambia (NAACZ). At this time it was noticed that the government did not favour the idea of spending much money from the budget in combating the AIDS pandemic in the country. According to Stephen Lewis (2005), he reports that throughout the 1990s the government of Zambia was disavowing the reality of HIV and AIDS and doing nothing to combat the problem. In 1999, the Post newspaper wrote in the editorial:

> We feel there has been a very poor approach to the HIV/AIDS problem by our government especially cabinet ministers, including President Chiluba. A look at what our government has allocated to the HIV/AIDS fight in this year's budget clearly reveals this irresponsibility (The Post 1999:16).

The new millennium signaled a marked change in political attitude and an entirely new level of determination to confront the epidemic. The National HIV/AIDS/STD/TB Council (NAC) became operational in 2002 by an act of Parliament. The NAC became the single, high-level institution responsible for coordinating the actions of all segments of government and civil society in the fight against HIV and AIDS.

In 2004, President Levy Patrick Mwanawasa declared HIV and AIDS a national emergency and promised to provide free antiretroviral drugs (ARVs) in all government

institutions. During his seven year period as Republican President, he provided high political will and commitment to combating the HIV and AIDS in Zambia.

1.2.7. The Prevalence and Impact of HIV and AIDS in Zambia

The Ministry of Health (2007) reported that Zambia is experiencing a generalized HIV and AIDS epidemic, with national prevalence rate of 17 percent among adult ages of 15 to 49. The report further states that the primary modes of transmission are through heterosexual sex and mother-to-child transmission.

HIV prevalence varies considerably within the country. Infection rates are high in cities and towns along the major transportation routes and lower in rural areas with low population density. The most affected are young women and girls. The United Nations programme against HIV and AIDS (UNAIDS, 2006) report estimates that 15 percent people aged 15 to 49 years old were living with HIV or AIDS. Of these million adults, 57 percent were women. These statistics clearly show that HIV and AIDS has worst hit those in their most productive years and this has resulted in disintegration of most families and many children left in destitution.

The impact of HIV and AIDS has gone beyond the household and community levels. According to the International Monetary Fund (IMF, 2003), Zambia's PRSP acknowledges that the epidemic is likely to affect economic growth and development in the country. The Zambia Business Coalition (ZBC, 2007) reports that 82 percent of

known causes of employee deaths are HIV related and 17 percent of staff recruited are to replace people who have died or left because of HIV related infections.

HIV and AIDS have had a dramatic impact on agricultural production and rural livelihoods. The Food and Agricultural Organization (FAO, 2003) reports that all dimensions of food security, that is, availability, stability, access to, and utilization of food are affected, particularly where the prevalence of HIV is high. A successful mitigation strategy must address the diverse impacts of the HIV and AIDS epidemic ranging from illness to food security.

Children have been much affected by the AIDS pandemic in Zambia. The UNAIDS (2007) reported that in 2007, there were 600 000 AIDS orphans in the country. Thousands of these children are abandoned due to stigma or to simple lack of resources, while others run away because they have been mistreated and abused by foster families.

The HIV and AIDS pandemic has also greatly contributed to the breakdown in informal institutions and culture. Informal institutions, customary practices and tradition are affected by HIV and AIDS. When a high proportion of households are affected, the traditional safety mechanisms to care for orphans, the elderly, the infirm and the destitute are overwhelmed. People have no time to devote to community organizations. The effects on informal rural institutions are creating a crisis, particularly among the extended family and kinship systems. This has implications not only for the spread of HIV but for the viability of rural institutions. The widespread loss of active adults affects the entire

society's ability to maintain and reproduce itself. Mechanisms for transferring knowledge, values and beliefs from one generation to the next are disrupted, and social organization is undermined. This has resulted in the emergency of numerous children roaming the streets in major cities and mushrooming of orphanages.

HIV and AIDS have taken a heavy toll on the poor. Affected rural families commonly shift to off-farm income earning activities such as small-scale trading, processing and servicing, which requires access to urban or peri-urban communities (PRSP, 2002). People may migrate in search of employment, or may look for rapid income, which can lead to high-risk behaviours such as drug abuse or involvement in prostitution. The consequences of poverty thus increase the risk of infection, and the disease in turn exacerbates poverty.

Whole communities thus become food insecure and impoverished. For instance, in some highly affected communities, there has been an irreversible collapse of the social asset base. It may be difficult to overcome this without assistance. Yet, the pandemic has a significant effect on formal institutions and their abilities to carry out policies and programmes to assist rural households.

According to NAC (2000), institutions may suffer considerable losses in human resources when staff and their families are infected with the HIV. Care for the sick family members, attendance at funerals and observation of mourning times reduces the work output. Skilled staff is often the first to be affected by the epidemic. The disruption in

services further aggravates the difficulties in meeting the needs of an HIV and AIDS affected population.

1.3. Institutions and Organizations

The study sites are characterized by diversified levels of institutional support. The most common formal organizations operating in the sampled areas are government institutions such as the Ministry of Agriculture and Cooperatives (MACO), the Ministry of Health, the Ministry of Education and the Ministry of Community Development and Social Welfare. Other notable formal institutions are the Non-Governmental Organizations (NGOs) such as the Programme Against Malnutrition (PAM), the Agriculture Support Programme (ASP), World Vision, the Adventist Development and Relief Agency (ADRA) and the Catholic Relief Services (CRS). In addition to formal organizations, the study sites also have several informal organizations. The most prominent of these being the Church, Rural Development Committees (RDCs), Parent Teacher Associations (PTAs), Anti-AIDS clubs and cooperative societies.

Collaboration with different partners in eradicating hunger and poverty is all the more pertinent in light of the HIV and AIDS epidemic. With the objective of joining forces to develop effective strategies to mitigate the impact of HIV and AIDS on rural livelihoods and food insecurity, CRS operate countrywide to empower local communities overcome the burden of the pandemic. While important progress has been made, HIV and AIDS is a major pandemic which needs effective and coordinated responses from all sectors of

society, that is, government, private sector, non-governmental organizations and civil society. The efforts of all these organizations are needed to continue to save lives.

In this regard, CRS has risen up to the challenge and responded by employing a number of communication strategies to educate people and raise awareness in mitigating the impact of HIV and AIDS and poverty in local communities.

1.4. Institutional Profile of CRS

CRS was founded in 1943 by the Catholic Bishops of the United States of America. It serves as the official international relief and development agency of the U.S. Catholic community. CRS works through local offices and an extensive network of Partners on five continents and in 98 countries. CRS has a long history of working in the HIV and AIDS sector in Eastern and Southern Africa. Since its first HIV and AIDS project in 1989 in Uganda, CRS has supported 180 HIV and AIDS projects in 40 countries.

The fundamental motivating force in all activities of CRS is the gospel of Christ as it preaches the alleviation of human suffering, the development of people and the fostering of charity and justice in the world. In terms of policies and programs, CRS reflect and express the Social Teaching of the Catholic Church.

CRS is a faith-based organization serving persons on the basis of need, not creed, race or nationality; and it is also a development organization, indirectly implementing through its partners, who include the Catholic Church, faith-based and community-based organizations. CRS operates in this way in order to empower local communities to take

ownership of their programmes, thereby being more fully involved in influencing their future.

1.4.1. The Operations of CRS in Zambia

CRS began its operations in Zambia in 1999 as part of CRS/Zimbabwe and later in 2001 CRS/Zambia established its country office. In its early initiatives, CRS focused on food security programmes in four dioceses of Zambia. However, CRS adopted multi-sectoral and multi-faceted responses to HIV and AIDS because of the devastating effects of the disease on large populations of people especially the poor people.

The programmes of CRS/Zambia are all guided by its HIV and AIDS strategy which is aimed at mitigating the impact of HIV and AIDS. Currently CRS has partnered with all the ten Catholic dioceses and the rural mission hospital network of Churches Health Association of Zambia (CHAZ) in the implementation of its programs. This means that CRS programmes cover the nine provinces of Zambia.

1.4.2. HIV and AIDS and Poverty Reduction Projects in Zambia

In its programming, CRS provides a comprehensive continuum of services, from initial testing to nutritional support to home based and palliative care. CRS is also reaching millions of young people and adults with prevention and education programs focused on abstinence and behavioural change and are providing Anti-retroviral Therapy (ART) to thousands of HIV and AIDS patients countrywide. Other HIV and AIDS related issues

addressed by CRS include stigma in communities and workplaces. Specific projects conducted by CRS throughout Zambia are outlined below:

1.4.2.1. AIDSRelief – Antiretroviral Therapy Programme

The motto for AIDSRelief is providing treatment and restoring hope. The goal of this programme is to access proper medicine and ART to People Living with HIV and AIDS (PLWHA). The introduction and availability of ARVs has given hope to HIV and AIDS patients throughout Zambia as these drugs are provided free of charge. With proper administration of the drugs the patients are once again able to provide for themselves and their immediate families.

Apart from making medicine and medical care accessible to AIDS patients, AIDSRelief also supports community education programs about HIV and AIDS and the importance of adherence to medication and a balanced diet. This programme reaches both the rural and urban communities throughout Zambia.

1.4.2.2. SUCCESS – Scaling Up Community Care to Enhance Social Safety nets

The SUCCESS programme aims at providing quality care to chronically ill patients through home based care providers and hospices. In these home based care units and hospices spread throughout the country, CRS provides quality, sustainable palliative care to patients. In this era of AIDS palliative care has come to mean care from the time of diagnosis, through to death, or more hopefully now,

to inclusion on life prolonging ART. The Success programme also provides nutritional supplements to AIDS patients which help to improve clients' quality of life. Under the SUCCESS program, CRS trains voluntary caregivers to care for AIDS patients through home visits, washing and feeding patients and treating simple infections. CRS through its SUCCESS programme also trains psychosocial counselors who provide Voluntary Counseling and Testing (VCT) services.

The SUCCESS program mainly reaches rural communities where health services are insufficient to meet demand.

1.4.2.3. RAPIDS – Reaching HIV Affected People with Integrated Development and Support; and CHAMP-OVC – Community HIV and AIDS Mitigation Project Orphans and Vulnerable Children

In the RAPIDS programme, CRS partners with World Vision, Africare, Salvation Army, the Expanded Church Response and Care International; and adopts a multi-sectoral approach to HIV and AIDS programming.

The goal of RAPIDS and CHAMP-OVC is to improve the quality of life of orphans and vulnerable children (OVCs) through provision of educational support, child protection, paralegal services, psychosocial and spiritual support as well as nutritional support. RAPIDS also aim at improving the quality of life of PLWHA through nutritional support, medicine assistance, psychosocial support and timely referrals to health centers.

RAPIDS also train psychosocial counselors to conduct VCT services in its sites. RAPIDS implement its programmes in Lusaka and Copperbelt Provinces.

1.4.2.4. C-SAFE – Consortium for Southern Africa Food Security Emergency and; LISAR – Livelihood Initiative in Support of Agricultural Recovery

In the C-SAFE programme, CRS partners with World Vision, CARE and Adventist Development Relief Agency (ADRA).

C-SAFE and LISAR programmes aim at addressing food insecurity in areas affected by droughts and helping families affected by HIV and AIDS. The C-SAFE program trains farmers in conservation farming methods, vegetable growing and construction of grain storage structures. C-SAFE also provides seeds to farmers for winter cropping and promotes locally available, drought resistant and highly nutritious foods such as sweet potatoes, soya beans, cow peas and groundnuts.

LISAR targets impoverished rural families especially women-headed households affected by HIV and AIDS, vulnerable youth and those chronically at risk. Poverty reduction programs implemented through LISAR include provision of seed vouchers and conducting vegetable garden fairs. LISAR also conducts trainings in drought preparedness and increases capacity of local organizations to support sustainable development processes.

The brief analysis of the above CRS' poverty reduction and HIV and AIDS programmes try to show how CRS has helped mitigate the impact of HIV and AIDS by reducing food insecurity; improving the quality of HIV and AIDS health related services; improving programming for vulnerable children, orphans and youth; and increasing partners' participation in HIV and AIDS policy development.

1.5. Statement of the Problem

The biomedical framework of HIV and AIDS prevention and care has dominated from intellectual debate to operational activities. Rogers and Singhal (2003) argue that the world has underestimated the role communication can play in reducing HIV infection in developing countries, which is a social, cultural and gender related problem and not just a medical one. Today, when the HIV prevalence has reached unprecedented levels in Zambia, it is important to critically analyze the existing and available strategies that have been used in combating the HIV and AIDS pandemic. The rapid spread of the deadly virus in Zambia has been attributed to such factors as political inaction, social stigma toward HIV and AIDS, promiscuity, poor communication strategies in use and the overall lack of funds available to control the spread of the disease. With this rapid increase in the HIV prevalence rate, estimated around 14.7 percent among the adult populations in Zambia (MoH, 2007), it is said that the myopic view of the HIV and AIDS pandemic as a biomedical problem has led to non utilization of proper communication strategies by various stakeholders in combating the spread of the disease. It is for this reason that the researcher has looked into the effectiveness of the communication strategies in use by CRS in mitigating the impact of the HIV and AIDS pandemic in Zambia.

The researcher has then highlighted the importance of using communication strategies that influence government policy and gender relations and harness the positive aspects of local culture. Communication is said to have the capacity to change attitudes, values and behaviour; and thus communication has been identified as a crucial tool in the fight against HIV and AIDS (NAC, 2005). The challenge is to identify communication needs in mitigating the impact of HIV and AIDS and poverty in Zambia.

1.6. Rationale

Because there is no vaccine or cure for HIV and AIDS, information is crucial for preventing the spread of the virus. Through widespread information about HIV and AIDS, people can gain the knowledge needed to change their behavioural response to the AIDS pandemic

Communication has been identified as a crucial tool in the fight against HIV and AIDS. Without proper communication, people will not know what to do to avoid catching the deadly virus, they will not know what to do once they have HIV and AIDS and they will not know what to do to their loved ones who have HIV and AIDS. Therefore, awareness and sensitization programmes have been identified as key in the prevention, treatment and control of HIV and AIDS.

The HIV and AIDS pandemic continue to have a heavy toll on the productive population of our country; and the disease has exacerbated the poverty levels in the country especially among rural communities. In this context, the research has emphasized the

important role communication plays in changing people's attitudes, beliefs, values and behaviour. The study highlights the fact that underestimating the role of communication in the battle against HIV and AIDS has undermined prevention programmes and will continue to undermine awareness campaigns.

Therefore, with its heavy involvement in HIV and AIDS and poverty reduction programmes, CRS is well positioned to influence change in attitudes, beliefs, values and behaviours of the Zambian people. It is for this reason that the research has tried to evaluate the organization's communication strategies in use.

1.7. Research Objectives

In this research, the researcher hoped to achieve the following objectives:

i. To evaluate CRS' communication strategies in use in mitigating the impact of HIV and AIDS and poverty in Zambia.

ii. To establish the extent to which CRS is contributing towards disease and poverty mitigation in Zambia.

iii. To determine the extent to which the local people are involved in CRS' HIV and AIDS and poverty reduction programmes.

iv. To assess the rate of adoption of social change campaigns pertaining to HIV and AIDS and poverty reduction programmes.

v. To assess the impact of CRS' HIV and AIDS and poverty reduction programmes on the beneficiaries.

1.8. Research Questions

i. Do the existing communication strategies of CRS affect the target population in bringing about change in attitudes, values and behaviours that put people at risk of contracting HIV?

ii. What communication strategies used by CRS in its HIV and AIDS and poverty reduction programmes is preferred by its target population?

iii. What is the people's source of information on HIV and AIDS and poverty mitigation especially in areas where CRS is running its programmes?

iv. Has CRS' programmes had any impact in reducing the HIV prevalence rate and uplift the target population's standard of living?

v. To what extent has CRS involved the local target population in designing and implementation of its HIV and AIDS and poverty reduction programmes?

vi. How and to what extent does CRS integrate the interests of its target population in designing messages on HIV and AIDS and poverty mitigation?

vii. What has been the response of the local target population to CRS' HIV and AIDS and poverty mitigation programmes?

CHAPTER II

2.0. METHODOLOGY

This study is an exploratory survey aimed at positioning communication as key to addressing development concerns such as HIV and AIDS and poverty in this country.

2.1. Research Design and Method

2.1.1. Qualitative and Participatory Research Methods

The psychosocial, contextual and behavioral dimensions of HIV and AIDS are better suited to qualitative methods that capture values, attitudes and beliefs, than to quantitative tools. Qualitative methods are highly useful in exploring motivations and underlying factors supporting discriminatory behaviors. At the onset of the study, participatory techniques (such as transect walks, community mapping, listing of health problems and timelines) were conducted in each of the communities to build rapport and gain insight into the general community layout and structure. The use of multiple methodologies to acquire data ensured triangulation and validation of the findings. The researcher has employed both the qualitative and the quantitative research methods. Realizing that the nature of the study requires several methods to be used to gather data, the researcher has triangulated in order to achieve objective results. Thus, the researcher has used the following qualitative methods:

2.1.1.1. Focus Group Discussion (FGD)

The method has been used to collect qualitative information that has revealed the perceptions, views, feelings, beliefs, emotions and attitudes of the respondents about the communication strategies of CRS and their impact on target communities. The researcher conducted 4 FGDs with four groups, where each group consisted of ten members of the target communities. These were chosen on the basis of being knowledgeable and representative of target population. The researcher conducted two FGDs in a rural setup which is Kasama site of CRS and the other one was conducted in an urban setup which is Lusaka. The researcher arranged the venue and set the date; and during the discussions all participants were encouraged to participate through expert moderation.

2.1.1.2. In-depth Interviews

The researcher conducted 4 in-depth interviews. Two interviews were done with CRS staff and two with members of the target population or communities. These people were chosen on grounds that they were knowledgeable about the HIV and AIDS and poverty reduction programs of CRS and that they were representative of the target population. The format of these interviews was semi-structured in form of a question guide to elicit responses. The researcher set the venues and times for conducting of these meetings and did the moderation. The researcher analyzed data and made summaries to the findings.

2.1.1.3. Participant Observation

The researcher gathered primary data through participant observation. Participant observation availed the researcher chance to actively participate in CRS' activities in Kasama. This also enabled the researcher to assess and make observations regarding the communication methods at play within the organization. The researcher took intensive notes which were later analyzed and summarized.

2.1.2. Quantitative Survey Methods

This was done by way of administering 100 questionnaires to a sample that was carefully selected from the target population that was well defined. There were questionnaires for the staff at CRS and for the public in target populations. The use of questionnaires has helped in obtaining numerical and statistical information that has allowed direct comparisons between CRS' communication strategies in use and their impact on target population's awareness about CRS' HIV and AIDS and poverty mitigation programmes. The same method also helped to measure change in attitudes, values and behaviour toward awareness about HIV and AIDS and food security.

2.1.2.1. Purposive Sampling

In this study, the researcher picked Kasama as a rural setup and Lusaka as the urban setup. Both of these places have CRS' HIV and AIDS and poverty reduction programmes which are still running. This also helped to make a comparative analysis of these programmes in two distinct environments.

2.1.2.2. Quota Sampling

The researcher first carried out a stratified sampling where the strata were identified in the target population and this was followed by conducting a convenience sampling. The researcher employed non-probability sampling methods because of limited resources.

2.1.3. Data Collection, Analysis and Ethical Consideration

The data for this study was collected between October 2008 and June 2009 by the researcher using the questionnaires designed by the researcher. A six-point scale, Likert type questions was used in the questionnaire to be administered to the staff at CRS and target communities. Data analysis was done at the University of Zambia (UNZA) using the Statistical Package for Social Sciences (SPSS). Descriptive statistics such as frequencies, percentages, means, bar charts and pie charts have been used to interpret data.

The researcher gave considerable thought to the selection of research tools to ensure confidentiality, privacy and personal safety of both participants and researcher while studying this highly sensitive issue. The researcher tested the research tools to ensure that they were applied flexibly and were appropriate for the issue and setting. Maintaining confidentiality and anonymity of study participants was another key component of the research process. Prior to each interview, informed consent was obtained from the participants.

2.1.4. Summary of Data Methods and Samples for Community-Based Studies

Study sites
Rural: Kasama district in Northern Province
Urban: Lusaka district in Lusaka Province

Comparative Community-Based Studies	
Participatory Research Activities	2
Key Informant Interviews	4
Focus Group Discussions	4
In-depth Interviews	4
Audience Survey	100

Table 2: Summary of data methods

2.1.5. Limitations of the Study

The researcher encountered many limitations to the success of this study, but two were outstanding and these are:

- Difficulties in arranging and organizing FGDs and in-depth interviews in Lusaka as most of the targeted respondents had busy schedules.
- The available monetary resources did not permit extensive investigations since the researcher totally depended on his personal financial resources.

CHAPTER III

3.0. CONCEPTUAL AND THEORETICAL FRAMEWORK

In this chapter, the researcher looks at the conceptual and theoretical framework in which various definitions of concepts pertaining to the study are presented; and equally the chapter presents various theories and how they apply to the study.

3.1. Conceptual and Operational Definitions

3.1.1. Participatory Communication

White (1994) defines participatory communication as a type of communication in which all the interlocutors are free and have equal access to the means to express their point of view, feelings and emotions.

In this study, participatory communication is operationalised to measure the extent to which members of the target communities can access CRS' HIV and AIDS and poverty reduction programmes. The concept further helps measure the people's involvement in the origination of programmes on HIV and AIDS and poverty reduction.

3.1.2. Participatory Communication for Development

This concept is similar in nature to participatory communication. Participatory development communication refers to the use of various forms of communication such as

mass media, interpersonal, group and traditional means to empower communities reach their potential and discover solutions to their particular developmental problems.

Uphoff (1985) identifies four different ways of participation that have been observed in most development projects claiming to be participatory in nature:

- Participation in implementation: People are actively encouraged and mobilized to take part in the actualization of projects. They are given certain responsibilities and set certain tasks or required to contribute specified resources.
- Participation in evaluation: Upon completion of a project, people are invited to critique the success or failure of it.
- Participation in benefit: People take part in enjoying the fruits of a project, this may be water from a borehole, medical care from a newly built health post, a new van to transport produce to the market, or village meetings in the new community hall.
- Participation in decision-making: People initiate, discuss, conceptualize and plan activities they will all do as a community. Some of this may be related to more common development areas such as building schools, clinics or building a bridge. Others may be more political such as removing corrupt officials or supporting a parliamentary candidate; and yet others may be cultural or religious such as organizing a traditional ceremony or prayers for an end to the drought.

From the above analysis of the various forms of participation in development, participation in decision-making is the most important form to promote. The reason being that it gives people control of their lives and environment. At the same time the people acquire problem solving skills and acquire full ownership of projects which are the two important elements for ensuring sustainable development in their community. The other three, participation in implementation, evaluation and benefit, are believed to be manipulative and only offer pseudo-participation where people are forced to accept plans made by other more powerful people (White, 1994).

In this research, these concepts have been operationalised to measure the level of participation by members of target communities in CRS' HIV and AIDS and poverty mitigation programmes.

3.1.3. Development

According to Agunga (1997) development means empowering people to make their own choices, and it is therefore, a communication process. Kasoma (1994) defines development as the improvement of human life condition at individual and societal levels which is achieved through desirable but fluctuating changes or adjustment in the environment. In the light of the devastating effects of HIV and AIDS and poverty in Zambia, these are major concerns that hinder full realization of human life and consequently they have presented a huge threat to social development and economic growth. Therefore, with regard to this study, an NGO that offer services to mitigate the

impact of the scourge of this magnitude needs to consider the centrality of communication in the realization of its intended goals.

3.1.4. Communication

Communication is a process of sending information from one source or one entity to another either through verbal means, writings, images or symbols in order to solicit for the receiver's thoughts, response or actions. Infante, *et. al.,* (1997) says communication occurs when humans manipulate symbols to stimulate meaning in other humans. Svenning (1969) communication is the key that opens the door to change; and Fraser and Villet (1994) add that communication is the key to human development. Bessette (2004) contends that communication is key to involving the community. In this study, communication has been identified as key in the success of the HIV and AIDS prevention and awareness campaigns. This study also attempted to explain how communication can help bring about people participation, and thus help make poverty reduction projects work more successfully.

3.1.5. Communication Strategy

Mefalopulos and Kamlongera (2004) define a communication strategy as a well-planned series of actions aimed at achieving certain objectives or change through the use of communication methods, techniques and approaches. In this study, the researcher endeavored to evaluate whether the communication strategies in use by CRS have achieved the intended objectives or not.

3.1.6. Target Population or Community

This refers to a specified audience or demographic group in an already defined geographical area for which CRS' HIV and AIDS and poverty reduction message is designed. In this study, it has referred to the recipients of CRS' services in Kasama and Lusaka.

3.2. Theories Applicable to the Study

3.2.1. Interpersonal Communication Theory

This theory refers to an interaction process between people either one to one or through mediated forms and feedback is immediate. In the case of CRS, this kind of communication occurs when trained caregivers visit HIV and AIDS patients and offer encouragement; as well as when CRS field staff holds meetings, workshops or discussions with stakeholders at various sites spread throughout the country. The typical example is application of the *social penetration theory* in the administration of ARVs and in conducting counseling sessions. The *social penetration theory* states that as relationships develop, communication moves from relatively shallow, non-intimate levels to deeper, more personal ones (Altman and Taylor, 1979). CRS trains psychosocial counselors and caregivers who help clients to reach a level where they can even disclose their inner selves or details of their life to the counselor. In this study, interpersonal communication has been operationalised to relate to the numerous relationships that exist between counselors and clients, caregivers and AIDS patients, and care supporters and caregivers.

3.2.2. Small Group Communication Theories

3.2.2.1. Functional Perspective

The functional perspective claims that there are four functions for effective decision which include an analysis of the problem, goal setting, identification of alternatives, and an evaluation of positive and negative characteristics (Hirokawa and Gouran, 1983). This is more applicable in small groups such as CRS' sites and diocesan offices especially during their routine meetings.

3.2.2.2. Dramatism

Dramatism says that the communicator must act as if he or she were an actor in a drama, where they are trying to get the audience to accept their view of reality as true. The communicator must try to identify with the audience through various means to gain acceptance (Burke, 1968). In dissemination of HIV and AIDS related messages there is need to identify with the group in order to reduce stigma.

3.2.3. Social Change Campaign Theory

According to McGuire (1989) social change campaign is a deliberate effort by one group, referred to as the change agent, who designs a program that is intended to persuade other people to accept, modify attitudes, practices and behaviour. Any effective social change campaign always takes into consideration local knowledge, that is, local techniques and practices already developed in those communities where a new programme is to be introduced. According to this study, CRS is the change agent who designs their HIV and

AIDS and poverty reduction programmes in order to bring about change and enhance people's livelihoods. Moreover, CRS as the change agent through its advocacy policy lobbies policymakers, especially government, and other stakeholders to prioritize poverty reduction programs by increasing funding to social sectors such as education and health.

3.2.4. Social Marketing Theory

Social marketing is the systematic application of marketing along with other concepts and techniques to achieve specific behavioral goals for a social good. Social marketing can be applied to promote, for example, merit goods, make the society avoid demerit goods and thus to promote what considers society's well being as a whole. This may include asking people not to smoke in public areas, for example, ask them to use seat belts, or prompting to make them follow speed limits.

Kotler and Roberto (1989) in their book entitled *"Social Marketing: Strategies for Changing Public Behaviour,"* characterizes social marketing as a social change management technology. According to Kotler and Roberto (ibid.) this involves the design, implementation and control of programmes aimed at increasing the acceptability of a social idea or practice in one or more groups of target adopters.

The primary aim of 'social marketing' is 'social good', while in 'commercial marketing' the aim is primarily 'financial'. This does not mean that commercial marketers can not contribute to achievement of social good. In this study, the theory has been applied in

designing prevention and awareness messages in combating the spread of HIV and AIDS and equally in mitigating the devastating effects of rural poverty.

3.2.5. Health Behaviour Theories

There are many health behaviour theories (HBTs) arising from the field of communications that have been designed to investigate the relationship between health information or communication and behavioural change (Noar and Zimmerman, 2005). HBTs can be divided into categories including explanatory theories and change theories.

Explanatory theories are those theories that address why a certain problem exists, and investigates the underlying variables that contribute to the problem (National Cancer Institute, 2005). Examples of explanatory behavioural change theories include the *Health Belief Model*, the *Theory of Planned Behaviour*, and the *Precaution Adoption Process Model.*

Change theories advance the development of health interventions by identifying important concepts that can be incorporated into information and communication messages and strategies (e.g., IEC). Change theories also provide a framework for evaluation of interventions. A benefit of change theories is that they inherently require an identification and analysis of assumptions prior to the design and implementation of any intervention programmes. *Diffusion of Innovations* and *Community Organization* are two examples of change theories.

HBTs can also be grouped according to their characteristics. Message-based theories are those that investigate how individuals or audiences respond to messages. Fear based models, for example, are designed to elicit change through invoking fear responses. Belief-based theories are those that examine the sets of beliefs and perceptions of individuals about health. If an individual perceives that changing their behaviour will result in an improvement in health, then they are more likely to make that change. Intervention-based theories focus on behavioural change by way of prevention. Information campaigns based on behavioural change theories advance the understanding of the ways in which the information changes the individuals who are exposed to the prevention messages.

The HIV and AIDS prevention messages designed by CRS also employ a lot of HBTs in changing the target population's attitudes and behaviour.

3.4. Media Theories

3.4.1. Agenda-Setting Theory

Agenda-setting describes a very powerful influence of the media, the ability to tell us what issues are important. The theory was advanced by Maxwell McCombs and Donald Shaw in 1972. The theory states that when the audience has been exposed to media agenda for a sufficiently long period of time, they get to internalize that agenda so that they get to prioritize the media issues. The theory claims that there is a relationship between the way the mass media treats events or issues and the opinions that mass

audiences develop about these issues or events. Dearing and Rogers (1996) observe that the media set the public agenda which in turn sets the policymakers' agenda.

Gilliam and Bales (2004) observe that public pinion research over the years confirms that news media constitute the main source of many people's information about public affairs. To this effect, Gilliam and Bales (ibid.) write:

> The real world is increasingly viewed through the lens of the news media. As issues rise and fall on the media agenda, so does their potential for attracting the attention of the public and policymakers. The ability of the news media to set the public agenda determines to a larger extent what issues policymakers will feel compelled to address. Indeed, media are often read by policymakers as proxy for public opinion (ibid. p.4).

The media is capable of creating a particular image about issues that the public should be paying attention to. Bernard Cohen observed that even though the media may not be successful most of the time in telling people what to think, but it is successful in telling people what to think about (McQuail, 2005).

Agenda-setting theory is very relevant in policy change campaigns. It is a useful technique that is able to direct and influence policymakers in adopting particular policy alternatives. This theory can also be used to strengthen advocacy efforts by NGOs to support a particular course of action or policy recommendation. Agenda-setting can as well contribute to alliance building and raising awareness around a particular issue. For example HIV and AIDS and poverty reduction awareness campaigns have used this theory to make policymakers respond to devastating effects of these problems.

3.4.2. Cultivation Theory

This theory was developed by George Gabner. The theory states that heavy viewers of Television (TV) tend to have perceptions of reality influenced by the programs they view. The combined effect of massive television exposure by viewers over time subtly shapes the perception of social reality for individuals and, ultimately, for our culture as a whole. Gabner argues that mass media cultivate attitudes and values which are already present in a culture.

Rogers and Singhal (2003) contend that entertainment-education programmes can effectively promote HIV and AIDS prevention behaviour. The examples given are soap operas that if a person keeps listening or watching a soap opera, they start to identify with certain characters in an entertaining way that is not preachy or didactic. The important thing is when the show is over, people continue to gossip about the characters and the message continues. Gossip is important in stimulating action.

This theory is very applicable when radio and television are used in public health campaigns especially dissemination of HIV and AIDS related messages. Rogers and Singhal (ibid.) qualify this with an example of how HIV infections were reduced and contained in Thailand. The number of new HIV infections cases in Thailand dropped from 143,000 in 1991 to 29,000 in 2000 due, in part, to a 48 million dollars education and public health campaign; the Thai President, Mechai Viravaidya, at that time, required the nation's 488 radio stations and 15 TV stations to air HIV and AIDS prevention messages

every hour. This strategy, combined with others, helped Thailand become the first developing country to successfully control HIV and AIDS.

In addition to HIV and AIDS prevention, Rogers says this communication strategy can be applied to combat other social problems such as poverty, illiteracy and environmental issues.

The two media theories, agenda-setting and cultivation, are not mutually exclusive in practice, they can be employed in the same communication campaigns for different purposes and with varying degrees of emphasis. Both theories apply to this study.

3.4.3. Multi-Step Flow Theory

According to Consumer Innovations (2004), the Multi-step Media Flow of communications show how consumers pass on information about innovations to other consumers within social networks. Apart from this, the multi-step theory describes the theory of *diffusion of innovations* which looks at the conditions that increase or decrease the likelihood that a new idea, product or practice will be adopted by members of a given culture or society (Rogers, 1983).

The theory is called multi-step because the communication process between the media and the point of decision making by the target population passes through many hands. Therefore, in rural communities where people live in clusters, the role of opinion leaders is very important since these are very close to the people and hence have a lot in

common. In implementation of its HIV and AIDS and poverty reduction programs, CRS engages partners who now reach out to various communities in their area. Thus, the partners help in diffusing information that can help to mitigate disease and poverty.

CHAPTER IV

4.0. LITERATURE REVIEW

This chapter has examined existing literature on the global dimensions of the HIV and AIDS pandemic and the communication strategies that have been used and those that are still in use as interventions in mitigating the impact of HIV and AIDS around the World, Africa and particularly in Zambia

Literature from around the world attests to the fact that underestimating the role of communication in the battle against HIV and AIDS has undermined prevention programmes and will continue to undermine awareness campaigns. Indeed, Singhal and Rogers (2003) have argued that it is a serious mistake to underestimate the role of communication when 14 thousand individuals become HIV positive daily, an alarming rate that underscores the failure of current prevention programmes and the burden of unaffordable pricing of HIV and AIDS medications. Hence, in their study, Singhal and Rogers (ibid) have highlighted the important role communication strategies such as, prevention programmes, play in educating people in developed and developing countries.

According to a study done by WHO/UNAIDS (2005) it is estimated that some 40 million people worldwide are infected with the HIV virus, 95 percent of whom live in developing countries. The number of people estimated to have been living with the virus by region in 1999 is shown in Table 3. Tragically, the prevalence of the disease is still increasing. Since the disease commonly strikes the most economically productive members of

society, HIV and AIDS is a problem of critical importance for agricultural, economic and social development. As illustrated in Figure 2, HIV and AIDS is a truly global epidemic. India with over four million people infected has the largest population of people living with HIV, but regionally the magnitude of the epidemic is greatest in sub-Saharan Africa where more than 24 million people are infected with the virus.

Africa is the world's second largest continent, encompassing about 22 percent of the total land area in the world, nearly 12 million square miles (*Figure 3*). The Sub-Saharan region covers the entire continent with the exception of the northernmost countries of Algeria, Egypt, Libya, Morocco, Tunisia, Western Sahara and, arguably, Mauritania (The Canadian International Development Agency, 2006). Sub-Saharan Africa is faced with numerous challenges and is characterized by high population growth, an increasing HIV and AIDS health crisis, limited financial resources, negative growth in agricultural and economic output, persistent droughts and political instability.

More recent literature (Horizons, 2007) show that HIV and AIDS is now the leading cause of death in sub-Saharan Africa and the cause of a 15 year drop in life expectancy in the region, from 62 to 47 years. New HIV infections are highest among young people, and young women have consistently been found to have higher (in some cases as much as six times as high) prevalence rates of HIV than men of the same age (UNAIDS, 2002). Brown and others (2003) reviewed 22 evaluated interventions (6 in developing countries and 16 in developed countries) that sought to improve attitudes, values, beliefs and behavior towards HIV and AIDS.

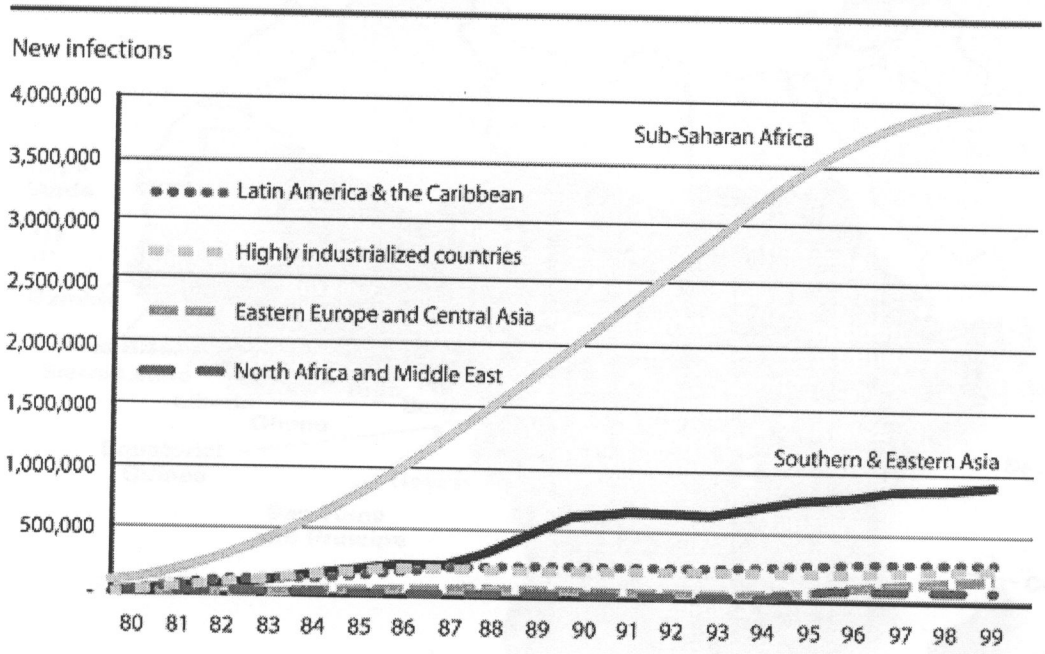

Table 3: Estimated number of people living with HIV/AIDS worldwide (1999)

Region	Number infected	Proportion of adults infected (%)
Global Total	34,300,000	1.07
Sub-Saharan Africa	24,500,000	8.57
East Asia & Pacific	530,000	0.06
Australia & New Zealand	15,000	0.13
South & South-East Asia	5,600,000	0.54
Eastern Europe & Central Asia	420,000	0.21
Western Europe	520,000	0.23
North Africa & Middle East	220,000	0.12
North America	900,000	0.58
Caribbean	360,000	2.11
Latin America	1,300,000	0.49

Figure 2: ***(Source: UNAIDS 2000)***

Figure 3: Sub-Saharan Africa (*Source: The Canadian International Development Agency, CIDA, 2006*)

The UNAIDS/WHO (2005) report indicates that approximately 95 percent of people with HIV and AIDS live in developing nations in Latin America, Africa and Asia which are now the epicenter of the AIDS epidemic. Despite the decreases in the rate of infection in some countries (attributed in part to changes in behaviour), the overall number of people living with HIV has continued to increase in all regions.

Sub-Saharan Africa has significantly greater prevalence of People Living with HIV and AIDS (PLWHA) than anywhere else in the world (UNAIDS, 2006). Although it accounts

for only 10 percent of the world's population, it has 63 percent of the PLWHA *(Figure 4)*. Seventy-two percent of the estimated 2.1 million AIDS-related deaths in 2006 were in Sub-Saharan Africa (UNAIDS/WHO, 2006). Of the 380,000 children who died in 2006 of AIDS, 87 percent (330,000) were in Sub-Saharan Africa. Although the pandemic has stabilized in the region, this means that the numbers of people who are newly affected with HIV are still roughly equivalent to the number of people who are dying from AIDS.

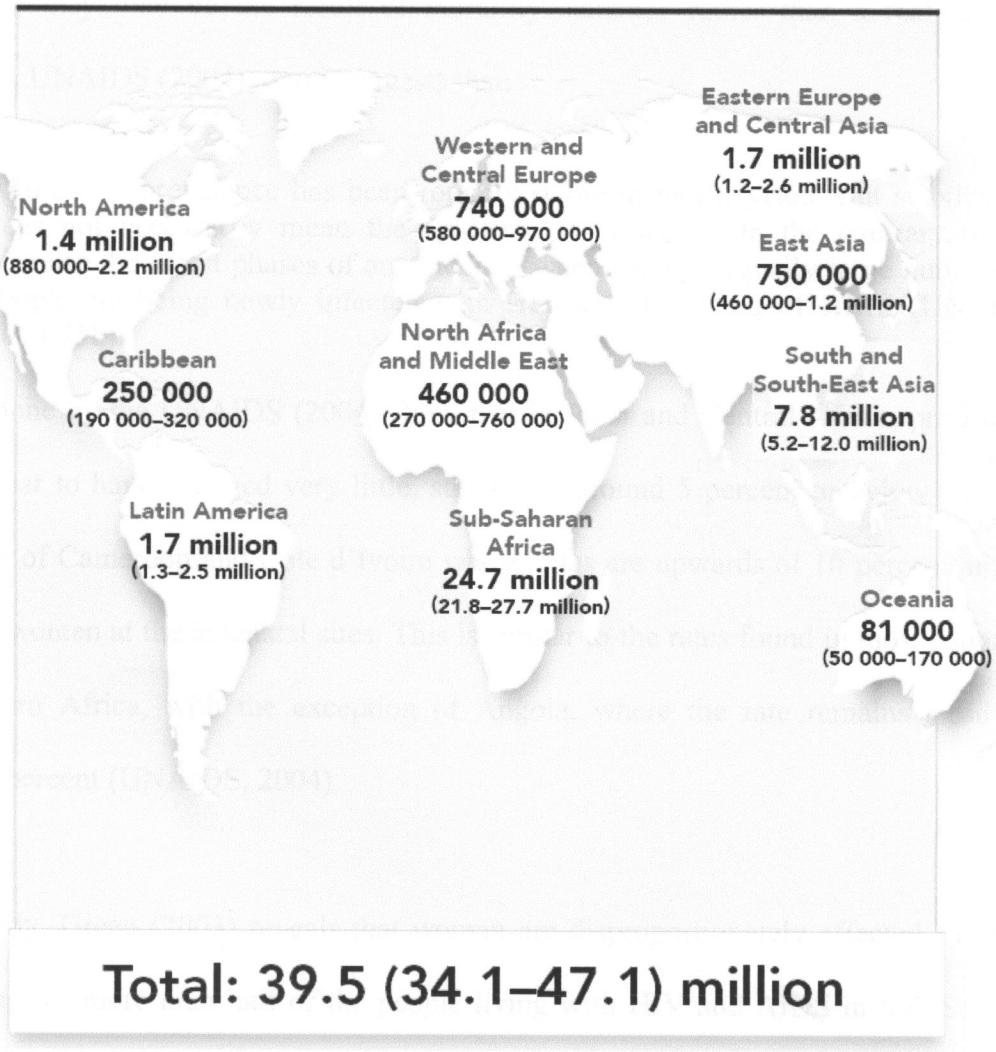

Figure 4: Adults and Children Estimated to be Living with HIV and AIDS (*Source: UNAIDS/WHO, 2006)*

A survey done by WHO/UNAIDS (2004) shows that there are regional variations of AIDS patterns within Sub-Saharan Africa. AIDS can be considered as multiple, regional epidemics (UNAIDS, 2004). In East Africa, Uganda has had the greatest gradual decline in prevalence rates, combating the problem through information and communication campaigns aimed at prevention. Infection rates for HIV and AIDS in Uganda have dropped from estimates of 18.5 percent in 1995 (Uganda AIDS Commission Secretariat, 2001) to 6.7 percent in 2005 (UNAIDS, 2006). These declines, however, may be deceiving; they may be the result of mortality statistics rather than a real drop in incidence. UNAIDS (2004) report suggests that:

> Adult HIV prevalence has been roughly stable in recent years. But stabilization does not necessarily mean the epidemic is slowing. On the contrary, it can disguise the worst phases of an epidemic when roughly equally large numbers of people are being newly infected with HIV and are dying of AIDS (UNAIDS, 2004:75b).

Studies done by the UNAIDS (2004) show that in West and Central Africa, prevalence rates appear to have changed very little, stabilizing around 5 percent or below with the exception of Cameroon and Cote d'Ivoire whose rates are upwards of 10 percent among pregnant women at the antenatal sites. This is similar to the rates found in most countries of Southern Africa, with the exception of Angola, where the rate remains steady at around 5 percent (UNAIDS, 2004).

In his study, Green (2003) reveals that women are disproportionately affected by HIV, accounting for more than half of the people living with HIV and AIDS in Sub-Saharan Africa. In most Sub-Saharan countries, the age of sexual debut for women is earlier than for men (Green, 2003). This suggests that women are likely to be infected at earlier ages

and more frequently than men, particularly among those aged 15-24 years (UNAIDS, 2004).

In 2000 the United Nations (UN) launched the Millennium Development Goals (MDGs), and the sixth goal is an effort to curb the spread or incidence of HIV and AIDS, Malaria, Tuberculosis (TB) and other major diseases by 2015. In response to this call by the UN, governments, NGOs and civil society around the world have engaged various communication strategies to address MDG number six.

According to Bessingera, Katendeb, and Gupta (2004) the case of Uganda offers a powerful example of the synergy between Information Science and Communications for HIV and AIDS prevention programmes. The dissemination pathways for HIV and AIDS information in Sub-Saharan Africa are often based upon a formal Information, Education, and Communication (IEC) strategy. These strategies provide goals for the dissemination of information from numerous partners within society (i.e. Multi-sectoral organizations) and can include government at all levels, NGOs, faith-based organizations (FBOs), community-based organizations (CBOs), bilateral and multilateral agencies, and private companies, although this is not very common. IEC strategies within the Sub-Saharan regions are often developed taking their specific cultural considerations into account (Albright, 2004). While these strategies provide the necessary political and civil support from within the country, they do not guarantee that AIDS information campaigns and messages will be targeted to the specific culture, particularly among organizations that come from outside the region.

In Uganda, the Ministry of Health credits that country's decline in HIV and AIDS to mass communication and safe sex promotion campaigns, that seek to increase the levels of knowledge of at least two methods of protection from HIV and AIDS (Uganda Ministry of Health, 2003). Bessingera, Katendeb, and Gupta (2004) attributed the knowledge and use of safe sex methods for both men and women to behaviour change messages in the media (i.e., radio, television, poster, or other print material). The greater the number of mass media channels through which people are exposed to HIV and AIDS messages, the greater the increased knowledge of safe sex methods and how to use them (Bessingera, Katendeb, and Gupta, 2004).

The Ugandan approach is based on communication, behavior, and care. Organizations involved in providing information and communication about AIDS focus on three main topics: (i) information about AIDS the disease; (ii) reducing the number of sexual partners, referred to as *zero grazing*; and (iii) caring for people with AIDS, which includes not assigning blame or passing judgment.

Low-Beer and Stoneburner (2003) in their study discovered that personal channels are the main source for communicating information about HIV and AIDS in both the urban and rural areas of Uganda. Between 1989 and 1995 there was a shift from mass and institutional communication to personal communication channels in Uganda for communicating information about HIV and AIDS (Low-Beer and Stoneburner, 2003). Mass and institutional communication channels account for the majority of HIV and AIDS communication in all other countries.

Therefore, the Ministry of Health in Uganda in their report of 2007 concluded that Uganda's drop in prevalence has included a combination of multi-sectoral approach coupled with unprecedented openness by prominent political, cultural, and community figures who have promoted the cultural integration of the HIV and AIDS message in Uganda. Rather than ignoring the problem, it has been openly discussed in the media and embraced as a national problem. This message has been repeated by official government sources as well as by non-governmental organizations (e.g., Human Rights Watch), faith-based organizations (e.g., World Vision), and other organizations who care for those who are infected.

Sahni and others (2005) did a survey in India on the initiative called *Freedom HIV/AIDS Game.* This initiative draws on the intense and increasing popularity of mobile phones to create and deliver interactive, entertaining learning solutions to teach people about HIV and AIDS. A strategy for this role-play-based game involves capitalizing on the popularity of the sport of cricket in India. The survey discovered that the games were made available free to 9 million subscribers on World AIDS Day 2005.

In South Africa, Soul City launched an edutainment initiative known as *Soul Buddyz 2* in 2000. This initiative was aimed at educating children in the 8-12 year age group. 86 percent of those with high exposure to multimedia said they know what HIV and AIDS is versus 60 percent of those with no exposure; and 68 percent of children exposed to the print materials said that a person with HIV can look health versus 49 percent of those with no exposure. The research conducted after two years of running this initiative

showed that there was an increase from 32 percent to 43 percent in children saying that abstaining from sex can prevent HIV infection.

In 2002, the Nelson Mandela Foundation (NMF, 2002) commissioned a national, household zero-prevalence survey of HIV and AIDS in South Africa. This document shares the results from a 2005 follow-up survey. Among the findings: Some HIV and AIDS communication campaigns have been successful in reaching audiences; other key sources for HIV and AIDS information include talk shows, dramas, feature articles, and entertainment programmes. People also learn about HIV and AIDS through forms of direct exposure, such as knowing someone with the disease or school programming. There are challenges associated with measuring communication impacts and responses due to an overlap between campaigns, as well as influence from sources of information beyond campaigns.

Meekers, Agha and Klein (2006) carried out a study on the *100 percent Jeune* which was a social marketing programme that promoted adolescent reproductive health through peer education in and out of schools, a monthly magazine, and an 18-episode radio drama with weekly call-in shows. These activities were supported by integrated television, radio, and billboard campaigns and by a network of branded youth-friendly condom outlets. The percentage of youth who used a condom in last sex with their regular partner increased from 32 percent to 45 percent for females and from 44 percent to 61 percent for males.

Townsend (2007) highlights how the collaboration between the Kaiser Family Foundation and the Black Entertainment Television (BET) is using the media to disseminate HIV and AIDS related messages targeting the 18-24 year old African

Americans in the USA. The programme is called *Rap-It-Up – United States* and draws on public service advertisements, long-form documentary and entertainment programming, and free printed and online resources. This initiative also targets community or grassroots events and contests. Among the 18-24 year old African Americans who had seen BET's HIV related programming, half said they had talked with a partner about safer sex; and nearly 40 percent said they had visited a doctor or had been tested.

The Ministry of Health in New Zealand launched a programme in 2003 called *No Hubba Hubba* in an effort to reduce high rates of sexually transmitted infections among teenagers. This initiative used a variety of media, including Television, cinema, radio, outdoor advertising, magazines, print resources and a website. As a result of the exposure to the campaign the proportion of respondents who said they would abstain or use safer sex methods increased.

In Rwanda, an NGO launched a project in 1999 which provided free play lifeline radios. This project provided orphaned child heads of households with a self-powered radio that is designed to provide distance education covering topics such as AIDS prevention, methods of increasing garden yields, and maintenance of goats. These radios have been designed for use in rural areas and can run for many hours on wind-up energy or solar power and are able to receive excellent reception. A survey conducted among end-users two years later revealed that there was improved understanding of the dangers of AIDS and improved yields from vegetable gardens.

The United States Agency for International Development (USAID) through the President's Emergency Plan for AIDS Relief (PEPFAR) in 2006 supported a campaign in

Kenya called *"Nimechill"* (Swahili-English slang meaning *"I have chilled" or I am abstaining").* This was aimed at promoting abstinence among urban youth. These messages were disseminated through TV, radio, print, billboards or posters. An evaluation of the Nimechill three years later revealed that youth exposed to 3 or more channels were 12 times more likely than youth who had not seen any Chill ads to strongly agree that "I will abstain from sex until marriage."

Caroline (1999) reports that the Family Health International (FHI) in Cambodia uses child-centered strategies in its efforts to raise awareness and promote non-discrimination through HIV prevention and impact mitigation activities held during events such as World AIDS Day, Children's Day and the Water Festival. Printed materials promoted the role of older caregivers and share positive coping strategies; a key focus has been producing educational items for those who cannot read or see small pictures. A radio spot has been developed to promote these materials and models.

The researchers in Thailand carried out a study in 2000 focusing on the role of communication in public health, and discovered that using communication strategies to bolster public health campaigns has been a successful approach. In Thailand the number of new HIV infection cases dropped from 143,000 to 29,000 in 2000 due, partly, to a 48 million dollars education and public health campaign. This campaign required that the nation's 488 radio stations and 15 TV stations to air HIV and AIDS prevention messages every hour. This was a successful campaign which saw Thailand control and stabilize the HIV rate of infection.

Johns Hopkins Bloomberg School of Public Health's Center for Communication Programmes (CCP, 2003) did a study in 2003 on the effectiveness of communication strategies in public health. With reference to HIV and AIDS, the study revealed that success has been scored through using communication strategies that combine several approaches in designing programs to prevent HIV transmission, support care and treatment efforts, or to reduce stigma. Those approaches include using various advocacy methods for structural and social change; incorporating HIV and AIDS messages into entertaining formats like radio and TV serial dramas; linking community-based approaches to mass media; improving interpersonal communication, counseling, and community outreach; harnessing new information and communication technologies to develop interactive media such as telephone hotlines, web-based products and distance education; establishing peer education systems; and promoting life-skills education in schools and communities and through various community-based media.

According to a survey conducted by Ministry of Health in 1990, HIV and AIDS prevention through awareness-raising began early in Zambia. An American journalist in 1988 reported, "*Zambia is waging one of the world's most aggressive educational campaigns against AIDS, surpassing anything being done in the United States.*" Much of the early campaign involved pamphlets and posters that warned of the dangers of AIDS and promoted abstinence before marriage, for example: "*Sex thrills, but AIDS kills.*"

The study done by the Ministry of Health (2000) shows that over the years, a wide range of media have been used to carry messages about HIV and AIDS, and children have been

taught at least the biological facts in school. There are encouraging signs that efforts to educate young people about avoiding HIV have had some success, although prevalence rates in Zambia have remained stable overall. HIV prevalence among certain groups is falling, and in June 2008, the Ministry of Health announced that the prevalence rate of the adult population has fallen from 17 percent to 14.5 percent. NAC annual report of 2007 indicates that the most notable finding concerns pregnant women aged 15-19 years surveyed in Lusaka. Among this group, the proportion living with the virus almost dropped from 30 percent in 1994 to 24 percent in 2004. Over the same period, there appears to have been a general decline in prevalence among young women in urban areas. It is thought that the falling prevalence levels indicate a drop in the number of new infections, possibly as a result of behavioral change.

The Copperbelt Health Education Project (CHEP) uses music, drama, group discussions and role play exercises to raise HIV and AIDS awareness, particularly in rural areas. In 2003, CHEP conducted a survey through its in-school youth programme, and it was discovered that CHEP educated some 25,000 students using these methods. The survey revealed that 75 percent of these youths they had used safe sex methods and 50 percent had abstained. Peer-centered education of CHEP also reaches sex workers, street children and soldiers, and the CHEP has established youth-friendly health services, in which trained peer educators work alongside clinic staff.

Hachunda (2000) did a study to evaluate the Phase I of Zambia's Helping Each other Act Responsibly Together (HEART) campaign. Viewership of HEART TV spots was "positively and significantly associated with high levels of efficacy to use condoms as

well as with ever use of condoms, holding background variables constant." Compared with non-viewers, campaign viewers were 1.61 times more likely to report primary or secondary abstinence and 2.38 times more likely to have ever used a condom. Television, radio and the press have also proved to be influential in raising awareness, even though not all people have direct access to them. Hachunda (ibid) further reveals that some 71 percent of urban and 37 percent of rural youth saw at least some of the HEART television campaigns in 2000, and it seems that their behaviour was influenced as a result.

In the late 1980s, one school in Zambia became perhaps the first in the world to set up an Anti-AIDS club, a concept that has since become very popular. Members are encouraged to spread messages about safer behaviour and compassion for those living with HIV. So long as their influence extends beyond their membership and reaches the most vulnerable children, Anti-AIDS clubs can be very effective.

According to NAC policy (2005), the thrust of the information, education and communication (IEC) has been the use of mass media to sensitize the public to HIV and AIDS. Popular channels have included television, radio, role-plays, billboards, brochures and pamphlets. IEC has also included the introduction of appropriate HIV and AIDS awareness materials in school curricula. Several NGOs and churches have also implemented IEC activities in their respective programmes.

Through the Ministry of Education, the government has adopted and mainstreamed the number of HIV and AIDS and reproductive health teaching materials in school curricula. This has been done in keeping with the need to impart life skills education to boys and girls at primary, secondary and tertiary levels. Special life skills have also been

developed for targeted groups such as commercial sex workers, truck drivers, out-of-school youth and military personnel. These programmes are, however, limited in the sense that they tend to cover smaller populations along the line of rail. Secondly, the development of IEC materials does not often involve beneficiaries resulting in these programmes lacking ownership. Equally of concern is that, in some cases, messages are not well targeted or culturally appropriate.

With the assistance from Johns Hopkins University Center for Communication Programs and Population Services International and Society for Family Health, the youth in Zambia launched a two-phase national mass media campaign in 2000. It focused on the promotion of safe sex for young people through their leadership and full participation in the planning, design, implementation, monitoring, and evaluation of the campaign. The preliminary results indicate high levels of comprehension and acceptance of campaign messages and reported discussions of the spots with peers and parents. Moreover, the campaign had significant impact on the behavior of the young people related to abstinence and consistent condom use. During the phase-two of the campaign, a controversy surfaced in relation to the way condom was promoted. In this regard, young people became more vocal in the debate and sought to make their position known to the public. Subsequently, they developed their analytical and communication skills. Furthermore, the campaign had strengthened the networks of youth and youth-serving non-governmental organizations.

Thus, Singhal and Rogers (2003) have strongly advised that as governments and health officials search for ways to control the spread of the disease in these nations, they should

not overlook the influence of strategic communication. Strategic communication has an important role to play, not only in advocacy for policy change and primary prevention, but also in the expanded range of interventions that are now integral to most national HIV and AIDS control programs. Those include voluntary counseling and testing, treatment of opportunistic infections, antiretroviral drug provision, preventing mother-to-child transmission, as well as community-based care and support for people living with HIV and AIDS.

From the above literature reviewed from around the world and Zambia in particular, it is clear that communication is an essential component in educating the public, shaping attitudes and perceptions, creating demand for services, and improving provider-client interaction within them.

CHAPTER V

5.0. PRESENTATION OF FINDINGS

This chapter was developed after the field data gathering which was done in a rural and an urban setting. The intensive process of data collection described above in chapter two yielded rich information on the dynamics of the different communication strategies that are at play in the fight against HIV and AIDS and poverty in the study sites.

Furthermore, the chapter is a delineation of the opinions of the 81 respondents who successfully took part in the audience survey through the personally administered questionnaires; the four members of the study sites with whom four in-depth interviews were conducted, and the four groups from the study sites who took part in the focus group discussions.

In the audience survey, the researcher administered two types of questionnaires:

- The first set was directed at the employees and staff of CRS where only 10 questionnaires were administered and successfully collected and analyzed.

- The second set was directed at the general public in the target communities where 90 questionnaires were administered and only 71 were successfully collected and analyzed.

- A total of 100 questionnaires were administered, but only 81 were returned to the researcher. The remaining 19 were either misplaced or lost and could not be collected during the required period.

Data collected through quantitative methods as outlined in the foregoing paragraph were analyzed using SPSS, and data collected through qualitative methods were analyzed without using SPSS. Therefore, this chapter contains bar charts, pie charts and frequency tables to show the nature of responses that the respondents gave to various questions they were asked.

5.1. Audience Survey to CRS Staff and Employees

5.1.1. Respondents by Age

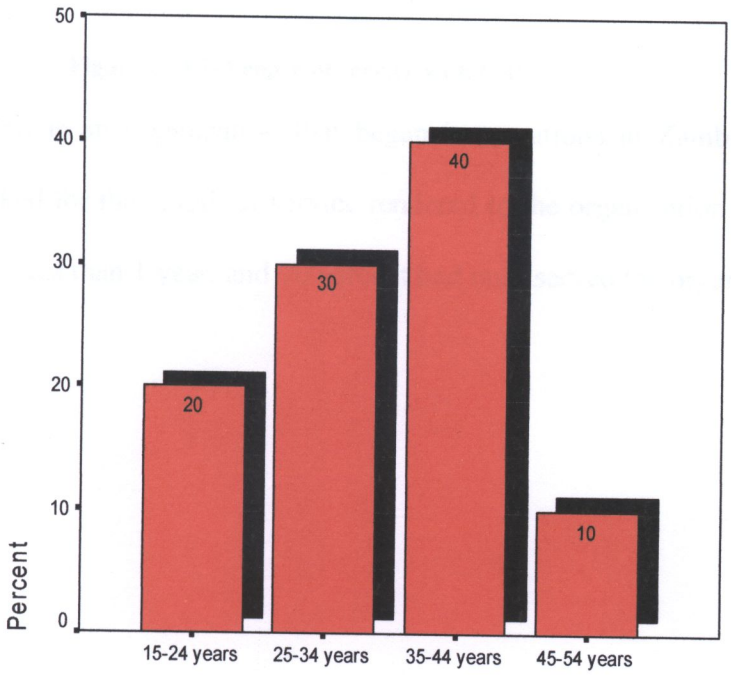

Figure 5: AS- Respondents by age

As illustrated in Figure 5, 20 percent of the sample was between the ages of 15-24 years old, 30 percent was between 25-34 years old, and 40 percent was between 35-44 years and 10 percent between 45-54 years. There was a balance between the young and old generations in the number of those who took part in the survey.

5.1.2. Length of Service with CRS

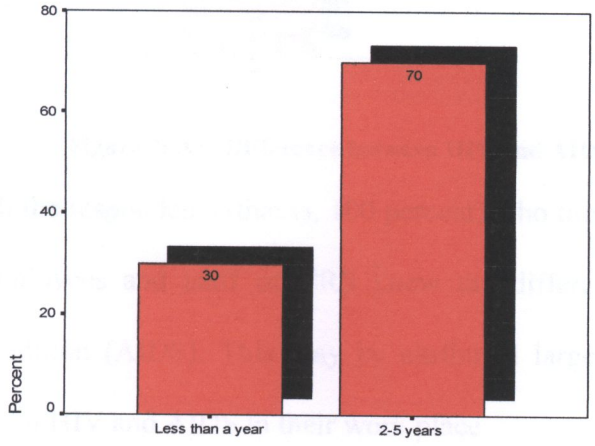

Figure 6: AS- Length of service with CRS

CRS is an organization that began it operations in Zambia in 1999. Therefore, when asked for the length of service rendered to the organization, 30 percent had only worked for less than 1 year, and 70 percent had only served the organization between 2-5 years.

5.1.3. Difference between HIV and AIDS

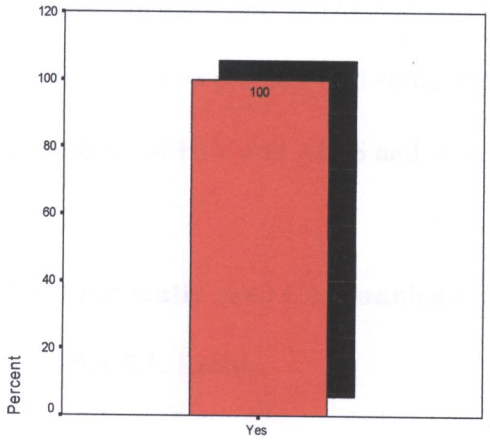

Figure 7: AS- Difference between HIV and AIDS

All the respondents (that is, 100 percent) who took part in the audience survey among the employees and staff of CRS knew the difference between the virus (HIV) and the condition (AIDS). This may be attributed largely to exposure to numerous literatures about HIV and AIDS in their work place.

5.1.4. Knowledge of Programmes which CRS supports to mitigate the Impact of HIV and AIDS and Poverty in your area.

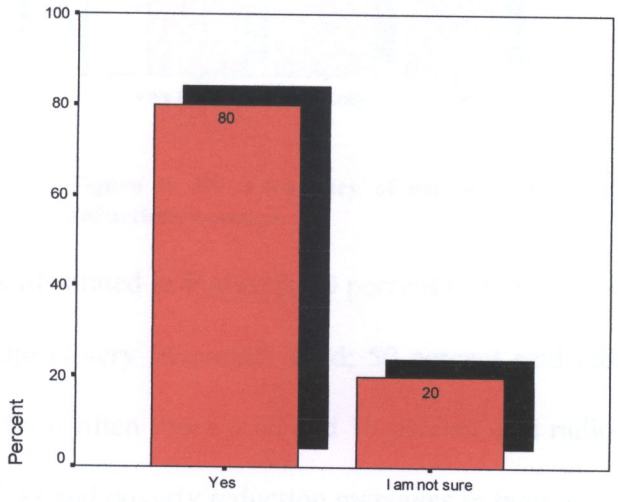

Figure 8: AS- Knowledge of programmes which CRS supports to mitigate the impact of HIV and AIDS and Poverty in your area.

When respondents were asked if they knew programmes which CRS supports to mitigate the impact of HIV and AIDS and poverty in their areas, 80 percent said they knew the existence of these projects and some were even beneficiaries; 20 percent were not sure of the presence of HIV and AIDS and poverty reduction programmes in their areas.

5.1.5. Frequently used Communication Strategies by CRS

5.1.5.1. Radio

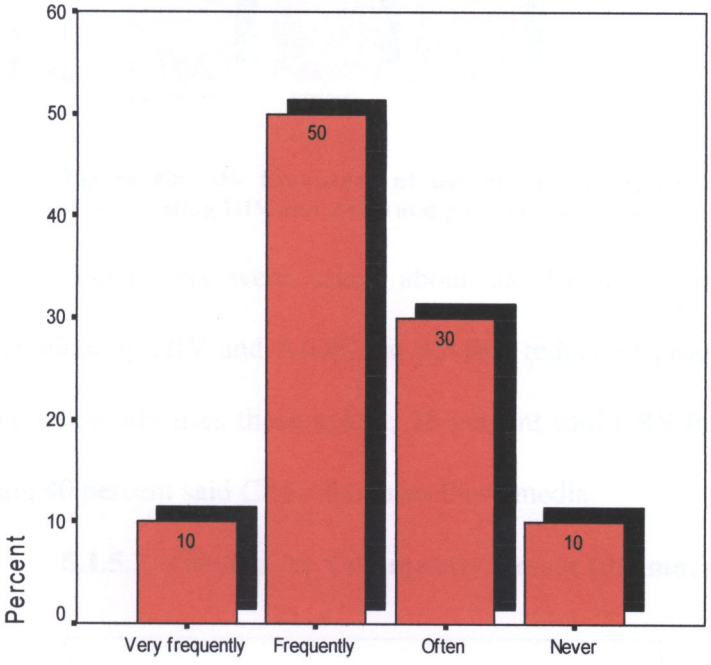

Figure 9: AS- Frequency of use of Radio in disseminating HIV and AIDS and Poverty reduction messages

As illustrated in Figure 9, 10 percent of those who took part in the survey from CRS said radio is very frequently used; 50 percent said radio is frequently used; 30 percent said radio is often times used and 10 percent said radio is never used to disseminate HIV and AIDS and poverty reduction messages in their areas.

5.1.5.2. Brochures, Pamphlets, Posters and Billboards

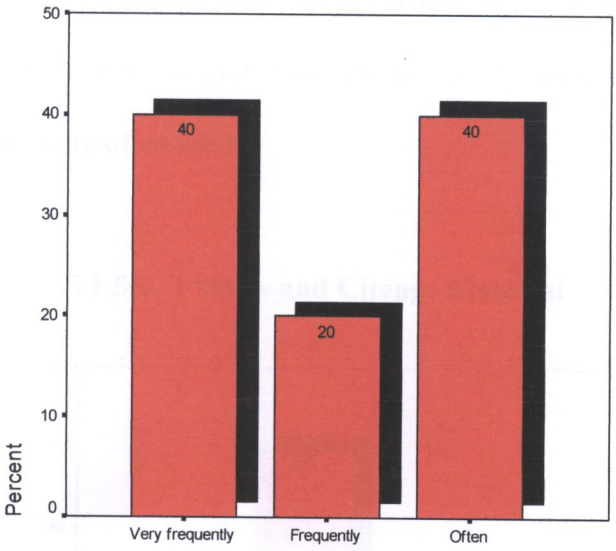

Figure 10: AS- Frequency of use of brochures, pamphlets, posters and billboards in disseminating HIV and AIDS and poverty reduction

When respondents were asked about the frequency usage of the above media in disseminating HIV and AIDS and poverty reduction programmes, 40 percent said CRS very frequently uses these media; 20 percent said CRS frequently uses these media and again 40 percent said CRS often uses these media.

5.1.5.3. Theatre for Community Action (drama, songs, drums)

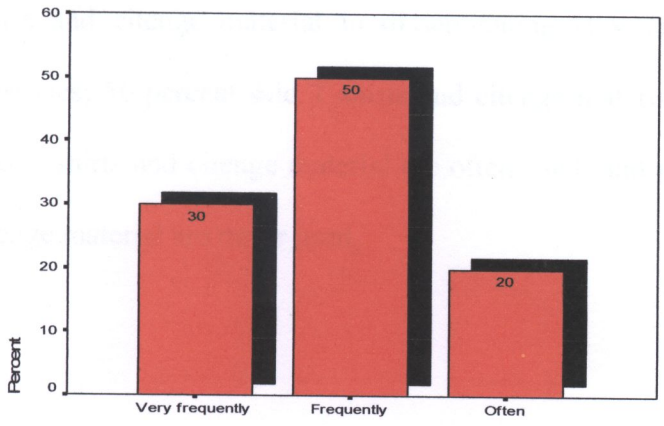

Figure 11: AS- Frequency of use of drama, songs and drums

When asked about the frequent usage of drama, songs and drums in disseminating HIV and AIDS and poverty reduction messages, 30 percent said these are very frequently used; 50 percent said these are frequently used and 20 percent said drama, songs and drums are often used.

5.1.5.4. T shirts and Citenge Material

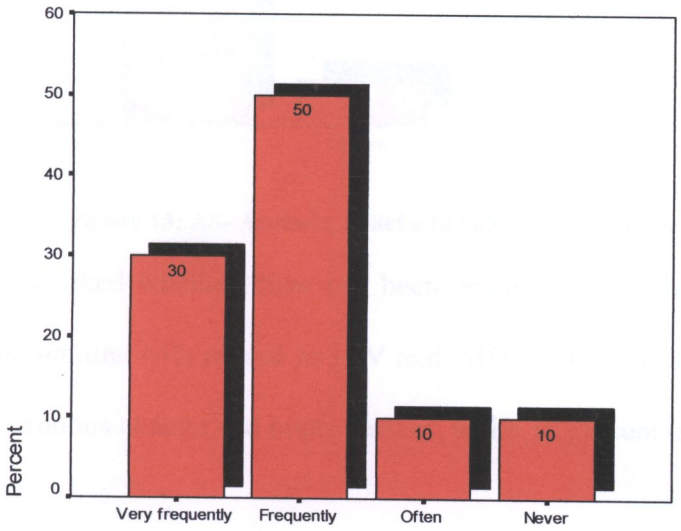

Figure 12: AS- Frequency of use of T shirts and citenge material

Figure 12 illustrates that 30 percent of the respondents said CRS very frequently uses T-shirts and citenge material in disseminating HIV and AIDS and poverty reduction messages; 50 percent said T-shirts and citenge material are frequently used; 10 percent said T-shirts and citenge material are often used, and again 10 percent said T-shirts and citenge material are never used.

5.1.6. Change in target communities' attitudes, beliefs, values and behaviour towards HIV and AIDS

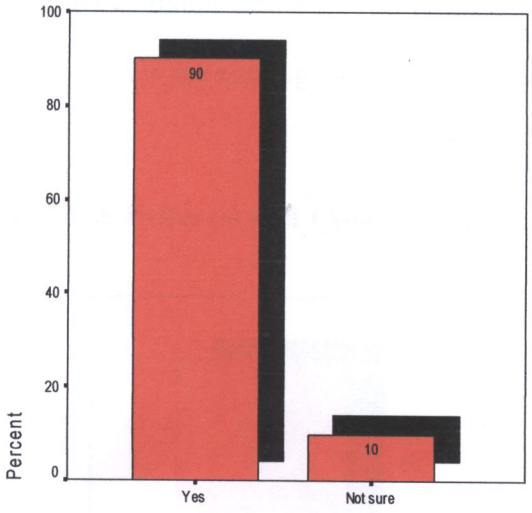

Figure 13: AS- Attitude, belief and behavioural change

When asked whether there has been change in attitude, belief and behaviour in target communities with regard to HIV and AIDS, 90 percent of the respondents said there is tremendous change and improvement, while 10 percent of the respondents were in doubt.

5.1.7. Poverty Reduction

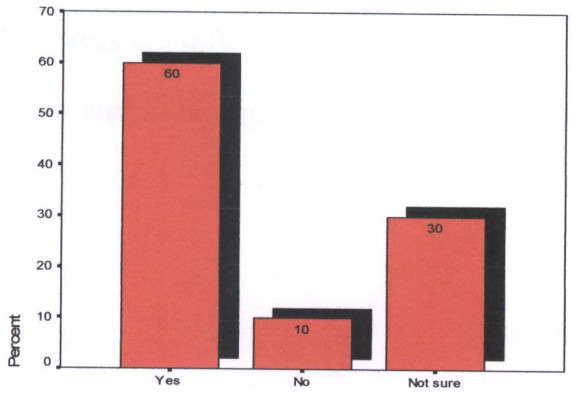

Figure 14: AS- Reduction in poverty levels in target communities

When respondents were asked whether there has been any reduction in poverty levels in the target communities, 60 percent said poverty levels have been reduced; 10 percent said poverty levels are still high and 30 percent indicated that they were not sure.

5.1.8. The Difference in Communication Strategies used in Rural Areas and Urban Areas

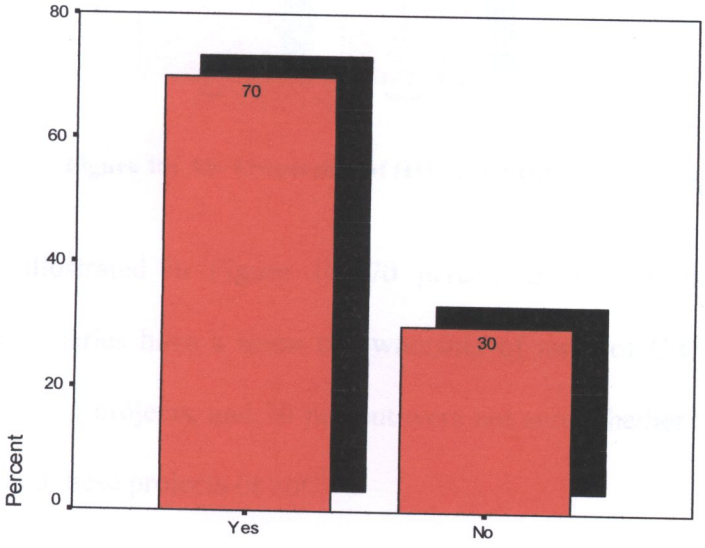

Figure 15: Differences in communication strategies

When respondents were asked whether communication strategies used in rural areas and urban areas are different, 70 percent said there is a difference and 30 percent said the communication strategies used are same everywhere.

5.1.9. Ownership of CRS' Programmes by Target Beneficiaries

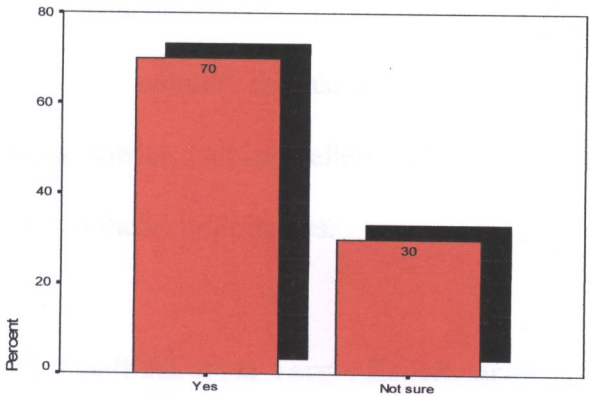

Figure 16: AS- Ownership of HIV and AIDS and poverty reduction programmes

As illustrated in Figure 16, 70 percent of the of the respondents said the target beneficiaries have a sense of ownership of most of CRS' HIV and AIDS and poverty reduction projects, and 30 percent were not sure whether the target beneficiaries felt they owned these projects or not.

5.1.10. Challenges Encountered in Disseminating HIV and AIDS and Poverty Reduction Programmes

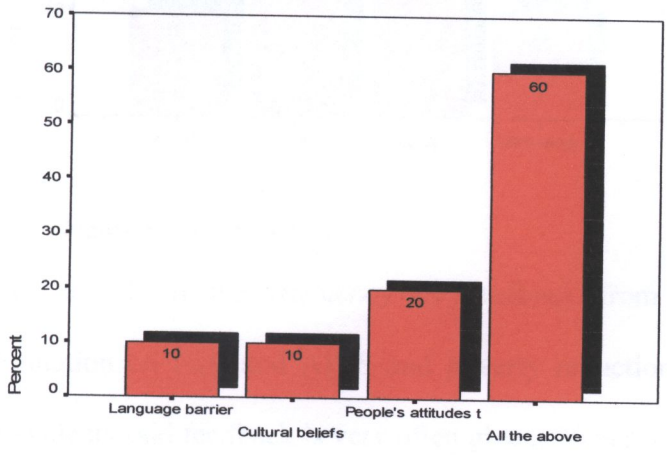

Figure 17: AS- Challenges encountered

When asked which challenges CRS encountered in disseminating HIV and AIDS and poverty reduction messages, 10 percent of the respondents said language barrier; 10 percent said cultural beliefs; 20 percent said people's attitudes, and 60 percent said language barrier, cultural beliefs and people's attitude were the major challenges for the success of these programmes.

5.1.11. Feedback from Target Beneficiaries

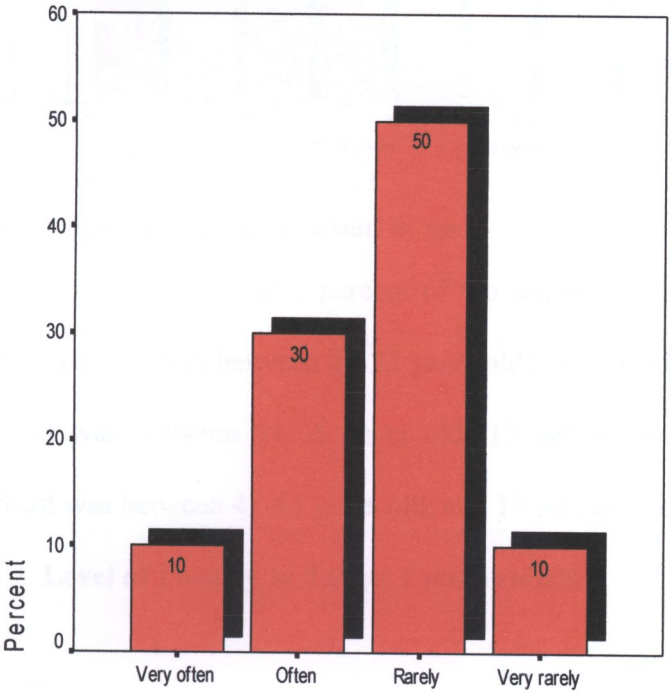

Figure 18: AS- Feedback

When asked on the frequency of feedback from target beneficiaries concerning information on HIV and AIDS and poverty reduction programmes, 10 percent of the respondents said feedback is very often given; 30 percent said feedback is often given; 50 percent said feedback is rarely given, and 10 percent said feedback is very rarely given.

5.2. Audience Survey from the General Public in Target Communities

5.2.1. Respondents by Age

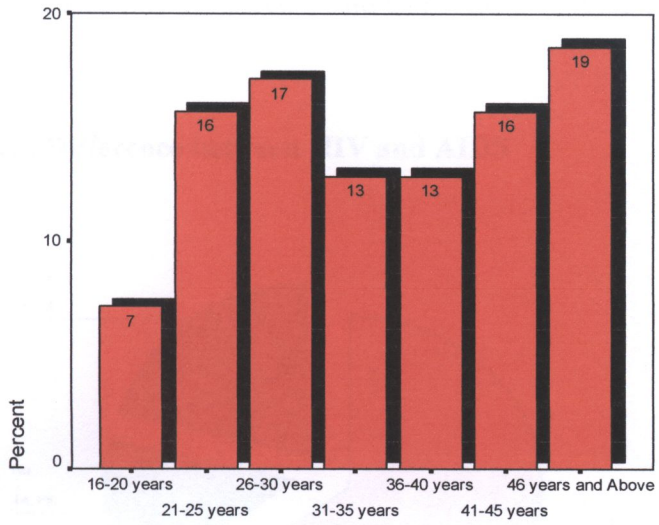

Figure 19: AS2- Respondents by age

Figure 19 illustrates that 7 percent of the sample was between the ages of 16-20 years old; 16 percent was between 21-25 years old; 17 percent was between 26-30 years old; 13 percent was between 31-35 years old; 13 percent was between 36-40 years old; 16 percent was between 41-45 years old, and 19 percent were 46 years and above.

5.2.2. Level of Poverty in Target Communities

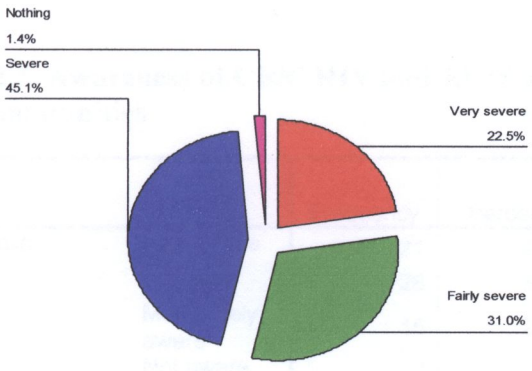

Figure 20: AS2- Level of poverty

When asked on the level of poverty in the target communities, 22.5 percent said poverty was very severe; 31 percent said poverty was fairly severe; 45.1 percent said poverty was severe, and only 1.4 percent said there was no poverty.

5.2.3. Difference between HIV and AIDS

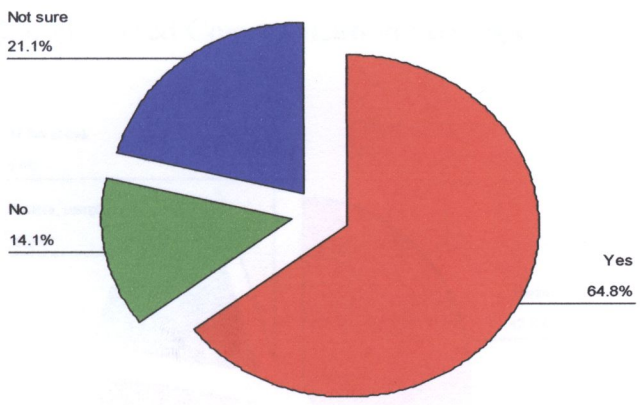

Figure 21: AS2- Difference between HIV and AIDS

Asked if they knew the difference between HIV and AIDS, 64.8 percent of the respondents said they knew the difference; 14.1 percent said they did not know the difference, and 21.1 percent said HIV and AIDS are the same.

5.2.4. Awareness of CRS' HIV and AIDS and Poverty Reduction Activities in Target Communities

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very aware	21	29.6	29.6	29.6
	Aware	28	39.4	39.4	69.0
	Moderately aware	15	21.1	21.1	90.1
	Not aware	7	9.9	9.9	100.0
	Total	71	100.0	100.0	

Table 4: HIV and AIDS and poverty reduction activities

When respondents were asked if they aware of CRS' HIV and AIDS and poverty reduction activities in their area, 29.6 percent said they were very aware of the activities; 39 percent said they were aware; 21.1 percent said they were moderately aware, and 9.9 percent said they were not aware of any activity aimed at combating HIV and AIDS and poverty in the area.

5.2.5. Preferred Communication Strategies

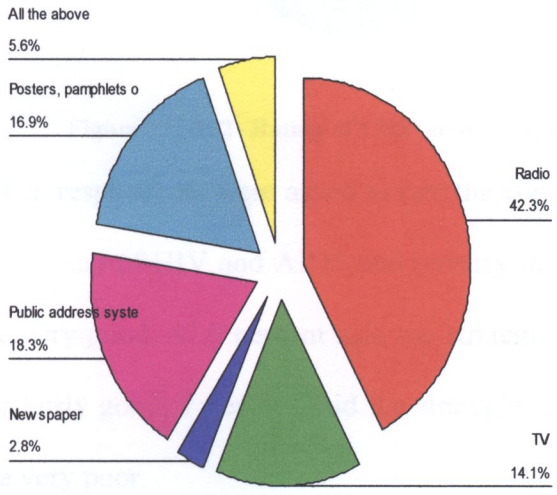

Figure 22: AS2- Media channels

When respondents were asked to mention the media channels they liked most, 42.3 percent said they preferred radio programmes; 18.3 percent said they preferred public address systems; 16.9 percent said they preferred posters, pamphlets and brochures; 14.1 percent said they preferred television programmes; 2.8 percent said they preferred the newspaper, and 5.6 percent said these media channels were appropriate and preferred.

5.2.7. Rating of CRS' Communication Strategies in Mitigating the Impact HIV and AIDS and Poverty among Target Beneficiaries

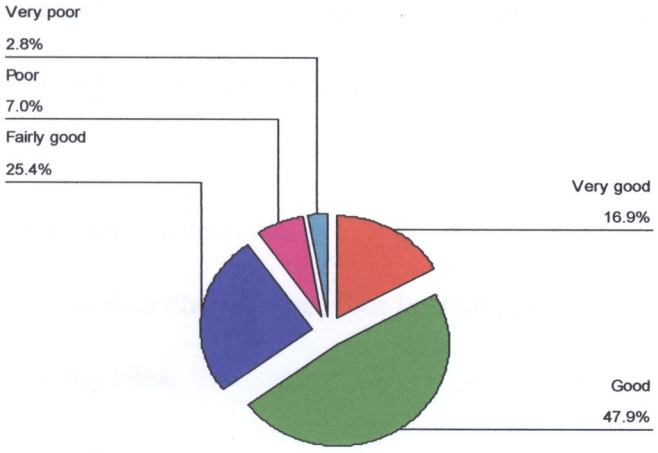

Figure 23: AS2- Rating of CRS' communication strategies

When respondents were asked to rate the communication strategies of CRS in mitigating the impact of HIV and AIDS and poverty in their areas, 16.9 percent said the strategies are very good; 47.9 percent said the strategies are good; 25.4 percent said the strategies are fairly good; 7 percent said the strategies are poor, and 2.8 percent said the strategies are very poor.

5.2.8. Participation of the Target Beneficiaries in CRS' HIV and AIDS and Poverty Reduction Programmes

	Frequency	Percent	Valid Percent	Cumulative Percent
Very adequate	11	15.5	15.5	15.5
Adequate	31	43.7	43.7	59.2
Moderately adequate	21	29.6	29.6	88.7
Inadequate	7	9.9	9.9	98.6
Very inadequate	1	1.4	1.4	100.0
Total	71	100.0	100.0	

Table 5: AS2- Level of participation

When respondents were asked whether they participate in the origination and running of CRS' HIV and AIDS and poverty reduction programmes, 15.5 percent said that participation at all levels is very adequate; 43.7 percent said there is adequate participation; 29.6 percent said participation is moderately adequate; 9.9 percent said participation is inadequate, and 1.4 percent said participation is very inadequate.

5.3. In-depth Interviews

As explained in chapter two, four in-depth interviews were conducted with four members of the study sites.

When interviewees were asked about which was the most frequently used media that CRS uses to disseminate its HIV and AIDS and poverty reduction messages to its audiences, 50 percent said group and individual approach were frequently used; 25 percent said drama, traditional songs and music were frequently used, while another 25 percent said brochures, pamphlets and posters were also often used. Statements such as: "as CRS we often go out to our clients and meet them in groups and then talk about HIV and AIDS and explain our programmes to them;" were typical of those who gave examples of the group approach as the frequently used mode.

When interviewees were asked about the effectiveness of the approaches that CRS uses to disseminate HIV and AIDS and poverty reduction messages, 80 percent said the approaches engaged were effective, while 20 percent said the approaches used were poor. A typical statement of those who said CRS' approaches were effective is "I am happy to

mention to you that since the HIV and AIDS and poverty reduction programmes began in Kasama Archdiocese we have been able to reach about ten thousand people." Moreover, those who said the approaches were effective gave statements such as "we are using caregivers to reach our clients." Those who said the approaches were poor gave statements such as "I can say not really because HIV is still spreading in our communities and the poverty levels are still high."

Interviewees were asked to mention some of the major weaknesses of communication strategies used by CRS. 80 percent said language barrier as most of the communication messages are designed in English, a language not widely spoken in target communities; 20 percent said the inability to effectively engage other media methods leaves out some members of the target communities especially those who are illiterate. Some interviewees gave statements such as "most of our clients cannot read or write, but we receive brochures, pamphlets and posters written in English, and so this disadvantages one section of the community." Other statements such as "you know that instructions on medicines like ARVs are in English, so what happens to our illiterate clients, it becomes difficult for them to follow adherence procedures as this disease is characterized by stigma."

When interviewees were asked if CRS had contributed to lowering the levels of HIV and AIDS and poverty in target communities, 100 percent said CRS, as a partner in the multi-sectoral approach to HIV and AIDS, has contributed through its HIV and AIDS and poverty reduction programmes.

5.4. Focus Group Discussions

Four groups consisting of ten members in each group were engaged in the focus group discussions that were conducted in the study sites.

In all the four focus group discussions, discussants were asked if they had attended a meeting, workshop or seminar organized by CRS to sensitize people about HIV and AIDS and poverty. 75 percent acknowledged having attended either a meeting or a workshop, or a seminar; 20 percent said they were invited to attend one of these but could not make it, and 5 percent said they have never attended any of the above.

When discussants were asked to mention the media that CRS uses to disseminate its HIV and AIDS and poverty reduction messages, 60 percent said group and individual approaches were used; 20 percent said radio programmes on Mano Radio; 10 percent said CRS uses drama and songs; and 10 percent said CRS uses T-shirts and citenge material to disseminate the information. Those who said CRS uses group and individual approaches gave statements such as "CRS calls us to attend their meetings and workshops and sometimes caregivers from CRS visit individuals at their homes. In addition, CRS' psychosocial counselors have helped many clients to access VCT services offered by CRS." Others gave statements such as "we receive T-shirts and citenge from CRS on which HIV and AIDS messages are written and these can be seen worn by many people."

In all the four focus group discussions, discussants were asked if the approaches employed by CRS to disseminate HIV and AIDS and poverty reduction messages were

effective. 60 percent said the approaches were effective; 30 percent said the approaches were less effective, and 10 percent said they were not effective at all. A typical statement from those who said the approaches were effective is "we have seen the increase in the number of people who want to be tested for HIV; some can even be as old as seventy." Those who said the approaches were ineffective gave statements such as "many people have still continued dying from AIDS, and so this clearly shows we need to explore other methods which can be more effective."

When the discussants were asked if they participated in the origination and subsequent running of CRS' HIV and AIDS and poverty reduction projects, 50 percent expressed ignorance of being actively involved; 30 percent said participation is only limited to CRS employees and no involvement of people from the grassroots; and 20 percent said there is adequate participation by all stakeholders.

When asked to mention some of the weaknesses in the communication strategies of CRS, 70 percent were of the opinion that messages targeting local beneficiaries should be designed in their local languages; 30 percent were of the opinion that CRS should try to use other communication methods to complement on the existing ones. Several discussants realize that young people have little information and support to protect themselves from HIV. Other discussants felt that the information exists but that youth choose not to change their ways, as illustrated by this quote from a peer educator in Kasama: "Information people are getting is straightforward. There are a lot of programmes on the radio and there are so many handouts. The problem is the youths who

are stubborn. We have the message, but we are not doing what the message is saying. Condoms are there but how many are using them? Just a few."

CHAPTER VI

6.0. INTERPRETATION OF KEY FINDINGS

This chapter presents the interpretation and analysis of the key findings as outlined in the preceding chapter. The chapter begins by giving a brief demographic description of participants in the study sites, and thereafter, key findings are presented and interpreted. The analysis of the findings is done by way of making comparisons of the results of similar themes of all the methods used to collect data. The interpretations done here are based on what the researcher found.

6.1. Demographic Information of Respondents

The survey reveals that most of the participants, both male and female, had attained some form of secondary education (28.2 percent junior secondary and 33.8 percent senior secondary). The survey also shows that a considerable percentage of the participants had attained tertiary education (26.8 percent). This is a clear indication that the population sample in the study sites was fairly informed on issues happening within the community and those happening outside their community. The majority of the participants had attained senior secondary of education which meant that the grasp of the research topic in these study sites was quite high. This is why 58.3 percent of the participants in the quantitative survey were fairly knowledgeable about the HIV and AIDS pandemic and its ravaging effects (Table 6).

What is your sex? * What is your level of education? Crosstabulation

		What is your level of education?				
		Primary	Junior Secondary	Senior Secondary	Tertiary	Total
What is your sex?	Male	7	10	9	15	41
	Female	1	10	15	4	30
Total		8	20	24	19	71

Table 6: Sex and level of education crosstabulation

6.2. Level of Awareness about HIV and AIDS

The data from the study sites shows high levels of knowledge about the basics of HIV. Almost all of the respondents in the quantitative survey know at least one correct mode of transmission and prevention. The qualitative data from all the study sites shows that a majority of respondents know that the main modes of transmission are through unprotected sex with a person with HIV or infected blood or needles. Many are also clearly aware that condoms are a key way to limit sexual transmission of HIV, and that reducing casual sex also reduces HIV risk. Similarly, people in all the study sites are keenly aware of the fact of mother to child transmission.

The data shows that an incomplete understanding of HIV and AIDS feeds fears about casual transmission. Many respondents, especially in the qualitative survey, do not understand that there is a difference between HIV and AIDS, how the disease progresses, and what the longevity of a person with HIV is. Less than one-third of the respondents in Kasama's qualitative survey know the difference between HIV and AIDS. Many respondents in all the study sites believe that a person with HIV will die very quickly, if not immediately. As an urban Lusaka man bluntly notes, "When they see that someone has HIV, they see him as already dead." Part of the reason for this belief is that, fearing

stigma and discrimination, people do not disclose an HIV-positive status until it has progressed into AIDS and symptoms can no longer be hidden. In other words, families and communities typically are unaware that they know people with HIV until those people are in the last stages of AIDS and, in fact, often near death. The qualitative findings also show that people with opportunistic infections (such as tuberculosis, chronic diarrhea, and herpes zoster) often are assumed to have HIV and, as a result, are also physically isolated and otherwise stigmatized. Furthermore, people often do not believe that opportunistic infections in those with HIV and AIDS are treatable and curable. While many do know that opportunistic infections such as TB are curable, others often equate TB with AIDS, consider TB symptoms to be those of AIDS, and thus consider opportunistic infections such as TB incurable. As the rural Kasama male and female participants in a discussion succinctly say, *"TB is AIDS."*

In Northern Province, the prevalence rate is estimated at between 12.8 and 14.8 percent (CSO, 2000), which is the lowest in the country. The prevalence of HIV and AIDS in the communities visited was reported to have been increasing. According to community leaders, up to four funerals a month can occur in a village; in the past, one or two months would pass without any funerals. Hospital data reaffirmed this perception. According to Kasama District Health Management Board (KDHMB), for instance, the number of suspected and confirmed cases of AIDS rose from 1.2 per 1000 in 1999 to 2.1 per 1 000 in 2003.

6.3. Level of poverty in target communities

According to the findings in both the quantitative and qualitative surveys, the levels of poverty vary among households. People's perceptions of poverty are very closely associated, and sometimes identified, with hunger or food insecurity, poor health, limited access to decent clothing, bedding, shelter and education. Some social segments of society, like OVC, the elderly, women and retirees, tend to experience these more than others. Poverty has a seasonal dimension. It is experienced more acutely during certain periods of the year or the month than in the others.

A simplified ranking based on respondent's perceptions of wealth revealed that most female-headed households, especially those fostering orphans, were in the poor category. The most common wealth indicators used by the communities were owning a well stocked trading shop, being able to stock food all year round, owning livestock, being able to send own children to school, and, to a lesser extent, owing an iron-roofed house.

What is your sex? * What is the level of poverty in your area? Crosstabulation

		What is the level of poverty in your area?				
		Very severe	Fairly severe	Severe	Nothing	Total
What is your sex?	Male	9	13	18	1	41
	Female	7	9	14	0	30
Total		16	22	32	1	71

Table 7: Sex and level of poverty

The majority of the respondents, both male and female, experience severe to extreme poverty as illustrated in Table 7.

The poor performance of the agricultural sector was seen by most respondents to be the major cause of poverty and of the fact that poverty levels are on the increase. Inadequate marketing of both farm inputs and of produce was reported in Kasama. Another cause was said to be the weather, that is, droughts in especially urban study sites and floods in others. Rural roads were also blamed for increasing the poverty levels, especially in remote areas of Kasama. Poor agricultural extension services were also blamed for the low farm production, hence food insecurity and hence poverty. The advent of the HIV and AIDS pandemic which is robbing the country of many of its trained and qualified manpower was said to be contributing to the poor performance of the extension services. Unemployment was also said to be on the increase especially in urban and peri-urban areas. Poor social service delivery compounds the poverty situation. Often there are shortages of drugs, school textbooks, and furniture. Staff is ill motivated for one reason or another.

Participatory research shows very clearly the holistic nature of life. This is seen, among others, in the perceived inter-linkages between the various factors which cause poverty. The holistic nature of human life and its resultant multi-dimensional aspects of poverty point to the need for inter sectoral collaboration in fighting it. In other words a very productive agricultural or industrial sector alone will not reduce poverty. Other players from other sectors should be involved in the fight against poverty just as CRS is doing.

The study findings also show that food insecurity or hunger accelerates the spread of the virus and the course of the disease. Hungry people are driven to adopt risky strategies to

survive. In desperation, women and children barter sex for money and food, exposing themselves to the risk of infection. For people who are already infected with HIV, hunger and malnutrition increase their susceptibility to opportunistic infections, leading to an earlier onset of full-blown AIDS.

6.4. Contribution of CRS in Mitigating the Impact of HIV and AIDS and Poverty in target communities

Many respondents in both the qualitative and quantitative surveys (90.1 percent) are aware about CRS' programmes aimed at prevention and raising awareness about the AIDS pandemic, and many participants are beneficiaries of the poverty reduction programmes. Most of them appreciated the role of CRS in mitigating the impact of HIV and AIDS among the vulnerable members of the community especially through its SUCCESS programme. Through this programme CRS has established home based care units and hospices throughout the country. It is through the SUCCESS programme that even AIDS patients in remote rural communities are able to access treatment such as ARVs and the food supplements. In a focus group discussion in Kasama, one female patient said "mostly the poor are overlooked due to their poverty; or when they go to medical institutions, the rich are given more attention than the poor people because of his or her status as a rich person."

The SUCCESS programme is heavily involved in training voluntary caregivers who are directly and immediately in contact with patients. Most participants said caregivers make home visits, wash and feed patients as well as treating simple infections. Moreover, through the SUCCESS programme, CRS also trains psychosocial counselors who provide

VCT services in target communities. A good number of participants agreed that through programmes such as SUCCESS, CRS was contributing to mitigating the impact of HIV and AIDS in the target communities. One participant in Lusaka said "through these activities CRS is impacting on the lives of many poor people who fail to access insufficient public health services." As a result, the availability of these services closer to ordinary people in target communities, CRS is a well known name in the study sites. As illustrated in Table 8, many respondents have knowledge about CRS and some of its activities.

With regard to poverty reduction interventions, many participants, especially those in the urban study sites, were actually beneficiaries of CRS' partnership programmes such as RAPIDS, CHAMP-OVC and C-SAFE. RAPIDS and CHAMP-OVC in Lusaka's Kanyama Township provide educational support, child protection, paralegal services, psychosocial and spiritual support as well as nutritional support to the vulnerable children and orphans. RAPIDS also in its programming, improves the quality of life of PLWHA through nutritional support, medicine assistance, psychosocial support and timely referrals to health centers.

Do you know anything about CRS Zambia? * Are you aware of any activities undertaken by CRS to combat HIV and AIDS Poverty in your area? Crosstabulation

		Are you aware of any activities undertaken by CRS to combat HIV and AIDS Poverty in your area?				Total
		Very aware	Aware	Moderately aware	Not aware	
Do you know anything about CRS Zambia?	Not sure	0	2	0	2	4
	Yes	21	26	15	5	67
Total		21	28	15	7	71

Table 8: Respondents awareness of CRS and its programmes

6.5. Preferred Communication Strategies

Since time immemorial, the African people have lived in communities and their way of life has been developed around oral tradition. This means that tradition has been passed on from one generation to another through stories, poems, songs, folk tales, riddles and drums. These interpersonal methods are still effective means through which HIV and AIDS and poverty reduction messages can be communicated even in today's scientific and technological world. From the survey findings, majority of the respondents (42.3 percent) preferred radio programmes from both the public media such as Zambia National Broadcasting Corporation (ZNBC) and community media such as Mano Radio in Kasama. Most participants, especially in the qualitative survey, liked radio drama, traditional songs and educational programmes. This means that if CRS has to be effective in disseminating the HIV and AIDS and poverty reduction messages, let them also consider getting spots either in the public radio stations or community radio stations which majority of the respondents in the study sites said they preferred. This is supported by most CRS staff who took part in the survey where it was discovered that more than 50 percent opted for the use of radio to reach the target communities.

From the study findings, CRS mostly uses the group and individual approaches through meetings, workshops and seminars and the use of care supporters and caregivers when communicating with members of the target communities. Care supporters and caregivers reach out to individual HIV and AIDS patients. Majority of the respondents also preferred the individual and group approaches as compared to other approaches such as TV or brochures or pamphlets because of the language barrier (Table 9).

How often do you have access to TV? * How often do you have access to Group discussions? Crosstabulation

		How often do you have access to Group and individual approaches?				
		Regularly	Sometimes	Rarely	Never	Total
How often do you have access to TV?	Regularly	1	3	3	1	8
	Sometimes	6	5	5	0	16
	Rarely	7	7	1	2	17
	Never	15	11	4	0	30
Total		29	26	13	3	71

Table 9: Comparison between Group and Individual approaches and TV

The findings further disclosed that some respondents preferred other approaches that CRS uses which included theatre for community action (drama, songs and drums), T-shirts and citenge material bearing messages about HIV and AIDS and also success stories where a person infected with HIV comes out publicly about his or her situation.

As indicated in the above data, the preferred communication strategies can also be said to be the most effective and widely accessible means through which HIV and AIDS and poverty reduction messages can be communicated in these communities. However, CRS should also explore other communication strategies such as TV, internet, and newspapers which can as well suit and work more favorably even in these communities because their audience is not only the poor or illiterate but everyone regardless of their status in society.

6.6. Effectiveness of the Strategies in use

The aim of any intervention in the fight against a pandemic of this magnitude is always to stop its further spread in order to limit its devastating effects on the lives of people.

Therefore, sensitization and awareness campaigns about such a disease come first even before a vaccine is introduced. In the case of HIV and AIDS, sensitization and awareness messages are designed to change people's beliefs, attitudes and behaviours. In the study sites, the majority of the respondents attributed the change in people's attitudes and beliefs to the massive awareness campaigns about the dangers of HIV and AIDS. CRS carried out massive behavioral change workshops which promoted abstinence and use of safe sex methods and most respondents these methods were said to be widely practiced. In the case of poverty, these messages are designed to help people learn better methods of food security. This entails that communication is vital in the success of any intervention.

Most of the respondents rated the communication strategies of CRS in the fight against HIV and AIDS and poverty to be good (approximately 70 percent) and majority of the participants (80 percent) recommended CRS to continue disseminating these messages as illustrated in the Crosstabulation in Table 10 below.

How would you rate the communication strategies used by CRS in mitigating the impact of HIV and AIDS and poverty? * Would you recommend CRS to provide information on HIV and AIDS and Poverty? Crosstabulation

		Would you recommend CRS to provide information on HIV and AIDS and Poverty?			
		Yes	No	Not sure	Total
How would you rate the communication strategies used by CRS in mitigating the impact of HIV and AIDS and poverty?	Very good	12	0	0	12
	Good	34	0	0	34
	Fairly good	18	0	0	18
	Poor	2	2	1	5
	Very poor	0	2	0	2
Total		66	4	1	71

Table 10: Rating of CRS' Communication Strategies

The interpretation of the above data is simply that people's lives have been touched and changed through the programmes of CRS in all the target communities. Consequently, it goes without saying that CRS has not only looked at HIV and AIDS as a biomedical problem, but also as a cross cutting problem that requires the vital component of communication in order to address it.

CHAPTER VII

7.0. CONCLUSION AND RECOMMENDATIONS

7.1. Conclusion

The fields of information science and communications both contribute to our understanding of the ways in which users seek and use healthcare information. Information science brings an understanding of individuals, including their cultural context, which is complementary to communications. Conversely, communications brings a theoretical background that strengthens the approaches used in information science. There are, however, many theories about health information and behavioural change that are characterized by redundancies and superficial perspectives that do not advance our understanding of the relationship between health information and behavioural change. What is necessary is to evaluate behavioural change theories and identify similar concepts in information science and establish a common understanding of health behaviour constructs across the different bodies of research. Together, they bring a sharper, more targeted understanding and use of theories to guide the development, implementation, and evaluation of HIV and AIDS prevention programmes in Zambia

The purpose of this study was to evaluate the extent to which CRS was using communication tools in mitigating the impact of HIV and AIDS and poverty in the study sites of Kasama and Lusaka and ultimately in its programming throughout Zambia. By undertaking this study, the researcher further hoped the results of this study would help

CRS to enhance its efforts in its quest to uplift the living standards of the people of Zambia. In order to achieve the aforesaid, the researcher undertook an evaluation of the communication strategies that have been employed by CRS in disseminating HIV and AIDS and poverty reduction messages in its programming.

The results of the study showed that CRS has tended mostly to use meetings, workshops, seminars, print materials, drama and printed T-shirts and citenge materials as approaches in communicating its messages. According to the available data from the study sites, these methods have been able to change people's beliefs, attitudes and behaviour especially with regard to HIV and AIDS. Therefore, this is a clear indication that CRS has greatly contributed to mitigating the impact of HIV and AIDS pandemic in the study sites and equally in all areas of Zambia where CRS has spread its tentacles.

However, it was observed that although CRS had made such tremendous contributions towards the fight against HIV and AIDS and poverty, it had failed to explore other effective communication tools such as radio which are widely used and favored by most people in the study sites. Moreover, it was also observed that CRS had not done much in translating print materials, such as posters, brochures and pamphlets, and printed messages on T-shirts and citenge and the instructions on medicines into local languages.

Finally, the study has also established that CRS has tried to involve people in target communities in its programming especially through the involvement of care supporters

and caregivers. This means that local people have been given an opportunity to actively participate in the HIV and AIDS and poverty reduction programmes of CRS.

7.2. Recommendations

Employing the appropriate types of information within a given context will account for not only the specific cultural considerations but will also result in a stronger ability to target specific audiences and individuals with specific needs. This study found that language and information on HIV and AIDS have important effects on the experience of stigma. The media, then, is a powerful tool by virtue of its tremendous reach and ability to influence people's opinions and actions. Institutions working with the media, and the media itself, can make messages and information about HIV and PLHA non-stigmatizing.

Phenomenological studies that investigate the situations of those infected with or affected by HIV and AIDS are needed to examine the results and the complexities of information and behaviour change. This approach is helpful to dig deeper into the underlying context of individual behaviour in order to locate the patterns of information seeking and use for HIV and AIDS information.

In the light of the interpretations of the findings above, the researcher suggests the following recommendations which will effectively contribute to CRS' dissemination of HIV and AIDS and poverty reduction information.

- Materials should be designed specifically for the target audience within their particular culture. Much of information passing in rural areas of Zambia is still based on oral tradition, so the use of non-print materials is likely to be more effective.

- Materials need to be available in the language of the target population. For example, there are over 72 languages spoken in Zambia. Despite the fact that English is the official language, many people in Zambia do not understand English. Therefore, materials printed in English will be ineffective. For example, all instructions on medicines administered to AIDS patients are written in English which subsequently compromises adherence to drugs such as ARVs. Radio programmes should also be available in the language of the target population.

- Because much of the population in Zambia is illiterate, materials need to be available in a variety of formats in addition to print. Some of CRS' projects mentioned the use of audio in information delivery (e.g., audio books, radio), drama, story, and song, as a few of the methods used to deliver the HIV and AIDS message. Additional formats for delivery that are culturally appropriate in the oral cultures of Zambia also need to be considered.

- Consider the collectivist culture of the target population. For example, information is commonly shared in community centers, youth centers, documentation centers, and multipurpose telecentres in case of urban areas. These

centers serve as a community centre where local forums and meetings can be conducted, both formal and informal.

- Regardless of other programmatic activities, peer education appeared to be the most common approach to spreading the HIV and AIDS message.

- The use of fiction is useful for making HIV and AIDS information more interesting, particularly for children and youth.

- Consistent, unambiguous messages are the cornerstone of effective communication.

- CRS should explore other communication tools apart from the ones currently in use in order to be more effective in disseminating its messages.

- Media can be used to provide up-to-date and complete information on HIV. In addition to providing correct information, the media can be used to negate misperceptions about HIV and AIDS.

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APPENDIX A

The University of Zambia
School of Humanities and Social Sciences
Department of Mass Communication

Audience Survey Questionnaire for CRS Employees and Staff

Dear Respondent,
We have sent this questionnaire to you because we believe you possess information critical to the success of this study about CRS Zambia. We thank you most sincerely for your corporation and we promise that the information you will provide is confidential and will only be used for academic purposes.

May you kindly answer the following questions? Simply tick [√] what is applicable to you.

SECTION I

1. What is your sex?
1. Male [ ]
2. Female [ ]

2. Your age.
1. 15 – 24yrs [ ]
2. 25 – 34yrs [ ]
3. 35 – 44yrs [ ]
4. 45 – 54yrs [ ]
5. 55 – 64yrs [ ]
6. 65 – 74yrs [ ]

3. Marital status.
1. Single [ ]
2. Married [ ]
3. Divorced [ ]
4. Widow/widower [ ]

4. For how long have you been working with CRS?

1. Less than 1 year [ ]
2. 2-5 years [ ]
3. 6-9 years [ ]
4. 10 and above [ ]

5. What is your level of knowledge about HIV and AIDS?

1. Very Good [ ]
2. Fairy Good [ ]
3. Good [ ]
4. Nothing [ ]

6. Is there any difference between HIV and AIDS?

1. Yes [ ]
2. No [ ]
3. Not sure [ ]

7. Do you know any programmes which CRS supports to mitigate the impact of HIV and AIDS and poverty in your area?

1. Yes [ ]
2. No [ ]
3. Not sure [ ]

SECTION II: Communication strategies used by CRS

How much of the following do you use in dissemination of the HIV and AIDS and Poverty relief messages?

	1. Very frequently	*2. Frequently*	*3. Often*	*4. Never*
8.				
TV				
9.				
Radio				
10.				
Newspaper				
11.				
Magazines				
12.				
Internet				
13.				
Brochures,				
Pamphlets and				
Posters				
14.				
Theatre for				

Community				
Action (TCA)				
15.				
Testimonies				
Such as Success				
Stories				
16.				
Workshops				
17.				
Talks				
18.				
Dialogue				
19.				
School Debates				
20.				
Meetings				
21.				
Others specify				

From your experience how fast are the following media in communicating HIV and AIDS messages to reach your target groups?

	1. ***Very Fast***	***2.*** ***Fast***	***3.*** ***Not Sure***	***4.*** ***Slow***	***5.*** ***Very Slow***
22.					
TV					
23.					
Radio					
24.					
Newspaper					
25.					
Magazines					
26.					
Internet					
27.					
Brochures,					
Pamphlet &					

Posters					
28.					
Public					
Address					

29. Basing on the communication strategies that CRS uses as indicated above, has there been any change in the target community's attitudes, beliefs and behaviour with regard to HIV and AIDS?

1. Yes [ ]
2. No [ ]
3. Not sure. [ ]

30. Basing on the communication strategies that CRS uses as indicated above, has there any reduction in the poverty levels of target communities?

1. Yes [ ]
2. No [ ]
3. Not sure [ ]

31. Which group has been CRS' main target in its communication strategies?

1. Children [ ]
2. Youth [ ]
3. Men [ ]
4. Women [ ]
5. All the Above. [ ]

32. According to your observation and current statistics, have your communication strategies helped to reduce the HIV prevalence in the country?

1. Yes [ ]
2. No [ ]
3. Not sure. [ ]

How effective are the following communication strategies in addressing the HIV and AIDS pandemic?

	1. ***Very Effective***	**2.** ***Effective***	***3. Not Sure***	***4. Less Effective***	***5. Not effective***
33.					
Mass Approach					
34.					
Group Approach					

35.					
Individual Approach					
36.					
Schools					
37.					
Door to Door					
Campaigns					
38.					
NGOs Approach					

39. Which of the following challenges do you face as CRS in disseminating HIV and AIDS information?

1. Language barrier [ ]
2. Cultural beliefs [ ]
3. People's attitudes to change [ ]
4. Not sure [ ]

40. Are there any differences in the communication strategies used in urban areas to those used in rural areas?

1. Yes [ ]
2. No [ ]
3. Not sure [ ]

41. How often do you get the feedback on the information you disseminate about Poverty and HIV and AIDS?

1. Very often [ ]
2. Often [ ]
3. Rarely [ ]
4. Very Rarely [ ]
5. Never [ ]

42. Do the target beneficiaries feel they own CRS' programmes?

1. Yes [ ]
2. No [ ]
3. Not sure [ ]

43. What materials do you produce as CRS for your target communities/groups?

1. Brochures [ ]
2. Newsletters [ ]
3. Posters [ ]
4. Magazine [ ]
5. All the above [ ]

44. Do you have a resource centre for Information, Education and Communication materials?

1. Yes [ ]
2. No [ ]

Thank you for kindly answering all the questions.

APPENDIX B

The University of Zambia
School of Humanities and Social Sciences
Department of Mass Communication

Audience Survey Questionnaire to the General Public in Target Communities

Dear Respondent,
We have sent this questionnaire to you because we believe you possess information critical to success of this study about the communication strategies of CRS in combating HIV and AIDS and Poverty in your area. We thank you most sincerely for your corporation and we promise that the information you will provide will only be for academic purposes.

Kindly answer the questions by simply ticking [√] what applies to you.

1. Your sex.
1. Male [ ]
2. Female [ ]

2. Your age.
1. 10-15years [ ]
2. 16-20years [ ]
3. 21-25years [ ]
4. 26-30years [ ]
5. 31-35years [ ]
6. 36-40years [ ]
7. 41-45years [ ]
8. 46 and above [ ]

3. Your level of education
1. Primary [ ]
2. Junior Secondary [ ]
3. Senior Secondary [ ]
4. Tertiary [ ]
5. Non of the above [ ]

4. Your occupation.

1. Employed [ ]
2. Self-employed [ ]
3. Unemployed [ ]
4. In school [ ]

5. What is your level of knowledge about HIV and AIDS?

1. Very good [ ]
2. Fairly good [ ]
3. Good [ ]
4. Nothing [ ]

6. What is the level of poverty in your area?

1. Very severe [ ]
2. Fairly severe [ ]
3. Severe [ ]
4. Nothing [ ]

7. Is there any difference between HIV and AIDS?

1. Yes [ ]
2. No [ ]
3. Not sure [ ]

8. Do you consider HIV and AIDS awareness campaigns important?

1. Yes [ ]
2. No [ ]

9. Do you know anything about CRS/Zambia?

1. Yes [ ]
2. No [ ]
3. Not sure [ ]

10. Has CRS conducted any HIV and AIDS awareness campaigns in your area?

1. Yes [ ]
2. No [ ]
3. Not sure [ ]

11. Are you aware of any activities undertaken by CRS to combat HIV and AIDS and Poverty in your area?

1. Very aware [ ]
2. Aware [ ]
3. Moderately aware [ ]
4. Not aware [ ]

12. How would you describe the information you receive from CRS about HIV and AIDS?

1. Excellent [ ]
2. Very adequate [ ]
3. Adequate [ ]
4. Fairly adequate [ ]
5. Very inadequate [ ]

13. Does the information provided by CRS on HIV and AIDS help in combating the spread of the disease?

1. Yes [ ]
2. No [ ]
3. Not sure [ ]

14. Is the information provided easy for everyone to understand?

1. Very easy [ ]
2. Easy [ ]
3. Moderately easy [ ]
4. Difficult [ ]
5. Very difficult [ ]

15. Do you consider the information provided by CRS on HIV and AIDS to be culturally acceptable?

1. Yes [ ]
2. No [ ]
3. Not Sure [ ]

16. Do you think there is adequate participation in the programs of CRS by the targeted beneficiaries?

1. Very Adequate [ ]
2. Adequate [ ]
3. Moderately adequate [ ]
4. Inadequate [ ]
5. Very Inadequate [ ]

17. How would you rate the communication strategies used by CRS in mitigating the impact of HIV and AIDS and Poverty?

1. Very Good [ ]
2. Good [ ]
3. Fairly Good [ ]
4. Poor [ ]
5. Very Poor [ ]

18. Which of the following media of disseminating HIV and AIDS messages is most appropriate for you?

1. Radio [ ]

2. TV [ ]
3. Newspapers [ ]
4. Public Address systems [ ]
5. Posters, Pamphlets or Brochures [ ]
6. All the above [ ]

Which of the following Media used by CRS do you have access to and how often?

MEDIUM	**1.** ***Regularly***	**2.** ***Sometimes***	**3.** ***Rarely***	**4.** ***Never***
19. Radio				
20. TV				
21. Group and Individual approach				
22. Internet				
23. Public Address				
24. Magazines				
25. Newspapers				
26. Brochures, Pamphlets and Posters				

27. Would you recommend CRS to provide information on HIV and AIDS?
1. Yes [ ]
2. No [ ]
3. Not sure [ ]

Thank you for kindly answering all the questions.

APPENDIX C

The University of Zambia
School of Humanities and Social Sciences
Department of Mass Communication

FOCUS GROUP DISCUSSION AND IN-DEPTH INTERVIEW GUIDE QUESTIONNAIRE

NAME.....
ORGANIZATION.....
QUESTIONNAIRE NUMBER.....DATE...../..../.....

1. In what ways have you been involved with CRS activities?

2. For how long have you been involved?

3. Have you ever attended any meeting organized by CRS?

4. If yes, how did you find the discussions?

5. Have you ever attended a meeting or workshop organized by CRS to sensitize people on the HIV and AIDS pandemic?

6. What is the difference between HIV and AIDS; and what are some of the methods in which a person contracts HIV?

7. In your view, are the approaches used by CRS to disseminate HIV and AIDS messages effective?

8. If you think they are effective, what are some of the things you can point out as successes?

9. Which medium is the source of HIV and AIDS messages for you?

10. Do you participate in the origination and running of these projects?

11. What do you say are some of the weaknesses of the communication strategies used by CRS in its quest to mitigate the impact of HIV and AIDS and poverty to the target communities?

12. What would you recommend to be done in order to improve the communication strategies of CRS?

Thank for sparing your time for this discussion.