

REACHING YOUNG PEOPLE WITH SEXUAL AND
REPRODUCTIVE HEALTH INFORMATION AND EDUCATION
FOR THE PREVENTION OF HIV/AIDS: AN APPRAISAL OF
THE STRATEGIES AND ACTIVITIES OF THE KABUSHI
HEALTH CENTRE IN NDOLA DISTRICT

THESIS

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DECLARATION

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

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DEDICATION

To my parents, Mr. Bonaventure Kaimba and Mrs. Maria Mutale Kaimba

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
BCC	Behaviour Change Communication
CBoH	Central Board of Health
CPHA	Canadian Public Health Association
CRS	Catholic Relief Services
CYC	Community Youth Concern
DHMT	District Health Management Team
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
JOICFP	Japanese Organisation for International Cooperation in Family Planning
NGO	Non Governmental Organisation
PPAZ	Planned Parenthood Association of Zambia
SAP	Structural Adjustment Programme

SIDA	Swedish International Development Cooperation Agency
SPSS	Statistical Package for Social Sciences
SRH	Sexual and Reproductive Health
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency For international Development
WHO	World Health Organisation
YWCA	Young Women Christian Association
ZDHS	Zambia Demographic and Health Survey
ZSBS	Zambia Sexual Behaviour Survey

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ABSTRACT

This report is a result of the attachment and study of the sexual and reproductive health services provided to young people in Kabushi Township of Ndola by the Ndola District Health Management Team. It is a culmination of an attachment to such services in partial fulfillment of the requirements for the Master of Communication for Development Degree at the University of Zambia.

The study intended to appraise the activities and the communication strategies used to disseminate sexual and reproductive health information and education especially HIV/AIDS prevention to young people in Kabushi Township of Ndola. The report presents what was found out in terms of the activities and strategies that were used to reach young people. The report starts by introducing the problem and the rationale for the study. It discusses the methodologies used to collect data and presents the results or the findings.

The findings of the study show that although a lot of young people identified HIV/AIDS as the most urgent and serious health concern, most of them did not access adequate information, education and services for HIV prevention. The approaches used so far of static service

at the health centre were not so effective in attracting young people to information and services.

There is need for wider approaches that take into consideration the fact that HIV is not a health problem only but a developmental problem too, requiring multi dimensional approaches, if the objective of reducing the further spread of the disease especially among young people has to be realized.

The major conclusion of the report is that, HIV/AIDS service delivery programmes should be designed to face complex tasks. Behaviour change strategies typically require the use of various channels to communicate messages. Because the disease is complex, it affects all aspects of human society from the cultural sphere to the religious, political and economic spheres and therefore must be tackled using multiple strategies.

The strategies and activities employed in Kabushi Township to attract young people to information and education on HIV/AIDS prevention need to be supplemented with a lot of community outreach activities. Some of the strategies and the activities that can be used to have an effective programme in Kabushi in particular and other communities in general come as recommendations at the end of the report.

CHAPTER 1

INTRODUCTION AND BACKGROUND

1.0 Introduction

The following is a report of a research study carried out to appraise the strategies and activities used by the Ndola District Health Management Team to disseminate information and education on sexual and reproductive health to facilitate HIV/AIDS prevention among young people. The research particularly covered interventions in Kabushi Township of Ndola. The report has seven chapters.

Chapter 1 of the report covers the background information and Zambia's profile, statement of the problem and the rationale for the study. The section for the problem background introduces the dimensions of the problem and the importance of addressing it in as far as it affects people, especially young people between the ages of 10 and 24 years. The profile of the country covers the geographical position of the country including its altitude, vegetation, the weather patterns, the administrative and political set-up, the economy and the health infrastructure as well as some important health indicators.

Chapter 2 describes the methodology used, i.e. the study design to measure the impact of the intervention that has been undertaken by Ndola District Health Management Team. It also looks at the research questions, sampling method used, data gathering procedures, data analysis and also discusses some of the limitations of the study.

Chapter 3 is about the theoretical framework of the study where concepts and their relevance to the study are discussed. The chapter has also both conceptual and operational definitions of the terms used. Fisher and Foreit (2002) state that while it is important to be clear about concepts used, operational definitions establish the rules and procedures that are used to measure the key variables of the study. They also provide unambiguous meaning to terms that may otherwise be interpreted in a different way. Wimmer and Dominick (1997) point out that research depends on observation and observation cannot be made without a clear statement of what is to be observed. An operational definition is such a statement.

Chapter 4 covers literature review and brings out some studies that have been done as well as some writings on the topic of the study. Chapter 5 presents the study findings including interpretation of the results. Chapter 6 discusses the results while Chapter 7 presents the

conclusions and recommendations. The report ends with a section on references used during the study. There are two attachments to the report, the questionnaire used for the quantitative method and the focus group discussion guide for the qualitative aspect of the survey.

1.1 Problem Background: The Incidence of HIV/AIDS

Africa, south of the Sahara is presently the epicentre of the HIV/AIDS pandemic, which now threatens the very existence of the region. For example out of the global figure of nearly 3 million people who are reported to have died of AIDS in 2001, Africa, south of the Sahara is estimated to have contributed 2.3 million. The estimated 3.4 million new HIV infections in 2001 mean that 28.1 million people in the Sub Sahara region now live with the virus. This is about 2/3 of the world figure (UNAIDS 2001).

For more than two decades now, Zambia has been grappling with HIV/AIDS not only to find ways of mitigating the impact of the pandemic but more importantly to halt further spreading of the disease. HIV/AIDS has become one of the greatest challenges that the country is facing. According to UNAIDS (Ibid.) National HIV prevalence among 15-49 year olds has stabilised at 19.75 percent after peaking close to 28 percent in the early 90s, although according to the 2000/2001 Zambia

Demographic and Health Survey, (ZDHS) (2002) the HIV prevalence is estimated at 16 percent of the adult population.

The United States Agency for International Development (2002) sums up Zambia's health situation as follows: *"Zambia's health needs are enormous. Approximately 20% of adults are HIV-infected. The HIV/AIDS epidemic is having a devastating impact on the people, institutions, and the country's ability to achieve sustainable development. As AIDS death rates have accelerated, a secondary epidemic of orphaned and vulnerable children has arisen. By the end of the year 2000, an estimated 1.25 million children (27.4% of children under age 15) were orphaned. Zambia also has some of the world's highest infant and under-five mortality rates. The maternal mortality ratio of 649 per 100,000 live births is one of the worst in Africa and the world. Largely because of the AIDS crisis, life expectancy at birth is declining". (P.1).*

The situation concerning young people in relation to HIV/AIDS in Zambia can be said to be of serious concern. To start with, Zambia has a youthful population. According to the 2000 Census of Population, young people below the age of 25 years are estimated at 75 percent of the population of the country. This is an extremely youthful population with many young people becoming sexually active and entering their reproductive phase at early ages. The Zambia Sexual Behaviour Survey

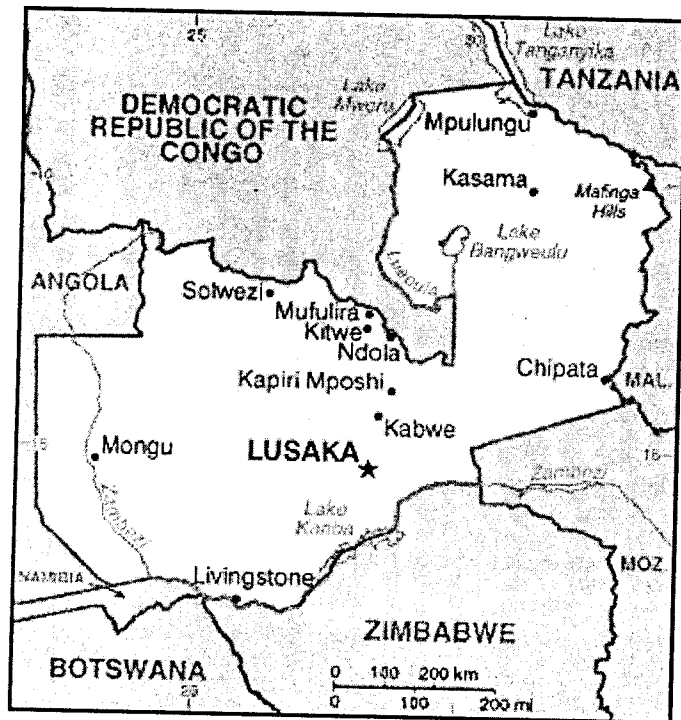
(2002) indicates that about 50 percent of Zambian boys and girls have their sexual debut by the time they reach 17 years. Adolescents and young people therefore need a lot of attention. This is because, they constitute a special group that is vulnerable to HIV infection, unwanted pregnancies and unsafe abortions. They have to be protected from HIV/AIDS infection. It is therefore important to appraise strategies implored to protect the lives of young people from HIV infection.

The study examined the effectiveness of activities and communication interventions that are used by the Ndola District Health Team to equip young people with life skills in reproductive health that contribute to the prevention of HIV/AIDS. . In assessing the effectiveness of the strategies, a survey was conducted among the intended programme beneficiaries of the Ndola District Health Team's programme for young people in Kabushi Township to determine the degree to which programme activities were perceived as effective in the dissemination of messages and contributing to behaviour change among young people. An individual questionnaire and focus group discussions were used to assess the effectiveness of the strategies employed.

1.2 Profile of Zambia

Zambia is a landlocked Southern Africa country sharing borders with the Democratic Republic of Congo in the north-west, Tanzania in the north, Malawi and Mozambique in the east, Zimbabwe and Botswana in the south, Namibia in the south-west and Angola in the west. The country which is located between one thousand and one thousand and six hundred meters above sea level and lies between the latitudes of 8 and 18 degrees south of the Equator and the longitudes of 22 and 36 degrees East, covers an area of 752 614 square Kilometres.

Fig.1.1 Map of Zambia



The country's vegetation and climate are tropical with open grasslands bushes and thick forests in some areas. There are three distinct seasons, a cool and dry season that lasts from the month of May to August, a hot and dry season from September to November and a hot and wet season from December to April. Soils and climatic conditions are suitable for agricultural production, although, only about one fifth of the arable land is under cultivation. The main crop in the country is maize, which is mainly produced by small-scale growers and relatively few commercial farmers. Other crops include cotton, tobacco, sunflower, groundnuts, cassava, sorghum and potatoes. In terms of natural resources, the country has extensive copper deposits. It also has in smaller quantities, deposits of zinc, cobalt, lead, emeralds and silver. Water resources are abundant.

1.2.1 Political Systems and Administrative Structure

Administratively, Zambia is divided into nine provinces, Central, Copperbelt, Eastern, Luapula, Lusaka, Northern, Northwestern, Southern and Western Provinces. The provinces are further divided into seventy-one districts. The country has a multi-party system of government with three separate organs, i.e. the legislature, the executive and the judiciary. Zambia is a unitary state which a single chamber parliamentary system and an executive president.

At the local level, the main administrative structure is the local authority i.e., city, municipal or district council. Councillors who are elected in wards constitute the council, which formulates development programmes for the respective area. Councils also have the mandate to pass by laws concerning the administration and management of their areas.

1.2.2 Ethnic Groups

Zambians form a real ethnic mixture with 73 ethno linguistic groups. The most numerous of these groups are the Tonga, Lozi, Ngoni and Bemba. They are all of Bantu origin. There are also the community of white Zambians most of who came during colonisation of the country, as well as Zambians of Asian origin. Finally, there is a sizeable community of expatriates working in the country

1.2.3 Languages

The most used local languages are Bemba, Kaonde, Lozi, Lunda, Luvale, Nyanja and Tonga. However, the official language is English, which is spoken throughout the country mostly by people who have had formal education.

1.2.4 Religion

The diversity in language can be observed at the religious level. The majority of religious Zambians have a Christian orientation, converted gradually since the arrival of first missionaries in the 19th century. However there are sizeable numbers of Moslems and Hindus.

1.2.5 The Economy

Zambia's economy has for a long time largely depended on mining. The country's economic performance can be described as one of noticeable improvement in the early post independence era followed by a period of stagnation in the 80s and then decline thereafter. Zambia has moved from being one of the more prosperous countries in Africa to one of the poorest in Africa and the world. Because of this situation, most of the social services in the country have deteriorated.

Economic performance of the country was impressive for sometime after independence in 1964. Growth rates were high, social and economic infrastructure expanded and employment opportunities increased. From the middle of the 1970s, however, the country started to face serious economic difficulties due to a number of factors, including the drop in the price of copper on the World Market and a high increase in fuel prices

Although successive governments have made a number of efforts to revive the economy, the problems of Zambia's economic development have not been resolved. Corrective measures such as the Structural Adjustment Programme (SAP) that have been put in place for sometime now, have not achieved the desired results. Many of these economic reforms have largely focused on economic liberalisation, i.e. the creation of a free market economy where most of business in the country has gone into private hands. So far, these so called austerity measures have not contributed to improving the standard of living for most people in Zambia. Poverty levels have gone up, and presently it is estimated that more than 80 percent of the population of the country live in severe poverty.

1.2.6 Infrastructure

All weather roads service major towns in the country. Access to the interior parts of the country is however difficult particularly during the rain season as some roads become impassable. The country has a railway network which is however not very extensive. The major railway line runs from Livingstone, south of the country to Chililabombwe on the Copperbelt. A second railway line was built in the 1970s from Kapiri Mposhi in the middle of the country to Dares salaam in Tanzania. In

terms of other telecommunication facilities, the country is fairly well serviced. Telephone facilities are available in all the districts in the country, although the network is not that efficient. Mobile telephone facilities have also been established. Air transport is available both for local and international travel. However, the country has had no national airline since the mid 1990s when the national airline Zambia Airways was liquidated. Private transporters undertake transportation of people and goods, so the government has no direct control as the industry is largely liberalised.

1.2.7 Employment

The employment situation in the country is very unfavourable. To start with, the country as already indicated, has a youthful population, meaning that the bigger proportion of the population is a dependent population. On the other hand, the move to liberalise the economy has led to the closure of many industries resulting in thousands of employees losing jobs. The problem has been compounded by high school drop out rates of both boys and girls. It has become difficult even for those that have successfully completed school to secure jobs. According to the Central Statistical Office (2000), the number of people in formal employment is estimated at only 350,000 out of a labour force of about 4,000,000.

1.2.8 Demographic Factors

The demographic indicators in Zambia still show the country as one, which is still in the first stage of demographic transition, i.e., a situation of high birth rates and high death rates. The 2000/2001 Zambia Demographic and Health Survey (ZDHS) (Ibid.) put the population growth rate of the country at 3.2 percent while the Fertility Rate i.e. the number of children born to every woman of reproductive age is 5.9. This makes Zambia have one of the highest fertility rates in the World.

Maternity Mortality Rates, which were falling, are said to have been rising and the country again has one of the highest maternal mortality rates in the world with an estimated 729 deaths per 100,000 live births. Infant Mortality is also reported to be high and at 110 deaths for every 1000 children, the country again has one of the highest rates in the World. The reversals indicated above could be attributed to ongoing deterioration in the standards of living, the increased prevalence of HIV/AIDS infection among children and adults and increasing poverty levels. Mortality rates could even rise further as the country gets poorer and as the HIV/AIDS. impact takes its toll. Below are the main socio-demographic indicators for the country.

Population in the year 2000 (million)		10.3
Density (pop. /sq.km)		13.7
Percent urban		36.0
Total Fertility Rate		6.0
Completed family size (women age 45-49)		6.8
Maternal mortality Rate		729
Infant Mortality Rate		110
Life Expectancy at Birth (years)	Men	47.5
	Women	51.7

Source: Zambia Demographic and Health Survey 2001 – 2002.

1.2.9 Government Policies and Regulations

The Government's attitude towards population has been positive over the years and has led to the promulgation of a Population Policy and implementation of population programmes. The Policy, which was developed in 1989 outlines the role of population in the development process of the country. It includes targets for population growth rates, fertility levels, infant mortality and family planning service availability and strategies of attaining set objectives in these areas.

In the recent past, a number of health policies that fall under the umbrella of the National Population Policy have been developed while some are being finalized. These include the 1997 Family Planning and

Reproductive Health Policy Framework: Strategies and Guidelines, launched in June 1997. The Safe Motherhood Policy, Adolescent Reproductive Health Policy, Reproductive Health Policy, and STD/HIV/AIDS Policy are being finalized.

These policies address challenges of implementing integrated services within the broad concept of sexual and reproductive health as reflected in the Programme of Action for the 1994 International Conference on Population and Development (ICPD). In addition, they are meant to support and guide the national and district levels in planning and implementing reproductive health programmes within the current health reform structure.

Other related policies include National Health Policy and Health Reforms; Child Health Policy, Youth Policy; Environmental Action Plan, Social Sector Rehabilitation and Development Programme and other programmes related to poverty alleviation.

It can therefore be argued that Zambia shows a lot of commitment and will, to address the many challenges that the country faces in the area of health in general and sexual and productive health in particular. This is evidenced by the promulgation and articulation of an array of policies as indicated above. However, the development of policy is no guarantee for

the effective implementation of such policy. A lot of advocacy may be required to implement some policies.

On the advocacy front, reproductive health is today a priority in the country's development agenda and is being addressed with more political commitment. Influential groups such as some churches and political leaders have come to accept the promotion of the concept of sexual and reproductive health. While some churches are still opposed to SRH issues, policy makers have supported discussion of population issues and formed a parliamentary group to spear head population issues in Parliament. The Zambian media on the other hand, has continued to publicize activities on reproductive health issues.

1.3 Problem Statement

Interventions for HIV/AIDS prevention and mitigation programmes stem from a realisation that, never in the history of mankind has there been such a widespread and fundamental threat to human development as AIDS. At the same time, Southern Africa is experiencing the most severe HIV/AIDS pandemic in the world and must therefore be the focus of interventions in preventing the further spread of the pandemic and mitigating the impact of the disease on those infected and affected.

The scale of the infection however is that while the world is so worried of the “Global Pandemic”, developments of recent years suggest something rather different. Jackson (Ibid.) argues that, although HIV/AIDS has reached every corner of the globe in public health terms, it has assumed more or less two distinct pandemics one global the other one regional. It is in the countries in Southern and Eastern Africa where the pandemic has struck most and it is in this region that the biggest efforts must be made to halt the pandemic.

Because HIV/AIDS continues to spread and affect the lives of millions of people in the world, a growing sense of urgency has developed about the imperative need to stop it. In all areas of the world, national HIV/AIDS programmes along with countless nongovernmental organisations and community-based organisations have initiated programmes to respond to the pandemic. The goal of these efforts is to prevent the transmission of HIV and to mitigate the consequences of AIDS through care, support and treatment. The programmes range from very large national efforts to small local efforts. . Whatever the size, the programmes have almost always involved some elements of planning, coordination, service delivery and involvement of communities and people living with HIV/AIDS.

All HIV/AIDS service delivery programmes face complex tasks. Behaviour change strategies typically require the use of multiple and appropriate strategies to spread messages to different social groups and in order to be effective and sustainable, these and many other aspects of the programme need to be implemented in settings where communities are involved and mobilized. Fisher and Foreit (Ibid.) state that HIV/AIDS programmes are complex because the disease is complex. It affects all aspects of human society from the cultural sphere to the religious, political and economic spheres. The infected and affected are many in number, diverse in nature and widely dispersed through out the world. HIV/AIDS programmes usually address such sensitive issues as sexuality and longstanding concerns about human rights, poverty, economic development, gender inequality and stigma and discrimination.

Zambia has since the 1980s been confronted with the issue of HIV/AIDS and this has become one of the greatest challenges that the country has ever faced. It is said to be threatening to arrest or even reverse some of the important hard won gains in various sectors such as health, agriculture, education and human resource development. It has developed from a health problem into a developmental crisis. It is not only having a very negative effect on the economy of the country, but it has also in a very profound way brought grave suffering and misery to people especially the vulnerable.

The estimated rate of HIV infection in Zambia according to UNAIDS (Ibid.) is 19.75 percent of the adult population. This means that out of every five adults in Zambia, one is infected with the virus that causes AIDS and will eventually get sick and die. The pandemic is therefore not only becoming the number one killer in Zambia but it is also the primary cause of an orphan crisis in the country that has brought about a new phenomenon that was unknown less than two decades ago, i.e. children living on the streets.

The number of orphans in Zambia, because of AIDS deaths is estimated at more than one million children or ten percent of the population of the country (UNAIDS) (Ibid.). The country has an unprecedented orphan crisis, which has resulted in many children living on the streets, in the urban areas. The majority of the people dying are those in the productive age groups who when they die carry with them their productive abilities and leave behind children and old people who are not economically that productive. Burns et al (2004) quoted a young man in Mansa District of the Luapula Province who said the following: *“Orphans are the order of the day here. They are many. The biggest problem they face is trying to afford school fees, including books and uniform. So many of them do not go to school”.*

One of the grave impacts that the pandemic has on the country is therefore that most of the population that has to support economic activity is under threat. The Ministry of Health and the Central Board of Health (1999) point out that what makes the HIV/AIDS pandemic so serious is that it has a pervasive impact on virtually all aspects of development and society in Zambia. So, to the extent that infection levels are high, all sectors have been affected and as a result, costs in many sectors have risen.

Jackson (Ibid.) says that AIDS threatens food security, productivity, human resource availability and development and may even jeopardize national and regional security. It hurts the individual, family and household first, but its impact reaches through to the microeconomic level. It is a long time development disaster on a scale never seen before.

Without quoting any figures, it is obvious that in the education sector there are losses in the number and quality of teachers. In agriculture, there is increasing mortality among workers while in health service itself workers are not spared from the pandemic. The disease burden has increased through occupancy of beds by chronically ill persons and providers' exposure to the risk of infection.

Increasingly the care for HIV infected persons is being transferred to households and communities. Therefore household capacity has been stretched. Resources that are meant to be spent on other household essentials are increasingly being committed to healthcare and eventually to funeral costs. Zambia's poverty is therefore being aggravated by HIV/AIDS.

There are several reasons or factors contributing to the spread of HIV in Zambia. The Ministry of Health and the Central Board of Health (Ibid.) point to the following factors:

- a) Prevalence of sexually transmitted infections,
- b) Multiple sexual relationships,
- c) Low use of condoms,
- d) Lack of male circumcision,
- e) Poverty and poor overall health,
- f) Low status of women,
- g) Urbanization and mobility,
- h) Early sexual activity and
- i) Some harmful cultural and traditional practices.

Whatever the causes of the spread of the pandemic, it should be acknowledged that Zambia has a very challenging problem to face. The

HIV/AIDS pandemic is not sparing anyone. Its impact on the country and on people's lives is severe. Zambia therefore needs to marshal both internal and external resources to fight the pandemic.

1.4 Rationale for the Study

It has been observed that many people particularly in the developing world are not well informed about the nature of HIV/AIDS and have little access to available preventive measures. Misconceptions about how the disease spreads are common such as transmission through sharing of food, cups and clothes, kissing and mosquito bites as well as non-transmission through a single unprotected sexual encounter and sex with a healthy looking partner. People are therefore in need of accurate information about the nature of the pandemic as well as means of preventing infection.

Young people especially in developing countries form one of the largest groups with unmet needs for reproductive health services. They need to be able to protect themselves against unwanted sex, STDs, unwanted pregnancy, too early child bearing and unsafe abortion. Unfortunately young people face these risks often on their own. In many parts of the world traditional family planning and community support is no longer available or has been unable to cope with rapidly changing realities. Organized community health or social measures have not yet filled the

gap. While the revolution in reproductive health services has helped to meet the reproductive health needs of many older married women and couples, young people have been largely left out.

Too often when adults discuss young people the most common word used is “problem”; the pregnancy problem, problems with STDs, behaviour problems, the problem of educating young people, the problem of irresponsibility etc. Nonetheless, young people are society’s potential for growth and development. They are the parents, workers and leaders of tomorrow. Meeting the sexual and reproductive health needs of today’s young adults requires more than solving problems; it requires investing in the potential of young people and helping them to prevent and solve problems for themselves.

As a group young people are said to be the healthiest members of their communities. Having survived infancy and early childhood diseases, they have the lowest mortality rates of any age group in both developed and developing countries. The risks related to sexual activity can therefore jeopardize not only the physical health but also the long-term emotional, economic and social well-being. The reproductive health risks that young people face include:

- Sexually transmitted diseases (STDs) including infection with human immunodeficiency virus (HIV) which results in AIDS,

- Sexual violence and coercion including rape, sexual abuse and selling sex,
- Too early pregnancy and childbearing with elevated risks of injury, illness, and death for both mother and infant and
- Unintended pregnancy, often leading to unsafe abortion and its complications.

Furthermore, young people who become parents too soon especially girls, face the social and economic consequences of lost education and lowered earnings.

Young people in Zambia constitute a large proportion of the population. It has also been established that young people in Zambia have increasingly become vulnerable to a deteriorating quality of life because of the extreme poverty being experienced. However, the important factor to consider is that young people are the future of any country and therefore their lives must be such that they are able to develop into responsible empowered people ready to advance the future and cause of the country. From this perspective, it is important that Zambia invests in the well being of its young people as this is the surest way of securing its future. Therefore, in the provision of social and economic services, particular attention must be given to the needs of young people.

In a situation where provision of social and economic services does not focus on young people, it is important that society is sensitized on the need to pay greater attention to young people's needs. For example in the area of sexual and reproductive health many health service delivery systems in many countries exclude young people from such services on the assumption that young people do not have sexual health concerns. Clinics are not 'Youth Friendly' and therefore services are shunned by youth that desperately need them. Given the fact that many young people need such services, it is important to examine how services are provided, in terms of whether the strategies used are able to achieve results.

It is important to reiterate that young people in Zambia are in dire need of information on HIV/AIDS prevention because information available is that young people in Zambia are equally if not more affected by the pandemic. In a publication titled *Issues in Public Health* (2001), it is stated that today's young people are the AIDS generation. They have never known a world without HIV. Millions have already died. Yet the HIV/AIDS pandemic among youth remains largely invisible to adults and to young people themselves. Stopping HIV/AIDS requires comprehensive strategies.

The vulnerability of young people stems from the fact that they do not usually access factual and accurate information on sexual health. Sexuality is not openly discussed, as this is considered taboo, while health service provision is biased towards adults and has little room for young people. Therefore youth sexuality is only recently being acknowledged. Adults and especially parents often find sexual relationships of adolescents such a difficult subject that they avoid it. Young girls and boys do not receive adequate information and counselling and lack the means to control fertility. If they get a sexually transmitted disease or experience an unwanted pregnancy, they often do not have access to services or even know about them. Health services often operate on the premise that sexual relationships are consensual while this may not usually be the case. Girls may be vulnerable to sexual abuse by partners or even by family members. In many cultures boys are under pressure from peers to have early sexual experience to "prove they are men".

Adults on the other hand often hold mistaken views about young people's sexual and reproductive health behavior and its consequences, based more upon assumptions or stereotypes than understanding. However, education is recognised to be important as a key to improving sexual and reproductive health and informing about sexual and reproductive health rights. SIDA (1997) state that strategies to reach out should include

formal as well as non-formal education, adult literacy programmes and school parent organizations. A problem of the development of effective programmes for young people in many countries is that so little is known about how to approach them or how development in society reaches them.

In Zambia, the major mode of transmission of HIV identified is heterosexual contact and it is in this area that many interventions have been introduced. These interventions have largely to do with public health and behavior change messages dissemination. They include promoting reductions in the number of sexual partners, encouraging delays in the onset of sexual activity among adolescents, promoting the consistent and correct use of condoms, strengthening programmes for STD control and encouraging voluntary counseling and testing.

It is widely acknowledged that HIV/AIDS infection is largely the outcome of an individual's sexual behavior. Among previous generations, sex was largely confined to marriage whereas today, young people marry later and thus more are having sex before marriage. This change puts many young people at a greater risk of contracting STDs including AIDS as well as for unplanned pregnancy. .

SIDA (Ibid), however, state that all people irrespective of age and marital status should have the right to know about sexuality and reproduction. In order to protect themselves from diseases and unwanted pregnancy, adolescents in particular need knowledge about sexuality and reproduction. Sexuality education should therefore be provided in schools, through the health system, youth organisations and through the media. Special efforts must be made not only to reach, but also to involve the young people.

Therefore, projects that target behavior change have been established. Many projects are involved in information dissemination and general awareness creation as away of getting young people especially acquire better knowledge, change attitudes and adopt behavior that will prevent the further spread of HIV. It is important therefore to appraise the communication strategies that have been employed and determine how effective such strategies have been and how the can be improved.

It is important to remember that, unfortunately in all this time, it has not been possible to develop a cure or a vaccine for the disease. Although some drugs have been said to reduce the virus load, and in some cases practically clear the blood of viral particles for sometime, these are very expensive especially for the developing countries, which have the majority of HIV/AIDS cases. The only hope of lessening the pandemic,

therefore, lies with prevention of infection. Goncalves (1994), points out that HIV is transmitted through blood and other body fluids, mainly sexual fluids and to a lesser extent breast milk. Heterosexual spread alone accounts for about 71 per cent of the cases worldwide, homosexual interactions 15 per cent, medical injections and drug abuse 7 per cent, and blood transfusion 5 per cent. The rest of the cases are from vertical transmission. Transmission through blood and blood products has already been addressed by providing screening facilities in most blood banks. Prevention of heterosexual infection therefore is the main route for stopping further infections.

1.5 The Health Infrastructure in the Country

In 1992, the Government of Zambia embarked on an ambitious programme to reform the health system and infrastructure. Underlying these reforms was the desire to build effective leadership, accountability and partnerships as leading principles to provide equal access to cost-effective quality healthcare as close to the family as possible. The Health Reforms Document (1993), states that:

“The major thrust of the reforms has been the devolution of the Ministry of Health’s key functions through the development of new structures such as the District Health Boards, District Health Management Teams, Hospital Management Boards and Central

Board of Health. The reforms focus on the districts as the focal points of integrating healthcare”

The Government, through the above reforms, has committed itself to financing a basic package of cost effective healthcare service. The population, through a cost sharing mechanism, carry the responsibility to contribute to the financing of healthcare services. In this package, sexual and reproductive healthcare is recognized as having a large impact on the well being of individuals and families as well as the socio-economic situation of the country.

The setting up in the provision of health services is that there is a District Health Board, which is the policymaking body at the district level. The District Health Board is mandated with the task of overall supervision of health provision in a district. Below the Board is the District Health Management Team. This is the team of professionals who plan and supervise the provision of services. The District Director of Health heads the District Health Management Team.

1.6 Objectives of the Study

The objectives of the study were:

- Explore the concerns of young people on the issue of HIV/AIDS.

- Examine the strategies used by Ndola District Health Management Team to address issues of HIV/AIDS prevention and mitigation among young people.
- Suggest ways of improving the effectiveness of communication strategies used by Ndola District Health Management Team.

CHAPTER 2

METHODOLOGY

2.0 Introduction

This Chapter describes the research setting, the research questions, sampling and how the data was collected, organized and analyzed. It also includes an aspect of the limitations of the study.

2.1 The Research Setting

Ndola is one of the four cities in Zambia having been a major industrial and commercial centre on the Copperbelt Province. It is the Provincial capital of the Copperbelt Province and shares an international boundary with the Democratic Republic of Congo. From Zambia's Independence up to about the late eighties the City of Ndola was very vibrant in industrial and commercial activity with big companies such as the Indeni Oil Refinery, Ndola Copper Refinery, Zambia Sugar Company and many parastatals and private commercial and industrial businesses located in the city. The early nineties however saw a vigorous programme of liberalization of the economy leading to privatization of many companies. As many of these concerns went into private hands, a lot of them were closed down leading to massive job losses among the residents of the city.

Townships like Kabushi, a dominantly low-income township that used to be sustained by the strong industrial and commercial base found themselves with a lot of unemployed and underemployed people. Presently the township is typical of the many low-income townships in most Zambian towns, characterized by deteriorating economic and social infrastructure with populations that are increasingly becoming poorer. Kabushi with a population of more than 12, 000 people, is served by one health centre. Like in many other communities, the majority of the population is that of young people below the age of 25 years.

Because of economic hardships, most of the people in the township do not access private medical and health services. They depend on the services provided by the government health centre. In many cases people tend to purchase medicines without prescriptions across the counter in small drug stores. People generally think that the health system in the township in particular and the country in generally does not guarantee effective service delivery as health facilities lack medicines and appropriate equipment for a good healthcare system. Therefore although the country under the health reforms strives to “provide quality, cost effective and affordable healthcare as close to the family as possible”, (Zambia Health Reforms 1992), many people are not able to access such

services because of a number of limitations, the major one being shortage of medicines in health facilities.

2.2 Research Questions

The research questions for the quantitative design were formulated to elicit responses on what the respondents regarded to be the most urgent health concerns that faced young people in the community, who they thought was addressing the concerns and how effectively these concerns were being addressed. The questionnaire also sought to elicit responses on what young people thought of the interaction and the level of communication between the service provider and the service recipients and whether the services provided were sufficient and appropriate.

The Likert Scaling or Summated Rating Approach Method was used in the quantitative survey. A question was posed and a number of statements indicated with regard to a situation. The respondents in most of the questions were expected to indicate their attitude towards a given situation.

The Focus Group Discussion questions sought to elicit responses on the sexual and reproductive health challenges that young people in Kabushi Township faced. The questions for discussion were designed to bring out young people's perceptions and experiences in the areas of availability of

services, accessibility to these services, relevance of the services, coverage, utilization, quality of the services and their quantity, efficiency and impact.

In considering the aspect of availability of the services, the intention was to look at whether the young people considered the services present in the community and whether they knew where to get them. The issue of accessibility concerned finding out whether what existed was actually within reach of those that needed it, while the issue of relevance dealt with the aspect of appropriateness of the services. Utilization dealt with the extent to which services were being used for the intended purpose while the aspect of quality sought to measure the standard of the services. Effort dealt with the aspect of what was being invested in order to achieve the objectives of the intervention while the issue of efficiency sought to bring out aspects of optimal utilization of resources. Finally the aspect of impact was concerned with whether what was being done was really making any difference.

2.3 Sampling Procedure

The sampling frame for the study was the population of young people in Kabushi Township between the ages of 10 and 24 years. The estimated population of the study cohort was about 3,600 or 30 percent of the population of the township. The questionnaire was administered using

one of the non-probability sampling methods, the Convenience Sample Method. Respondents were selected from whatever cases happened to be available at the time or place of the research. However, the respondents were required to have the following characteristics: Male or female resident in the township at the time of the research and between the ages of 10 to 24 years. A number of respondents reported to be above the age of 24. Eighteen of them who reported to be above 25 years but not more than 28 years were interviewed.

Participants in the Focus Group discussions were selected on the basis of their availability and willingness to participate in the discussion. However, the selection was also based on some socio-demographics for eligibility. The Focus Group Discussions involved 32 young men and women in categories as follow:

- i) 'In School' Girls,
- ii) 'In School' Boys,
- iii) 'Out of School' Girls and
- iv) 'Out of School' Boys.

2.4 Sample Size

The sample size for the questionnaire was 100. During the survey there was no deliberate effort made to consider gender representation, as the type of sampling used was the Convenience Sample Method. For the

Focus Group Discussions however, 8 'In School' Girls, 10 'In School' Boys, 6 'Out of School' Girls and 8 'Out of School' Boys participated in the discussions. Therefore a total of 132 respondents were recorded.

2.5 Data Analysis

Data collected was organized examined and reviewed using both quantitative and qualitative analyses. Data from the quantitative design was coded and entered into the computer using the Statistical Package for Social Sciences (SPSS). It was analyzed in terms of percentages, frequencies, and other characteristics. The data from the Focus Group Discussions having been transcribed was also analyzed and examined to draw out responses and opinions about the services available to young people. Anecdotes were noted for paraphrasing.

2.6 Limitations of the Study

The study had the following limitations:

- Limited Time: The time for the study was shared with the requirements of a new appointment on the part of the student following the restructuring of the employing organisation.
- A Non-probability sampling method was used. Fisher and Foreit (Ibid.) point out that Nonprobability sampling procedures are not good for obtaining a sample that is truly representative of a larger population.

obtaining a sample that is truly representative of a larger population. Almost always Nonprobability samples tend to over select some population elements and under select others. When the known probabilities of selection are not known, there is no precise way to adjust for such distortions.

CHAPTER 3:

CONCEPTUAL FRAMEWORK

3.0 Introduction

The conceptual framework is meant to explore the meaning of the terms or concepts used and to assess the theoretical understanding and application of theories related to the interventions made by the change agent. The chapter will therefore make an assessment of the use of the theories and principles of communication especially behaviour change communication.

Prevention of HIV infection is about behavior change and for people to change behavior; they need to be helped to honestly confront what they are doing and why they do those things. Any programme that is about behavior change must therefore enable people to honestly reflect on their behavior, develop positive attitudes about changing their behavior and eventually change behavior in line with the new values that have been adopted.

3.1 Behaviour Change can therefore be defined as, or referred to as adoption of new practices as a result of acquiring new knowledge, skills and attitudes. Promoting behavior change is a complex process mostly

requiring an understanding of culture as well as behavior. Behavior change must be facilitated rather than dictated. It must be persuaded rather than coerced. Infante, Rancer and Womack (1997) state that persuasion differs from coercion because with persuasion audience members can choose to agree or disagree. So, for any programme to be effective and to achieve the change in behavior that is envisaged, it is of utmost importance to get a thorough understanding of the determinants of behavior change. This therefore requires an understanding of the theories behind behavior change and how these can be applied to real situations in order to bring about the required change. Tones and Tilford (1996), argue that adoption of proper behaviour is considered to be proper insofar as the behaviour leads to the prevention of disease. They further argue that the provision of knowledge is not important for its own sake but only for its contribution for the approved behaviour outcome. The central outcome should therefore be clear i.e. the attitude change strategy that should be able to motivate the individual into action.

UNAIDS (Ibid.) point out that interventions to stem the spread of HIV through out the world are as varied as the context in which they are found. Not only is the HIV epidemic in terms of treatment options, prevention strategies and disease progression complex, but sexual behavior which remains the primary focus of AIDS prevention efforts worldwide is widely diverse and deeply imbedded in individual desires,

worldwide is widely diverse and deeply imbedded in individual desires, social and cultural relationships, and environmental and economic processes. This makes prevention of HIV, which could be an essentially simple task, enormously complex and involving a multiplicity of dimensions.

As HIV transmission is almost entirely a factor of behaviour, theories of individual behaviour change have proved useful for the planning and implementation of many prevention programmes in the world and in Zambia. The change efforts have been premised on theories that explain and predict how individuals change behaviour. These theories show the stages or the process that people go through to adopt new behaviour. The Theory of Reasoned Action for example assumes that human beings are rational and make good use of information that is available to them. Human beings are regarded to be conscious of the consequences of their actions and once given further information on an issue they are bound to use that information for their own good.

Based on individual behaviour change theories, several models have been used to explain behavioural change in relation to disease before and since the advent of HIV/AIDS. The development of most of these models has been based on experiences in the developed countries and may not apply in the developing countries with their different cultures and

outlooks. However, some of the theories can be extended to HIV/AIDS prevention in sub-Saharan Africa and in Zambia. Two of these, which seem to be most applicable, are the Health Belief Model, and the AIDS Risk-Reduction Model. The Health Belief Model assumes that the individual's attitude plays an important role in the prevention of a disease. These attitudes are the individual's perception of susceptibility to the disease, seriousness of the disease, benefits of health action, and barriers to health action.

According to this model, sufficient knowledge of the disease is essential but not the only prerequisite to behaviour change. They also include peer support for safer behaviour, self-efficacy or belief in one's ability to avoid disease, and skills in communicating and enacting safer behaviour.

The AIDS Risk-Reduction Model and some other models include some of the above factors like knowledge of disease transmission, belief in the severity of the disease, and perceived risk of becoming infected. They also include peer support for safer behaviour, self-efficacy or belief in one's ability to avoid disease, and skills in communicating and enacting safer behaviour.

As already stated individual behaviour theories and models have been used to influence behaviour change especially among adolescents and

young people but using these approaches has not done much in changing behaviour. UNAIDS (Ibid.) point out that overemphasis on individual behaviour change with a focus on the cognitive level has undermined the overall research capacity to understand the complexity of HIV transmission and control. Focus only on the individual psychological process ignores the interactive relationship of behaviour in its social, cultural and economic dimension thereby missing the possibility to fully understand the crucial determinants of behaviour.

Aggleton, quoted by UNAIDS (Ibid.) points out that in many cases motivations for sex are complicated, unclear and may not be thought through in advance. Therefore for an individual to engage or not to engage in a certain action is influenced by a number of factors most of which are societal. Societal norms, religious criteria and gender-power relations are considered crucial in influencing behaviour and therefore change efforts have to take these into consideration.

It is important to recognize that individual models of change ought to be complemented with social models. This is because while the former aim at change at the individual level, the latter aim at a qualitative change at community and societal levels. Individual theories can be said to be addressing the effects of certain behaviour orientations in society while the social theories target the root causes of certain behaviour because it

is the society that shapes such behaviour. Society can be looked at as broken into sub-cultures and most of what human beings do is influenced by those sub-cultures. So the sub-culture surroundings like the family, peer group, opinion leaders, etc have a big influence on individual behaviour.

Theories that can be used to induce social change at community level include the Diffusion of Innovation Theory. The theory outlines a process or stages through which an innovation or new idea passes before it can be accepted by a community. The stages identified are:

- | | |
|-----------------------|---|
| a) Awareness- | This stage includes exposing people to a message so that they gain knowledge about the problem. |
| b) Interest- | This is the stage where people begin to seek additional information. |
| c) Assessment- | This is the stage where people use information to determine the benefits of the innovation. |
| d) Trial- | People acquire and apply the innovation to assess its utility. |
| e) Adoption- | People adopt the idea because they are convince about it. |

The above process is important in effecting behaviour change and the process takes cognisance of the fact that effecting change is a social process. Its central tenet is that individual behaviour is a product of a social process. Kegeles quoted by UNAIDS (Ibid.) states that people are most likely to adopt new behaviours based on favourable evaluations of the idea communicated to them by other members who they respect. Individual behaviour is therefore more likely to be consistent with perceived social norms.

The Theory of Gender and Power is especially significant in societies where the status of women is low. Women may lack power to influence decisions. They may have no or little power or skills to negotiate for risk reduction behaviour with their partners and therefore may be highly vulnerable to HIV infection. Using this theory to guide intervention programmes, one could determine how women's commitment to relationships and lack of power could be a big factor in risk reduction strategies.

Economic and environmental factors should also be given a place in determining behaviour. Some theories point out that sexual behaviour should be seen as a function of not only individual and social aspects but of structural and environmental factors as well. When people live too

closely like in many high-density areas of Zambia, there is room for more intense interaction and the possibility of heightened sexual activity.

Therefore, for any intervention to succeed and for individuals to change behaviour, context specific information and skills are critical. So there is need for different approaches in understanding and predicting behaviour. Interventions must be based on the consideration of social influence, social networks, cultural norms, peer association, environmental situation, power relations between men and women economic factors and other relevant considerations including policies. UNAIDS (Ibid.) point out that individual approaches have shown impact but to stem transmission on a larger scale for longer-term maintenance of changed behaviour, community and structural level programmes are a critical component. Programmes must therefore be about social change. They must be more community rather than individual centred and emphasise what has been termed as trans- theoretical approaches.

Effective HIV infection prevention must extend beyond the giving of basic information. In addition to information giving intervention programmes must aim at sensitising individuals to personal risk, improving couples sexual communication, facilitating the perception of lower risk practices as a social norm and help people receive support and reinforcement for their efforts at changing behaviour. This therefore calls for a broader

view of approaches to combat HIV/AIDS. The different approaches must be seen to complement each other.

Many organisations have adopted mass communication channels to disseminate issues of a developmental nature. Many times this is done without paying attention to mass communication theories. The Magic Bullet Theory was at one time an important model in understanding how organisations use the mass media to disseminate messages. The theory emphasised the powerful or strong effects of the media. Here an audience and individuals are seen to be passive and susceptible to media messages. Although this theory was discarded, currently the dominant effects paradigm is still accepted. The media are seen to be capable of influencing and shaping public opinion and persuade the masses toward nearly any point of view desired by the author of a particular media text. In this way the media can provoke particular beliefs and attitudes in people.

Also helping to explain communication are The Two Step Flow of Information Theory and The Multi-Step Flow of Information Theory. These theories postulate that information does not flow direct from the text into the minds of the audience unmediated. Information rather filters through other channels like opinion leaders who then communicate it to their less active associates over whom they have influence. The audiences then

mediate the information that they have received directly from the media with the ideas and thoughts expressed by the opinion leaders. Thus the audiences are influenced not by a direct process but a variety of other channels.

Organisations that believe in the latter theories tend to emphasise community-based activities in which community leaders may play important roles. Activities should therefore be analysed in the light of which theory of communication is dominant. However, The Agenda Setting Theory is presently more plausible in explaining communication. The theory postulates that there is a correlation between what the media deems important and salience in the public mind. What the media finds important will eventually be mirrored in what people think is important. Eoff (2002) quotes Protesse and McCombs (1991) who state that; "Agenda setting shifts the focus of attention away from immediate effects on attitudes and opinion to longer term effects on cognition". The notion of Agenda setting is that there is a positive association between the media and the audience. The media are seen to have the ability to tell the general public what is important.

Agenda setting describes a very powerful influence of the media. People are seen as depending on the media to describe important events and to focus on those events. This theory shows why it is important to use

mass media to address critical issues like HIV/AIDS. The advent of community media in Zambia, especially community radio stations should be taken advantage of in the communication of development messages. The area of study is covered by a community radio and it would be important to use this radio station to disseminate information on sexual and reproductive health for the prevention of HIV infection.

3.2 Communication for Behaviour Change

Most of the activities that organisations engage in to combat HIV/AIDS are based on Behaviour Change Communication (BCC). Behaviour Change Communication is a strategy that aims at promoting positive action or bring about desired change in behaviour. Behaviour change is complex. BCC approaches therefore recognize that presenting facts alone does not ensure behaviour change

BCC is a process of using communication approaches and strategies to develop the skills and capacities of the target audience to promote and manage their own health and development by fostering positive change in behaviour as well as in knowledge and attitudes. Rather than just information provision, BCC is done in partnership with families, schools, health services and communities to influence the social norms and environment within which people function.

BCC activities address the larger context that affects an individual's behaviour, culture, societal norms, socio-economic environment, laws, policies etc. BCC therefore must apply interactive approaches. Some of these may be face to face communication, such as counselling and peer education, to address deeply rooted behaviours, mass media to reach a broader audience and introducing new behaviours, combining education with entertainment to engage audiences especially young people, connect youth with parents or other role models, schools, communities and spiritual groups.

In a publication of the Population Programme (1995), it is stated that sex education and reproductive health programmes for young adults often face opposition. For such programmes to succeed, they must work with parents and within community norms. At the same time programmes must advocate new social norms that protect the health of young adults. Current norms may be rewarding boys but punishing girls for having sex, they may glamorise irresponsible sexual behaviour in the media but reject young people's interest in sexuality. Attention must be paid to such norms in the implementation of behaviour change programmes.

3.3 Young People

The term young people, includes those who are referred to as adolescents and or youth and are between the ages of 10 to 24 years. The United

Nations Fund for Population Activities UNFPA has the same age range in its definition of a young person. The term young people may however have a cultural definition and may be applied in accordance with who is regarded as a young person. The term may be used to define several groups apart from their definition in terms of age. Burns et al (Ibid.) point out that using the term young people can conjure in the mind several groups such as rural boys or girls, married adolescents, street children, orphaned and vulnerable children in communities, adolescents engaged in commercial sex, child soldiers and many other sub groups in society. It is therefore important to bear in mind such operational definitions when formulating an intervention programme. Programmes need to be target specific with objectives that are measurable, achievable and realistic. Without defining the target audience a programme may not be effective.

3.4 Reproductive Health means that people have the capability to have children. Women and men have the right to health services for contraception and treatment of infertility. Everyone must therefore have a right to good care. This includes appropriate health care during pregnancy, childbirth and the prenatal period.

3.5 Sexual Health means that people should be able to have a safe and satisfying sex life including a health psychosexual development.

Gender relations should be equal, responsible and mutually respectful. The concept of sexual health is broader than that of reproductive health. Its importance has been highlighted by such health problems as the HIV/AIDS pandemic. However, sexual health must always be seen in the light and norms of expectations of the society, which encourage responsibility and restraint before marriage. Strong family values are believed to be the basis of a strong society.

3.6 Reproductive Rights means that couples and individuals have the right to decide if and when they want to have children, without any discrimination, coercion or violence. Reproductive rights apply to all sexually mature men and women irrespective of social status, and include the right to knowledge about sexuality and reproduction and to reproductive health care services, including fertility regulation. They also include the right of women to appropriate maternal health care.

3.7 Sexual Rights include all people's rights to decide about their sexual life with full respect for the integrity of the partner and the right of women and girls to say no to sex. It includes not only legislation, but also norms and practices which hinder women and men from taking responsibility for their sexual behaviour.

3.8 Stigma and Discrimination

Stigma, which results into discrimination, is a major factor in HIV/AIDS programmes to which particular attention must be paid. Stigma can be seen as negative thoughts or prejudices about people from particular groups or with certain characteristics. HIV/AIDS related stigma is a real or perceived negative response to a person or persons by individuals, communities or society. The characteristics of stigma are:

- Denial,
- Rejection,
- Isolation,
- Blame,
- Disregard,
- Underrating, and
- Social distance

Individuals, especially young people may have difficulties in accessing services if stigmatisation is not dealt with effectively. To effectively address stigma, it must be considered that stigma has sources or origins, which may be either social or psychological, and in the society spheres it can be used as a tool of social control that can be used to exclude, marginalize or exercise powers on individuals who show certain characteristics.

HIV/AIDS related stigma and discrimination are most closely related to sexual stigma. This is because HIV/AIDS is mainly sexually transmitted and in many areas of the world the epidemic initially affected populations whose sexual practices are different from the “norm”. Contracting HIV/AIDS is perceived to be as a result of irresponsibility, promiscuity and immoral behaviour associated with prostitution on the part of women. This is why most HIV positive people and their families are not willing to come out in the open about their HIV status.

Because of stigma and discrimination attached to HIV, people many fail to tell friends, colleagues or family about their status. They may risk being isolated socially, discriminated against at work or prevented from gaining access to services such as housing, fertilizer loans and other benefits. Some of the adverse effects of stigma are that for people infected with HIV, stigma can prevent seeking early treatment of opportunistic infections, while for those not aware of their HIV status, stigma can prevent seeking counselling and testing services

Examples of stigma and discrimination at family level are that, sometimes a person living with HIV/AIDS may be left to eat alone and often family members may not use the utensils they use. People living with HIV/AIDS suffer isolation and lack of care from family members who might be afraid of contracting the disease. Family members



sometimes do not wash clothes for people living with HIV/AIDS or bathe them. Sometimes patients are left on their own, while spouses sometimes desert partners living with AIDS.

At community level, people in the community may show fear towards people living with HIV/AIDS. Isolation and exclusion from community activities may be experienced. People living with HIV/AIDS are sometimes insulted and abused by neighbours. In areas where an infected person is engaged in business in the market, people may refuse to buy goods from them. In many incidences people in the communities may often laugh at the physical appearance of those living with AIDS.

Therefore sources of stigma in the community could be many and may include family members and relatives, friends and neighbours, groups, organisations, and Services and programmes.

Stigma and discrimination should be fought if programmes have to succeed because where there is stigma services may be shunned.

CHAPTER: 4

LITERATURE REVIEW

4.0 Introduction

There are numerous studies, concerning youth and reproductive health and the issue of HIV/AIDS prevention, which have been undertaken. These studies have been on the global as well as regional level and those at country level. Most of the studies have focused on behavioural change strategies in terms of how effective they have been in bringing about desired behaviour change in order to stem the spread of HIV/AIDS.

Equally there are numerous papers that have been written concerning adolescent and youth sexuality and the incidence of HIV/AIDS. Centerwall and Laack (2000) point out that many evaluations and articles have shown that knowledge and facts regarding sexuality education are an important platform for individual decisions over sexual matters. They argue that primarily no person should tell another what to do, who they are or what attitudes they should have because this does not change behaviour. "The "shoulds" we demand, distance us from

other people and in the worst case we create silence, distrust and, distance from people” (p.10)

Swartz (1998) undertook a study whose aim was to investigate the existing HIV/AIDS preventative services for adolescents within the NGO sector. Results of the study indicated that the majority of NGOs provided training for reproductive health education, which varied from teachers to peer counsellors. Their programmes covered ‘In’ and ‘Out of School’ youth for both urban and rural areas. The age category 12-18 years was identified as the most vulnerable group. The study also found out most of the programmes focused on preventative issues although there was some emphasis on reproductive health services and contraceptive use.

4.1 Joint United Nations Programme Review

In a review commissioned by the Joint United Nations Programme on HIV/AIDS (UNAIDS 1997), evidence indicated that sexual health education for children and young people did not necessarily lead to promiscuous behaviour among young people. In this study UNAIDS commissioned a review of sixty eight reports on sexual health education from France, Mexico, Switzerland, Thailand, the United Kingdom, the United States, as well as from different Nordic Countries. This was reported to be the most comprehensive and up-to-date review of studies in this field, looking at sexual health education programmes and those

incorporating education about the prevention of HIV. The review's primary intention was to inform policy makers, programme planners and educators about the impact of HIV and sexual health education on the behaviour of young people. The focus of the review was on research that studied the behavioural impact of HIV/AIDS and sexual health education on young people.

The main conclusions of the review were that:

- Education about sexual health and/or HIV does not encourage increased sexual activity. Only three studies out of 68 reported a relation between such education and increased sexual interaction and these studies were regarded as having severe methodological limitations;
- Good quality programmes help delay first intercourse and protect sexually active youth from sexually transmitted diseases, including HIV, and from pregnancy. A total of 22 studies reported that HIV and/or sexual health education either delayed the onset of sexual activity, reduced the number of sexual partners or reduced unplanned pregnancy and STD rates.
- Responsible and safe behavior can be learned; This revelation emphasized the importance of the fact that people can learn and

adopt new behaviour as long as they perceived the benefits of the new behaviour

- Sexual health education is best started before the onset of sexual activity.

4.2 Effectiveness of Health Education

A study by Hoag (1992) in Cambodia revealed that due to a limit in resources, health educators were often provided only one short course on using Information, Education and Communication (IEC) materials or giving health education before they actually implemented their work. Refresher training was very rare. Without sufficient knowledge and skills in giving the messages, the IEC activities could not attract people, especially young people in the long-term. It was difficult for IEC to reach people in mountainous areas and minority people. People in mountainous areas were disadvantaged in accessing mass media such as TV or radio. They also met difficulty in understanding many of the health terms in Kinh; a widely used language while the translation into their own language was sometimes very confusing.

Gender differences were not considered adequately and boys were often missing in the communication and other intervention strategy. It was pointed out that girls and boys had different concerns and had different power. It was very important therefore to empower the girls in improving

their health and protecting themselves. It was recommended that IEC messages and distribution channels should be apparently specific for boys and girls to increase the effectiveness.

4.3 Review Of HIV/AIDS Activities in Zambian Schools

A study done in Zambia (Malambo 1998) to review HIV/AIDS activities in schools and among youth stated among other conclusions that

- The HIV/AIDS related education did not encourage sexual experimentation.
- HIV/AIDS information alone did not lead to decreases in HIV prevalence and had not led to changes in sexual behaviour.

A Baseline Needs Assessment Survey by the Canadian Public Health Association (August 2002) revealed that in most programmes youth had difficulties in accessing services and youth friendliness was lacking.

Yet another pertinent observation by UNAIDS (Ibid.) has been that reproductive health and HIV prevention programmes for youth rarely address the reality of the coercive sex that many youth face. Many young women and men experience non-consensual sex which is a violation of a person's rights and can have severe physical, mental and reproductive health consequences including the risks of unwanted pregnancy and HIV and other sexually transmitted infections.

UNAIDS (Ibid.) point out that young men have largely been left out of efforts to address the health and social consequences of early sexual intercourse. Girls receive most of the attention, whether positive or negative in form of social disapproval and punishment. Successfully addressing the consequences of young adults' sexual activity requires including both young women and young men.

Young men are let off the hook when the society including parents do not hold them accountable for sexual activity. At the same time boys are left in the dark because their own reproductive health needs are ignored. Boys are less likely to require commitment to or from a partner before sex; they are more likely to be proud of their sexual experience.

Boys' sexual behaviour and attitudes reflect the double standard that exists in most societies: tacitly approving and even encouraging premarital sexual activity for young men and extra marital sexual activity for older men while disapproving of and often punishing such behaviour in girls and women. In nearly all societies young men usually face fewer repercussions than girls do when unplanned pregnancy occurs outside marriage. In some societies fathering a child even when quite young or outside marriage gives a young man prestige. Not surprisingly boys are less likely than girls to worry about unintended pregnancy.

Programmes need to learn more about young women's reproductive health issues, including contraceptive use, STDs, forced sex and unplanned pregnancy as well as boys' perception of masculinity, responsibility and gender roles.

According to the Centre for Communication Programmes (1995), young men and women need:

- Accurate and relevant information about sexuality and reproductive health, including full information about their own risk of acquiring STDs and how to avoid STDs,
- Access to information and services where they feel comfortable and accepted,
- Encouragement to delay sexual activity until they are better prepared to cope with the emotional and health needs.
- Education and jobs that encourage and delay parenthood and
- Communication skills to talk honestly with partners about sexuality as well as negotiating skills necessary to refuse unwelcome sex.

Parents, policy makers and programme managers debate whether schools should teach young people about sex and reproduction or should leave that to families. Meanwhile young men and women around the

world say that they learn about sex not from their schools or families but from their friends, other peers and books, magazines and the mass media. Much of the information young people learn from these sources is misleading, incomplete, or wrong. Around the world, young people say that they learned too little, too late about sexuality.

Although policy makers, programme managers and parents themselves often agree that parents are the preferred providers of sexuality education, in many societies few parents talk to their children about sex. More schools are therefore adding family life education to the school curriculum.

Learning about sex and adopting behaviour change does not of course take place in any one classroom or with one television show. Instead it is a complex process of gradually increasing understanding. Young people learning about sex do not just gather information; they also observe the behaviour of peers and other people, develop attitudes and values and experiment with behaviour. A young person relies on different sources for sex information during different stages of life and interprets messages differently according to his or her own sexual development and experience.

Thus understanding how young people learn about sex is not as simple as asking them to name information sources. Better understanding the influences that various information sources exert on young people's values, attitudes and perceptions of behaviour norms might help programmes not only to increase knowledge but also to influence behaviour. Does sex education cause promiscuity? That is the fear of opponents of sex education programmes. They argue that discussing sex will arouse young people's curiosity, reduce their reticence about sexual matters and encourage sexual activity. The evidence says otherwise.

According to a review commissioned by the World Health Organisation, (2000), there is no support for the contention that sex education encourages sexual experimentation or increased activity. After analysing more than 1000 reports on sexual education programmes worldwide, the authors concluded that sex education courses did not lead to earlier sexual intercourse and in some cases they delayed it.

Community programmes can therefore give young people the skills they need to postpone having sex for the first time. However, as already pointed out such programmes must be grounded in some theory. The social learning theory, for example, posits that people learn behaviour by observing and imitating others as well as through formal education. Social influence theories suggest that because groups and individual

norms and attitudes shape behaviour it is helpful for people to develop individual and group values and support and expectations about health and appropriate behaviour. Theories of reasoned action assert that people's intentions to adapt to new behaviour reflect their own beliefs and perceived social norms.

Whereas it may be very desirable to use such approaches as teach young people to "just say no", programmes based on these theories have learnt that the decision to have sex may be an individual's choice but may also be influenced by the social setting. Although young people may seem to be choosing sex, some may in fact have sex because for example, they are afraid to refuse, crave affection, fear hurting their partner's feelings, or need or want the money and or gifts, which they receive.

There are a number of lessons and tips that can be used for serving young people. In the first instance, it should be appreciated that at every stage in physical and social development, young people need information and advice to cope with the changes they are experiencing. They can be especially confused with the conflicting messages they receive about sexuality. Parents, teachers and other elders usually stress the negative, the possibility of disease and unwanted pregnancy. At the same time young adults see that many members of the older generation seek out and enjoy sexual relationships. Both modern entertainment media and

traditional values often put a premium on male sexual conquest, isolating sex from other aspects of human relationships and ignoring spiritual, social and health consequences.

The other dimension, however, is the issue of reaching out to 'out of school' young people with information and services. While school-based prevention programmes have the advantage of a captive audience that can progress through programmes and curricula, the 'out of school' young people may be a difficult target to reach. The school setting provides the opportunity to work with the same group to teach and practice the skills with them and to address their questions and concerns over a period of time. Many youth who are out of school and unemployed spend much of their time on the streets especially for those in the urban areas. Here, they may become more vulnerable to experimentation and with risky behaviours such as alcohol and drug abuse. The abuse of alcohol and drugs is associated with unsafe sexual behaviour and its consequences of sexually transmitted infections and unintended pregnancy as well as increased risk of violence.

Very young adolescents, because of their lack of skills and experience are especially vulnerable to coercive or abusive situations and the reproductive and the reproductive health risks those situations engender. Adolescents who are not in school are more likely to be

overlooked by programme planners, less likely to receive skill training and reproductive health information and at a greater risk of sexual exploitation.

4.4 Tips for Attracting Young People to Services

A first step in attracting young people is therefore working with them to find out what they need. Their unmet needs often differ, even among young adults of similar age and the same sex. Senderrowitz (1995) points out that the following tips are important in carrying out a successful programme to reach young people with programmes of sexuality:

4.4.1 Identify and assess your audience: Early efforts to serve young adults assumed that this group was homogenous and that adult professionals knew what was best for them. Both assumptions proved false. There may be profound differences among youth even within the same country or region. These differences may therefore require different responses from programmes. Programmes can develop the appropriate responses only when they learn from the intended clientele. This is true with young adults who usually constitute a subculture of their own, with their own points of view, values and even vocabulary.

4.4.2 Field –test plans and products: Initial research with clients is not enough. Plans, services and messages must be tested, often repeatedly with the group to be served.

4.4.3 Integrate and collaborate: Integrating a desirable new service into an ongoing new programme can attract new clients and increase overall use of services. This must however be done wisely so that the new activity does not keep away the older clients.

4.4.4 Communication and Outreach: Twin tactics: Communicating with young adults has special importance. They are learning about developing values. At the same time peers, subject to conflicting influences, influence them and very selective about whom they trust. Other strategies must therefore be used so that there is a larger influence. Outreach programmes are therefore very important.

4.4.5 Consider the cultural context: It is axiomatic that each programme takes into account its specific cultural setting. At the same time, however, cultural values and practices should not be accepted simply because they are traditional. Some traditional practices such as widow and widower inheritance by sexual cleansing may be risky and may contribute to the further spread of HIV.

4.4.6 Do not promise more than you can deliver: many programmes set objectives more optimistically. Ambitious objectives may attract funding but could lead to disappointment later. Public health campaigns take time to change attitudes and behaviour on a large scale. Too many programmes have succeeded in educating clients but for lack of services failed to create or bring about the much-needed change. Information dissemination must therefore go together with the provision of services because the raising of awareness through increasing people's knowledge creates increased demand for services.

4.4.7 Use policy to enable. Do not let it be a barrier: Laws and policies do not always determine or precede social change, and they are often ignored if they are not in consonant with cultural realities. Even in the absence of enabling legislation programmes that answer to urgent societal issues can be a catalyst for subsequent legislation.

4.4.8 Take risks and commit to change: Bold leadership is required to advocate the meeting of young adults' reproductive health needs. Such leadership takes risks, acknowledges the importance of faith, culture and tradition, while also making a commitment to change. Many programmes fail because of lack of courage to keep up public advocacy on new and sensitive issues. One risk worth taking is providing

information to young people early ideally before they have sexual intercourse. Few programmes have been willing to do so.

4.4.9 Involve young people in planning and implementing

programmes: Another risk worth taking is letting young people speak for themselves by involving them in programme design. Young people can provide insight relevant to programme design, argue convincingly for change in their changing world and they can take action.

4.4.10 Respect for young people: Programme content and delivery should respect young adults' perceptions and preferences. Young people need non-judgemental, confidential and caring professionals. Educators and service providers, however too often take a moralistic and condemnatory attitude toward young people. A sure way to lose young people's trust is to ignore their needs, exclude them from project planning and preach, "what is good for them". Education and service programmes for young people will thrive where community norms support openness and respect. Such norms encourage communication within the family and in the community. These norms will allow programmes to go beyond simplistic campaigns that only condemn unhealthy behaviour and instead to deal with the complexity of young adults' educational and developmental needs. Together programmes and

communities can help young people find their way to health and safe behaviour.

CHAPTER: 5

FINDINGS/RESULTS

5.0 Introduction

This Chapter presents the findings of the study for both the quantitative and the qualitative designs. The presentation of the findings is in two parts, first the quantitative design results and secondly the findings from the Focus Group Discussions which was the qualitative design.

5.1 Study Findings

Data was collected using a questionnaire. Five research assistants were trained to administer the questionnaire. Three of the assistants were male while two were female. One hundred questionnaires were administered.

5.1.1 Characteristics of Respondents

Out of the 100 respondents, 45 were female while 55 were male. More males than females were ready to be interviewed. A good number of females said that they were busy and could not therefore spend time being interviewed. The age range was from 10 to 24 years. Eighteen of the respondents were, however, above the age of 25 years but below the age of 30. The table for age distribution is given below.

Table 5.1: Age of Respondents

Age

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 10-14 Years	2	2,0	2,0	2,0
15-19 Years	35	35,0	35,0	37,0
20-24 Years	45	45,0	45,0	82,0
25 Years >	18	18,0	18,0	100,0
Total	100	100,0	100,0	

In terms of education, most of the respondents had gone beyond primary education. They constituted 81 percent of the respondents. The quantitative study therefore dealt with people who were literate enough to understand some concepts and to analyse situations. The table below gives the frequencies and percentages for education levels attained by the respondents

Table 5.2: Education levels of Respondents

Education

Education	Frequency	Percentage	Accumulative%
Nil	9	9	9
Primary	10	10	19
Junior Sec	31	31	50
Senior Sec	33	33	83
Tertiary	17	17	100

The majority of the respondents were not in employment at the time of the study, as only 11 percent reported to be in employment. For the others, 19 percent said they were self-employed while 38% reported to be still at school or in college. The rest, (32%) reported to be unemployed. The majority of the respondents (58%) reported to be permanent and urban residents of Kabushi Township while the others lived in the peri-urban. Seventeen percent said they lived in the rural areas and were visitors of Kabushi Township.

5.1.2 Most Urgent Health Concern

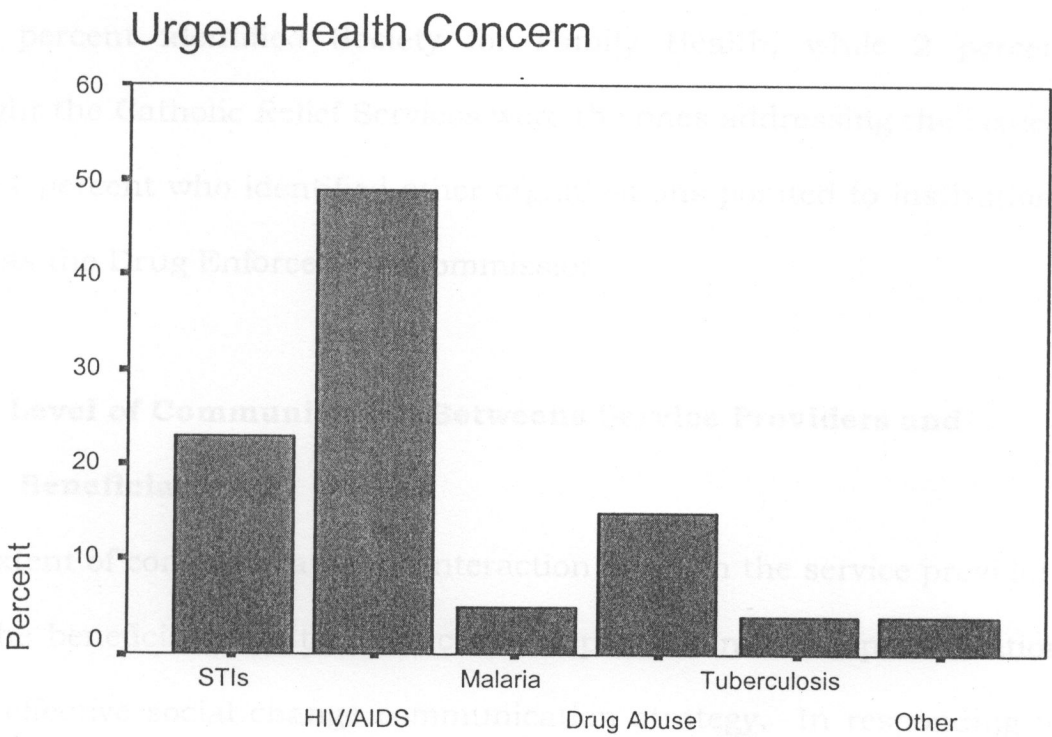
Nearly half of the respondents (49 %) identified HIV/AIDS as the most urgent health concern or challenge that young people faced in the community. This was followed by Sexually Transmitted Infections (23%). Fifteen percent of the respondents thought that drug abuse was the major problem young people faced while for tuberculosis only 4 percent identified it as the most urgent health concern. Four percent of the respondent identified other concerns, among them, short eyesight. Below are the frequencies and percentages for responses on the most urgent health concern for young people.

Table 5.3 Identified Urgent Health Concerns

		Urgent Health Concern			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	STIs	23	23,0	23,0	23,0
	HIV/AIDS	49	49,0	49,0	72,0
	Malaria	5	5,0	5,0	77,0
	Drug Abuse	15	15,0	15,0	92,0
	Tuberculosis	4	4,0	4,0	96,0
	Other	4	4,0	4,0	100,0
	Total	100	100,0	100,0	

The Bar chart below gives a graphic representation of the responses

Figure 5.1 urgent Health concerns



Urgent Health Concern

5.1.3 Organisation Addressing Young People's Health

Concerns

The aspect of identifying which organisation was in the forefront in addressing young people's health revealed that most of the respondents were able to identify the Government Clinic in Kabushi as the one, which was addressing the identified health concerns. Fifty nine percent of the respondents identified the Government Clinic as having intervention to address the health concerns identified. Ten percent however thought that the Young Women Christian Association was addressing the issues while another 10 percent thought that the Planned Parenthood Association of Zambia was the organisation addressing the concerns. Four percent identified Society for Family Health, while 2 percent thought the Catholic Relief Services were the ones addressing the issues. The 14 percent who identified other organisations pointed to institutions such as the Drug Enforcement Commission.

5.1.4 Level of Communication Between Service Providers and

Beneficiaries

The extent of communication or interaction between the service providers and the beneficiaries of the services is important in the implementation of an effective social change communication strategy. In responding to this question, 13 percent of the respondents thought that

communication was 'Excellent' while 26 percent of the respondents thought it was 'Very Adequate'. Forty percent thought the communication was 'Fairly Adequate' while 18 percent thought it to be 'Inadequate'. Three percent described the communication levels as being 'Very Inadequate'.

5.1.5 Level of Awareness of Activities Being Implemented

Most of the respondents demonstrated a high level of awareness of the activities undertaken by Kabushi Health Centre in addressing the sexual and reproductive health concerns of young people. However, those who were not aware also constituted a good percentage at 19 percent. Most of the respondents were able to point out that the Health centres main function was the provision of general health services while 17 percent responded that the Health Centre provided adolescent sexual and reproductive health services.

5.1.6 Provision of HIV/AIDS Information/ Education

While 78 percent of the responded agreed that Kabushi Health Centre provided education on HIV/AIDS, 9 percent thought this was not so while the rest (13%) did not know. Below is a table for responses on the Provision of HIV/AIDS information and education.

Table 5.4: Provision of HIV/AIDS Information/Education

Provision of HIV/AIDS Education

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	78	78,0	78,0	78,0
	No	9	9,0	9,0	87,0
	Don't Know	13	13,0	13,0	100,0
	Total	100	100,0	100,0	

5.1.7 Promotion of HIV Prevention Among Young People

The perception of whether the education provided promoted HIV prevention among young people brought out the following responses: The majority of the respondents (67%) agreed that the education given promoted HIV prevention among young people while 9 percent thought the education did not promote HIV prevention. The rest (24%) however could not tell whether the education given promoted HIV prevention. Below is the table indicating the respondents' views on the aspect of promotion of HIV prevention.

Table 5.5 Promotion of HIV Prevention

Promotion of HIV Prevention

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	67	67,0	67,0	67,0
	No	9	9,0	9,0	76,0
	Don't Know	24	24,0	24,0	100,0
	Total	100	100,0	100,0	

5.1.8 Youth Friendliness of the Services Provided

The majority of the respondents thought that the services provided were 'Youth Friendly'. Those who perceived the services to be 'Very Youth Friendly' were 35 percent. Another 32 percent perceived the services to be 'Youth Friendly' while 28 percent thought the services were 'Moderately Youth Friendly'. Those who perceived the services to be 'Youth Unfriendly' were 4 percent while only 1 percent of the respondents thought the services were 'Very Youth Unfriendly'

5.1.9 Addressing the Real Issues

The assessment of whether the services provided addressed the real issues affecting young people's sexual and reproductive health revealed that 16 percent of the respondents thought that the activities addressed the issues 'Very Appropriately' while 41 percent thought the activities to be appropriate in addressing real issues. Twenty three percent thought

the issues were being addressed 'Fairly Appropriately' while 18 percent thought that the activities were 'Inappropriate' with 2 percent reporting that the activities were 'Very Inappropriate' and could not therefore address the real issues that contributed to risk sexual behaviour by young people and that could make them susceptible to HIV infection.

5.1.10 Preferred Channels of Communication

There was a strong preference (62%) for radio and television as the preferred sources of information and education on HIV/AIDS. However 17 percent preferred printed material other than newspapers, preferred by 4 percent of the respondents. One significant source mentioned was community activities at 8 percent. Elders and parents were only preferred by 3 percent, and another 3 percent for community leaders. The other 3 percent preferred other sources.

5.1.11 Cultural Appropriateness of Information and Education Provided

Whereas the majority of the respondents (58%) thought the information and education provided was 'Culturally Appropriate', 22 percent did not think so while the rest (20%) did not know whether the activities were in tune with the cultural context of the community and the country as a whole.

5.1.12 Participation of Target Beneficiaries

Sixty five percent of the respondents thought that young people participated in the planning and implementation of activities in which they were the primary beneficiaries. However, 35 percent of the respondents did not think so. For the latter, there was no participation by young people. Adults were directing the activities.

5.1.13 Level of Participation

The level of participation was considered 'Very Adequate' by 17 percent of the respondents, 'Adequate' by 35 percent and 'Moderately Adequate' by 20 percent. Twenty one percent thought that the participation was 'Inadequate'. The rest (27%) thought there was 'Very Inadequate' participation on the part of young people.

5.1.14 Assessment of strategies used

Only 4 percent of the respondents thought the strategies implemented were 'Excellent', 24 percent said they were 'Very Good' while 16 percent thought the strategies were 'Good'. The rest of the responses were 30 percent for 'Fairly Good', 21 percent for 'Poor' and 4 percent for 'Very Poor'.

5.1.15 Preference for other Organisations

The need for other organisations to undertake activities in the community was overwhelming with 91 percent preferring other organisations to have interventions such as drama, peer education, edu/sport (education combined with sport) and community counselling services. Nine percent did not see the need.

5.1.16 Success of Interventions

Perception of success of the interventions revealed that while the majority of the respondents thought the intervention of creating a Youth Friendly Corner was 'Successful', a significant number regarded the same to be 'Unsuccessful'. Out of the 37 percent who responded that the intervention was 'Unsuccessful', 8 percent thought that the intervention was 'Very Unsuccessful' in contributing to the reduction of the spread of HIV infection among young people.

5.2 Focus Group Discussion Findings

Four Focus Group Discussions were conducted. There were four categories of participants. These were 'In School' Girls, 'In School' Boys, 'Out of School' Girls and 'Out of School' Boys.

5.2.1 'In School' Girls

The discussion with 'In School' Girls revealed that many of them did not think the provision of sexual and reproductive health information and

education in Kabushi Township to be adequate. Most of the information they said was on television, which they said was not interactive for them to get accurate information. Girls identified HIV/AIDS as the number one health concern of the young people in the community. They, however, stated that they did not think the government clinic in the area was adequately addressing the concerns of young people especially in the area of sexual and reproductive health. They preferred a multi dimensional approach where community based peer educators and HIV/AIDS counsellors could provide education. The girls also revealed that most girls in the community did not go to the 'Youth Friendly Corner' at the health centre for information and education, as the counsellor who was there was male. They reported that girls felt discouraged and were not confident to go and discuss sexuality issues with a male counsellor.

On the other hand, parents were reported not to be keen when it came to discussing sexuality issues with their children. It was revealed that most parents avoided to discuss such issues but only resorted to warnings and threats about consequences of sexually promiscuous behaviour.

5.2.2 'In School' Boys

The 'In School' Boys presented similar situations to that of the girls. They stated that information was not enough and that most of the

information and education was accessed either by radio or on television. They also added the aspect of getting information from friends and not from parents or guardians. Alex had this to say; “Information about issues of HIV/AIDS is not there. There is no knowledge. Therefore young people do not know what is good for them”. They further stated that only the clinic gave out information, which young people accessed through the ‘Youth Friendly Corner’. However, out of the 10 In School Boys who participated in the discussion less than half (4) had been to the ‘Youth Friendly Corner’. They pointed out that many youth did not know about the YFC and those that knew did not feel like accessing the services. There was therefore unanimity on the aspect of having other organisations providing services in the area as a way of ensuring that as many youth as possible were reached with information and services.

5.2.3 ‘Out of School’ Girls

‘Out of School’ Girls emphasised that other organisations should join in to provide reproductive health information and education, on how individuals and families should protect themselves from HIV/AIDS. They stated that most young women including some married ones had become morally weak hence the need for organisations to come in and provide information about the dangers of “sleeping around”. Janice Chota had this to say, “Some young ladies behave as if they have been bewitched if

they do not find a man to sleep with. What they do not realise is that they will die and the money they want from the men will remain”.

The ‘Out of School’ Girls also said that they found it embarrassing to go to the ‘Youth Friendly Corner’ for services because of the fact that only a male peer counsellor was presently found at the ‘Corner’. They preferred to get information from a female peer counsellor. They emphasised that the government should move in quickly to provide services that could be accessed by all because everyone was in need of information about protecting themselves from HIV/AIDS. .

5.2.4 ‘Out of School’ Boys

The ‘Out of School’ Boys also stated the need for more activities in the community. They stated that even if a number of youth knew the existence of the friendly corner where young people could obtain information and services, the same was not advertised. The services were not therefore attractive to young people and as a result many of them could not access the HIV counselling and testing services.

The discussion also revealed that many young people did not have information about antiretroviral drugs, how they worked and how to access the drugs if one needed them. They said that this information was not readily available and as a result young people who suspected

themselves to be infected were unwilling to go for voluntary testing. They therefore recommended that other organisations come in to provide services to young people before “we get finished”. There was a revelation that many young people did not want to go for VCT. Daniel Shawa said, “Going for VCT is like killing oneself”. Many young people did not want to know their status. One of the participants however, said that he had been tested for HIV. His friends, however, jokingly taunted him that he had only subjected himself to the test because he had to undergo an operation. However, he countered that it was good for him since he knew his HIV status.

Chapter 6

Discussion of Findings

6.0 Introduction

Zambia is one country that has a youthful population. According to the 2000/2001 Central Statistics Office Preliminary Census Report (2002), almost 75 percent of the population consists of young people below the age of 25 years. It is therefore cardinal to pay greater attention to this segment of the population not only because of the fact that they presently constitute the larger proportion of the population but also the important consideration that they are the future of the country. Their health and well-being is therefore very important. It becomes imperative that issues that affect young people's health are addressed with a sense of seriousness and urgency.

Zambia has a serious HIV/AIDS pandemic to grapple with given the HIV/AIDS prevalence rate estimated at 16 percent (Based on the 2000/2001 Zambia Demographic and Health Survey) of the adult population. In Zambia, young people constitute the larger proportion of the population. The young people are, however, not spared by the pandemic. Their vulnerability stems from the fact that they do not usually access factual and accurate information on sexual health. In

Zambian society generally, sexuality is not openly discussed, as this is considered taboo, while health service provision is biased towards adults and has little room for young people. Therefore youth sexuality has to be acknowledged.

To address such a serious development Zambia needs to mobilise all the possible resources. In this connection, the Central Board of Health (Ibid.) called for strategic planning activities to prepare 'road maps' on how the country can address the HIV/AIDS pandemic. They stated that the following questions ought to be asked:

- What are the fundamental strategies to be adopted to bring the pandemic under control?
- What interventions need to be rapidly scaled up in coverage or targeting?
- What organisations should be involved?
- What more should the different sectors or organisations be doing?
- Are there additional policies that need to be adopted?
- Are more resources needed and who should provide them?
- How will expected results be measured and how will the effectiveness of interventions be evaluated?

The exploration of such issues led to the formulation and creation of many intervention strategies in the fight against HIV/AIDS. It was realised that all sectors of the population were important in addressing the pandemic. One of these strategies has been to target young people with information and education on sexuality including HIV/AIDS prevention. This has been out of the realisation that young people often know little or have incorrect information about sexuality and the more important aspect of HIV/AIDS. Adults and especially parents often find it difficult to discuss issues of sexuality with young people. As revealed in the findings in the last chapter, young people do not receive adequate information and counselling and lack the means to control fertility, for example. If they get a sexually transmitted disease or experience an unwanted pregnancy, they often do not have access to services or even know about them. Health services often operate on the premise that sexual relationships are consensual while this may not usually be the case. Girls may be vulnerable to sexual abuse by partners or even by family members. In many cultures boys are under pressure from peers to have early sexual experience to “prove they are men”.

In the study in Kabushi Township, the perceived most urgent health concern or threat to the health and well being of the youth was clearly HIV/AIDS followed by Sexually Transmitted Infections and then Drug Abuse. During the Focus Group Discussions many participants agreed

that they have known many young people in the community who had had AIDS or had suffered from a sexually transmitted disease. They also reported knowing some young people who had died of AIDS.

As revealed in the Focus Group Discussions, information and education on sexuality is not readily available to young people hence rendering them susceptible to STI/HIV/ infection. Participants agreed that programmes needed to be intensified to respond to concerns for more information in the community.

In a project document published by Planned Parenthood Association of Zambia (2004), the organisation states that one important goal of sexual and reproductive health education among young people is to establish standards of acceptable or ideal behaviour. They further say that broad-based community strategies can eventually turn the tide if they are developed at once, applied vigorously and disseminated widely. HIV/AIDS prevention strategies that focus on young people must therefore be innovative, creative and comprehensive. They must address both individuals and behaviour that places young people at risk and the variety of social, economic and cultural conditions that contribute to risky behaviour.

6.1 Perception of Availability of Services

For an intervention to be successful, the beneficiaries' perception of the availability of the service is important. Sometimes potential clients or beneficiaries may not be aware of the availability of the service, while at other times the services may be available but inaccessible because of a number of constraints. These constraints could be:

- Physical and geographical constraints; whereby there may be too few service delivery points and those that do exist may be too far away for people to reach with ease;
- Cost and affordability factors; which dissuade clients from utilizing such services either because they have other priorities or because they simply do not have the money to pay for them;
- Cognitive constraints; whereby potential clients do not consider the services because they have not heard of them;
- Barriers to service; which include provider biases, attitudes, and undue restrictions as well as administrative barriers;
- Stigma and socio-cultural factors also play an important role in limiting one's sense of freedom to access quality services. There may, for example, be fear of being seen by other members in the community and consequently labelled or ridiculed.

In the case of the sexual and reproductive health services for young people in Kabushi one can identify some of the constraints to accessing

services cited above. While there were no physical and geographical constraints as the facility is in the community, there were some cognitive constraints where some young people were not aware of the services offered. This was because the services were not publicised in the community. For behaviour to change people go through a process. One model of the behaviour change process is the KAIPA Model, which postulates that for a new behaviour to be adopted the following process is important:

- Knowledge; a person acquires information about something
- Attitude; a person develops an opinion or value towards the acquired knowledge
- Intention; one prepares to put the acquired information in practice
- Practice; one engages in new behaviour
- Advocacy; one promotes the new behaviour to others

An understanding of this process is very important. Therefore activities must be embarked upon to deliberately make people especially young people aware of the services in the community. This can be done through a variety of community activities such as drama, motivational talks, printed material and other strategies.

6.2 Participatory Communication

Many scholars agree that, change strategies that succeed are the ones that pay attention to interactive communication between the change agents and the beneficiaries of an intervention. Community mobilisation can only be achieved if there is good communication between the change initiators and the target audience. Mody (1991) points out that achieving communication is not easy, but it would be impossible to continue as a truly human community without approximating it, without understanding each other, however imperfectly. He puts across some steps that have to be followed if effective communication has to be realised which range from learning everything about the topic or issue to be addressed to evaluating whether the message is achieving its knowledge feeling and behaviour goals.

Piotrow et al (Ibid.), point out that communication programmes rarely succeed by accident. They succeed as a result of a systematic planning and implementation process. They further state that the success of any programme depends on accurate analysis of the problem to be solved, the people, policies, programmes and organisations needed to resolve it and the communication resources that can be mobilised.

Communicating with the audience about all aspects of a programme is therefore of great significance. Reuss and Silvis (1985) state that no set

of communication objectives can be complete without knowing audience needs and interests. Community understanding, support and commitment must be earned and this is only possible where an established programme of regular communication is put in place. Better communication will encourage target beneficiaries to make a greater contribution to a programmes goals simply because they have a better understanding of the goals purposes and objectives of a programme project or activity.

More effective communication will stimulate increases ideas from the target beneficiaries who will be encouraged to pass ideas to the programme or project planners. Better communication will secure wide support for a programme and this will contribute to advocacy for the programme and hence wider coverage. In the study, most of the respondents to the questionnaire thought that there was adequate communication between the change agents and the target adopters. This was however a little bit in contrast with the Focus Group Discussion where it was revealed communication was not that adequate and that more needed to be done

6.3 Sexual and Reproductive Health Services for Young People

Sexual and reproductive health service provision, which includes services in HIV/AIDS prevention and mitigation, has been mainstreamed into

health service provision in many of the public and private health facilities in the country. For young people, this has seen the creation of what is referred to as 'Youth Friendly Sexual and Reproductive Health Services' through the establishment of 'Youth Friendly Corners'. Most of the respondents were aware of such services and some in the focus group discussions indicated to have accessed such services. What happens at a 'Youth Friendly Health Corner' is that young people can visit the place to access information and counselling on matters of sexuality including issues of HIV/AIDS and other STIs. Those that need services are referred to service providers within the facility to access services. The idea is to make young people gain confidence and feel free to access services.

The main contention for the services in Kabushi was, however, that the services did not adequately respond to the needs of the youth. Accessing the services on the part of the youth especially girls and young women was constrained by the absence of female sexual and reproductive health counsellors. 'Out of school Youth' especially young women revealed that they missed a lot in terms of access to information. Burns et al (Ibid.) agree that programmes for 'out of school youth' must be flexible to meet the needs of this large and varied population. This is because out of school youth may be found in mixed age groups with highly diverse skill and education levels. They may be on the move and unable to adhere to

school youth may be found in mixed age groups with highly diverse skill and education levels. They may be on the move and unable to adhere to a fixed schedule. Any programme must have strategies or approaches to effectively reach 'out of school youth' as a target group.

6.4 Provision of HIV/AIDS Prevention Information and Education

According to the International Planned Parenthood Federation, IPPF, (2004) young people account for over 50% of new infections worldwide making it important to provide them with education and services including those for HIV counselling, testing and care. Such services must take into account the social context of young people's lives. The services must be age appropriate, using language and example that are familiar while service provider's attitudes and their level of comfort in talking to young people about their sexual health must be appropriate. While 67 percent of the respondents agreed that the Kabushi Health Centre provided information and education on HIV/AIDS, only 58 percent of the same respondents thought the information and education were 'Culturally Appropriate'. Some felt that the information and education needed to emphasise personal moral responsibility as well as spiritual dimensions of living and conducting one self. This came out much more prominently in the Focus Group Discussions. Some of the respondents called for a reassessment of the activities so that such aspects could be included.

6.5 Communication Channels

Although most of the respondents were aware and approved the activities of the Kabushi Health Centre in providing information and education on sexual health, there was a preference to have other channels or sources of information. The electronic media, i.e. radio and television were the more preferred sources of education and information followed by print materials and then community activities. There was therefore need to use different channels which was not the case at the moment. The Focus Group Discussions brought out more emphasis on community activities including use of peer educators, conducting drama, outreach counselling sessions and community motivational talks. A multimedia approach is regarded as necessary for a successful behaviour change campaign. Talk sessions, peer education, sports, and many other entertainment/education programmes could be useful in reaching young people with the much needed information and education. However, more important also was the question of individual counselling. This was found to be necessary and was seen as a strong factor, which could enable changes in sexual behaviour to avoid infection and also enable informed decision-making about sexual relationships and other SRH issues. It could also Improves uptake of SRH services through referral and provide an opportunities and support to inform partners of the benefits of HIV testing.

6.6 Participation in Programme Activities

Participation in programme activities forms one of the requisites for a successful project or programme. Community members are the consumers of the services and therefore they have a role to play in the realisation of the objectives or purpose of an intervention.

Communities must therefore be involved in programmes and projects that affect them. Mody (Ibid.) talks of putting the masses back into communication and points to the need for dialogue based interaction between the change agent and the target beneficiaries. Servas et al (1996), look at participation as a higher level of involvement of the public or community in a communication system. It may include the involvement of the community or target beneficiaries in the planning process and in the implementation and management of the communication strategy. Participation of the target audience is essential because of the following important factors:

6.6.1 Empowerment

The involvement of target beneficiaries in programmes contributes to the building of skills in the community for continued development problem identification and resolution. Community involvement empowers people to determine and take part in their own development agenda. In the case of young people their involvement in activities at planning,

of young people their involvement in activities at planning, implementation and evaluation level does not only build their skills at problem identification and resolution but will also enable them gain confidence in addressing future concerns.

6.6.2 Relevance and Effectiveness of Programmes

Programmes in which the target beneficiaries are genuinely involved are likely to be more relevant to the people and more effective. Through participation communities identify real priorities according to their local context. The satisfaction of such priorities lead to contextually meaningful and effective development.

6.6.3 Synergy

Involving communities in development efforts leads to communities supplementing the resources through combined effort. Developmental returns may therefore be higher. The young people in Kabushi for example recommended the expansion of activities by engaging the youth as peer educators and information providers. This would improve programme coverage, as activities would reach more young people in the community.

6.4.4 Sustainability

The involvement of beneficiaries in programme activities results into community identification with development programmes. The people in the community will identify a project as their own. This in turn enhances programme sustainability.

6.7 Suitability of Strategies

An intervening organisation must realize the need for a creative outreach strategy to engage the youth in programmes that will provide them with appropriate information and motivation in the fight against HIV/AIDS. The information must address the root cause of young people's risky sexual behaviours to ensure sustained behaviour change outcomes and hence contribute to the reduction of HIV infection. Programmes must therefore as much as possible seek to create a conducive atmosphere for the young people to be empowered with life skills that will enable them avoid HIV infection.

To achieve the above there is need to involve other segments of the population in activities. In undertaking programmes to reach young people, it is important to take cognizance of the roles those other segments of the population may play. Adults for example must also be reached with information on how they can effectively communicate with young people on matters of sexuality, especially HIV infection prevention. There

should be mutual understanding of the issues that have to be addressed by communities to prevent HIV infection. Addressing the HIV/AIDS epidemic among young people requires reaching not only youth themselves but also others who influence their lives. Parents and other family members can help prevent HIV/AIDS among young people. Similarly AIDS prevention programmes can do more to address men both adolescents and adults, who often play dominant roles in sexual relationships. Young and adult men need sensitization on matters of HIV counselling and testing and its importance in mitigating the further spread of HIV/AIDS.

Reproductive health motivation must however include the political management of localities to identify with the programme. Programmes must strive to ensure that communities identify themselves with the programmes and activities that are going to be undertaken. The drawing up of activities should therefore be in consultation with the people in the communities. Local leaders ought to be involved, so are religious leaders, school authorities, health authorities and other stakeholders in the communities. It is important to recognize that individual behaviour is more likely to change in the context of a supportive community.

The Japanese Organisation for International Cooperation in Family Planning (2003) advocate a model called AIDS Total Management Model

HIV/AIDS prevention, care and support services. The model espouses the importance of creating substantial linkages between existing sexual and reproductive health services and HIV/AIDS intervention. The argument is that, single intervention without linkages with other interventions can only make limited impact. There should be synergy among the interventions to boost clients' motivation for such services as HIV testing.

Behaviour change communication within the community should therefore be able to appeal and motivate people to undergo behaviour change process. In a community, activities that promote behaviour change are important. Before young people decide to access services they need information. This information within the community should be able to provide the motivation to access services for example and to acquire positive behaviour.

Chapter: 7

Conclusion and Recommendations

7.0 Introduction

In Zambia young people who constitute the larger proportion of the population have not been spared from the pandemic of HIV/AIDS and tend to be at greater risk because of lack of accurate information on sexuality including HIV/AIDS prevention and mitigation. Zambia is therefore in a great hurry to provide service to young people to enable them build life skills to avoid infection for those that are not yet infected and to enable those that are infected to live positively so that they do not infect those uninfected or re-infect themselves.

Since the onset of the HIV/AIDS pandemic a number of strategies have been formulated to address both the spread of the disease and to institute mechanisms to mitigate the impact of the pandemic on both the infected and the affected. Most of these have been premised on behaviour change. This has been out of the realisation that the incidence of HIV/AIDS is an issue that is not likely to be completely

resolved with drugs for a long time. The prevention of infection and promotion of health in as far as HIV/AIDS is concerned will have to involve some changes in lifestyles or human behaviour.

The Ministry of Health, through the Central Board of Health (Ibid.), has spelt out a number of measures to limit or reduce infection through a number of strategies such as:

- Reducing the number of sexual partners,
- Delaying the onset of sexual activity among adolescents,
- Promoting the use and availability of condoms including female condoms,
- Controlling other sexually transmitted diseases and
- Encouraging voluntary counselling and testing.

These strategies have led to the creation of many interventions targeted at various segments of the population and one of these has been the establishment of 'Youth Friendly Sexual and Reproductive Health Services'. In Ndola, Kabushi Health Centre is one of the growing number of health centres providing services that try to create a conducive environment for young people to access services. This study was therefore undertaken to look at how the recipients perceived the services in terms of appropriateness, effectiveness and other considerations.

Respondents to both the quantitative method (Questionnaire) and the qualitative technique (Focus Group Discussions) were asked on what they considered to be the most urgent health concerns of young people in the community especially for those between the ages of 10 to 24 years. There were also questions on how they perceived the activities undertaken in terms of appropriateness, effectiveness, and whether the activities addressed issues of HIV/AIDS among young people. Respondents were also asked to state the preferred sources of sexual and reproductive health information and education. The Focus Group discussions included suggestions of what interventions young people preferred in the community.

It should generally be agreed that false assumptions about sexual behaviour could impede a society's willingness and ability to meet the needs of others. Reproductive health programmes should therefore be increasingly aware of young adults needs. This has not been the case as so far most efforts so far have been small and isolated. This includes the services that were being offered in Kabushi. Most sexual and reproductive health programmes began and continue with a focus on married women, a large group with an obvious need for reproductive health care. In contrast efforts to meet young peoples needs are still struggling to find approaches that are both effective and acceptable to policy makers and adults in general.

For a project to effectively address the issues, analysis of the “triggers” for unsafe sexual behaviour such as alcohol abuse, peer pressure etc is important. Therefore key elements of HIV/AIDS education that any programme should address include:

- Providing accurate and appropriate information about sexuality,
- Using appropriate strategies to behaviour change,
- Focusing on reducing specific risky, sexual behaviour,
- Having clear messages about sexual activity,
- Dealing with peer and social pressure,
- Personalizing information,
- Using appropriate information and materials that suit the age of the target group and
- Involving committed people as teachers and facilitators.

Communities should be sensitised on youth sexuality for them to understand and appreciate the need to address youth sexual and reproductive health concerns in the community. The involvement of the Kabushi community in the reproductive health services for the young people in the community was not particularly evident. The community was not highly sensitised and as a result young people were not keen to access services.

Sensitisation should also be for the purposes of mobilizing community support for an intervention and fostering project sustainability. Leaders need to be sensitised as well and these should include government leaders, civic authorities, chiefs, headmen and women, religious leaders and other gatekeepers in the communities. This will create synergy needed for the full community involvement. Again, mobilisation of the community in Kabushi was not very evident and as a result many young people were not aware of the services offered and those that were aware did not utilise the services.

It is also important when mobilising the community to bear in mind that communities may differ in their socio economic environment and these differences influence the context within which HIV may be transmitted. Some communities may be stable agricultural villages; others may be mobile fishing camps. Some communities may be located on major roads and have access to market towns; others may be more remote with very difficult access to market centres. Some communities may have schools, health clinics, electricity and good water supply while others may not have these things. So there may be a number of socio economic and cultural differences affecting the context within which sexual relations take place and HIV is transmitted. Kabushi Township is a typical low-income urban township with many of the people not in formal employment. It is therefore generally vulnerable to many adverse

activities many of which may be pretty crime for some people to survive the harsh economic conditions. This includes prostitution.

Communities also differ in individual and institutional support for HIV/AIDS prevention, care and support programmes. In some communities influential local leaders may strongly support sexual behaviour change including condom distribution programmes. In other communities leaders may be resistant to these programmes and there could be substantial stigma and discrimination associated with HIV/AIDS.

In some communities there could be very active anti AIDS clubs for youth and strong People Living with HIV AIDS organisations and effective orphan care NGOs. In other communities such institutions may be absent. In Kabushi such were absent. The differences in individual commitment to and institutional support for HIV/AIDS programmes affect the sexual behaviour of individuals, the level of stigma and discrimination, and the transmission of HIV.

7.1 Recommendations

The following are the recommendation for an effective intervention communication strategy to reach young people in Kabushi Township with sexual and reproductive information, education and services that

will lead to behaviour change resulting into a reduction of HIV infection among young people and thereby contributing to the achievement of better health:

7.1.1 Institute Participatory Communication in the planning and implementation of interventions: Participation of the beneficiaries of an intervention avoids the assumption that the change agent's way or logic is correct, universal and applicable to all. Before any programme is instituted the community must be involved in problem identification and definition. They should be able to identify the alternative solutions to the problem and come up with strategies to resolve the problem. In Kabushi, participatory communication must be encouraged by ensuring that the community, especially the young people are involved in the planning and implementation of the programme to reach fellow young people with sexual and reproductive health information and education. Community members should be involved in the implementation of peer education activities and community based peer counselling for HIV/AIDS. This will make more young people not only be aware of the services available but will also improve programme coverage.

7.1.2 Undertake Community Analysis

The starting point for any community-based activity is to get to know the community. It is important to have a profile of the community in order

to identify any special features, which will affect the success of the programme. In any community there will be individuals with special influence. It is important to find out who the opinion leaders are and what they think are the needs of the community. Such people can help in many ways. It is therefore of outmost importance to undertake a community analysis before introducing a programme or an intervention in a community. Mody (Ibid.) says that it is conventional wisdom to collect information on audience and topics while Piotrow et al (Ibid.) state that long before communication messages are developed and media channels selected, a needs assessment and careful analysis should be undertaken to identify who the primary and secondary audience are, what behaviours need to be changed and what information and services are required to make those changes. The analysis should identify what the people know believe, hope for and practice.

Communication in this case should take the audience's perspective. Planners must listen to what the people say and learn what people really do think and believe. In Kabushi it is important for example to confirm the sexual and reproductive health knowledge that exists among young people especially in HIV/AIDS prevention and mitigation. It is also very important to know the attitudes of young people on issues of sexual abstinence, voluntary counselling and testing, ARVs, etc. This is the only way one can come up with effective intervention strategies.

7.1.3 Involve Young People in Programme Planning and

Implementation

One important result of the study was that there was inadequate involvement of young people in the planning and implementation of the programme in Kabushi. However, participation by the intended audience helps to ensure high programme quality. An effective way of to design messages for example is to ask audience members to talk about the problem in their own words and then to design messages accordingly.

It will therefore be necessary for the programme in Kabushi to involve young people in programme planning as well as activity implementation, for them to identify with the programme as well as advocate for it. Their ideas are important in the drawing up of effective strategies while their involvement in either peer education or community counselling will not only improve coverage of the programme but will also make the programme more effective and relevant.

7.1.4 Publicise the Programme

Publicising service does not only make people aware of the services being provided but serves as its main purpose to attract people to the service. Publicity has therefore much to do with improving the utilisation of services and therefore achieving a broader or better impact of the

programme. Thus the activities in Kabushi need to be promoted through a number of ways such as information pamphlets, posters, billboards, and even through community entertainment. At the time of the study, these were absent.

7.1.5 Involve Other Organisations or Stakeholders

It was very clear that other organisations needed to be involved in the dissemination of sexual and reproductive health information and education in Kabushi Township. Networking and collaboration in community programmes has a synergic effect. It is generally accepted that collaboration leads to reduction in costs by avoiding duplication of efforts. It also creates opportunities for multiple points of view and may contribute to quality programming. It was clearly established that the Kabushi Health Centre could not do everything and therefore needed other organisations to collaborate with especially in community outreach activities such as drama, SRH education education/sport, community talks and other community activities.

7.1.6 Use a Variety of Channels to Communicate Messages

To be able to reach a wider audience, it is important to use a variety of channels. Community radio should be taken advantage of since most of the respondents indicated radio and TV as preferred sources of information and education. The media as already indicated set the

therefore be catalytic in the mobilisation of communities' response to critical issues like HIV/AIDS. Radio Chengelo for example could therefore be a good channel of information and education on HIV/AIDS for the young people in Kabushi Township.

7.1.7 Institute Mechanisms to Monitor and Evaluate Programme.

Any programme must ensure that the strategies and activities are appropriate for the intended audience. Both monitoring and evaluation are therefore essential to any communication programme or project. While monitoring focuses on outputs thereby telling planners and managers of programmes whether activities are taking place as planned, evaluation is about whether the project objectives are being met. The intended audience must not just be exposed to the message but the message must be appropriate, using appropriate channels and must be in context with the local cultural and social setting.

In Kabushi there was need to have additional channels to communicate information and education on SRH. Community activities were seen as a very important channel, which could provide information and education in an entertaining way. All these views can be brought out through monitoring and periodical evaluation of programmes and projects.

It is important therefore for the interventions in Kabushi to be subjected to constant monitoring and routine evaluation if young people are to be

effectively reached with information and education on sexual and reproductive health, which will enable them change behaviour that will contribute to the reduction of HIV infection and lead to the improvement of the health of young people.

Piotrow et al (Ibid.) state that monitoring projects should be simple and routine so that project managers will know immediately if activities are not carried out properly. Monitoring also serves the purpose of permitting quick changes if they are needed to make a programme more effective. Project managers and planners need feedback so that they can react while there is still time to make changes. The activities in Kabushi therefore need to be monitored to ensure that what has been planned is being carried out and also to introduce new activities when and where necessary.

REFERENCES

- Burns et al (2004) "Reaching Out of School Youth with Reproductive Health and HIV/AIDS Information and Services", Arlington Family Health International, YouthNet Program
- Central Statistical Office (2002) 2000/2001 "Census preliminary Report"
- Centerwall E, Laack S (2002), *Young Men As Equal Partners*, Dar-es-Salaam, Business Printers Ltd
- Canadian Public Health Association (2002) "Zambia Reproductive Health Project Survey Report"
- Fisher A A, Foreit J R (2002) *Designing HIV/AIDS Intervention Studies An Operational Research Handbook*, New York, Horizon Program
- Hancock A (1981) *Communication Planning for Development; An Operational Framework*, Vendome, UNESCO
- Hoang Tu Ahn et al (1996) *Assessing the HIV/AIDS situation in Vietnam*
<http://www.ifm.ku.dk/HIV/AIDS/Comm.Vietnam>

International Family Planning Perspective, The Alan Guttmacher
Institute

International Planned Parenthood Federation, United Nations Fund for
Population Activities (2004) “Integrating HIV Voluntary Counselling
and Testing into Reproductive Health Services”, IPPF/UNFPA

Jackson H (2002) *AIDS Africa; Continent in Crisis*, Harare SAfAIDS

Infante D S, Rancer A S, Womack D F (1997) *Building Communication
Theory*, Illinois Waveland Press Inc.

Maria D, Rogala C, Sundstrom K (2001) *Teenage Sexual and
Reproductive Behaviour in Developed Countries*, Stockholm, The
Alan Guttmacher Institute

Ministry of Health/Central Board of Health (1997) *HIV/AIDS in Zambia;
Background, Projections, Impacts, Interventions*

Mody, Bella (1991) *Designing Messages for Development Communication*,
New Delhi, Sage Publications India Pvt Ltd

Piotrow P T et al (1997) *Health Communication: Lessons from Family
Planning and Reproductive Health* Westport, Praeger Publishers

Planned Parenthood Association of Zambia (2004) "Project Proposal for Northern Region"

Population Reports (1995) Baltimore The John School of Public Health

Reuss C, Silvis D (1985) *Inside Organizational Communication*, New York, Longman Inc.

Servaes J, Jacobson L T, White S A (1996) *Participatory Communication for Social Change*, New Delhi, Sage Publications India Pvt Ltd

Swedish International Development Cooperation Agency (1997) "Strategy for Development Cooperation; Sexual and Reproductive Health and Rights", Stockholm

Swartz L; (1996) "Survey of Adolescent Reproductive Health"

<http://www.gov/DOCUMENTS/PILOTSTUDY.htm>.

Tones K, Tilford S (1996) *Health Education; Effectiveness, Efficiency and Equity*, London, Chapman and Hall

UNAIDS; (1999) *HIV/AIDS Global Report*

UNAIDS; (2001) *HIV/AIDS Global Report*

UNAIDS Review (1997) "Sexual Health Education: Does it lead to Safer Sexual Behaviour"

Wimmer R D, Dominick J R (1997) *Mass Media Research: An Introduction, 5th Edition*. Belmont Wadsworth Publishing Company

Zambia Demographic and Health Survey 2000/2001

Zambia Health Reforms (1992)

Zambia Sexual Behaviour Survey Report (2002)

APPENDIX I

QUESTIONNAIRE ON SEXUAL AND REPRODUCTIVE HEALTH SERVICES FOR YOUNG PEOPLE IN KABUSHI TOWNSHIP

NO.	QUESTION	CODE	COMMENT
01	Permission to continue	Yes.....1 No.....2	
02	Sex of informant	Female.....1 Male.....2	
03	Age	10-14 years.....1 15-19years.....2 20-24years.....3 25years>.....4	
04	Education	Nil.....1 Primary.....2 Junior Sec.....3 Senior Sec.....4 Tertiary.....5	
05	Occupation	Employed.....1 Self employed.....2	

		School/College.....3	
		Unemployed 4	
06	Area of Residence	Rural.....1 Peri-Urban.....2 Urban.....3	
07	What would you consider to the most urgent or serious health problem faced by young people between the ages of 15 to 24 years in your community	STIs 1 HIV/AIDS 2 Malaria 3 Drug Abuse 4 Tuberculosis 5 Other 6	
08	Which Organization or Organizations are addressing the concerns that you have identified?	GRZ Clinic/Hospital.....1 YWCA.....2 PPAZ.....3 CYC.....4 CRS.....5 FLMZ.....6 SFH.....7 Other.....8	

09	How would you describe the communication between the organizations rendering service and the target groups?	Excellent1 Very Adequate.....2 Adequate.....3 Fairly Adequate.....4 Inadequate.....5 Very Inadequate.....6	
10	Are you aware of the activities that are undertaken by the local Health Centre to address the sexual and reproductive health concerns of young people in your community?	Very Aware.....1 Aware.....2 Moderately aware..... 3 Vaguely Aware.....4 Not aware.....5	
11	What issues do you think the local health centre address concerning young people in your	Adolescent SRH.....1 General Health.....2 Youth Delinquency.....3 Youth Unemployment.....4 Other (Specify).....5	

	community?		
12	Does the local health centre provide information/education about HIV/AIDS?	Yes.....1 No.....2 Don't Know.....3	
13	Does the education and information provided promote HIV prevention?	Yes.....1 No.....2 Don't Know.....3	
14	Is the education and information that is provided youth friendly?	Very Y/Friendly.....1 Youth Friendly.....2 Moderately Friendly.....3 Youth Unfriendly.....4 Very Y/Unfriendly.....5	
15	Do you think the activities undertaken address the real issues facing young people?	Very Appropriately.....1 Appropriately.....2 Fairly Well.....3 Inappropriately.....4 Very Inappropriately.....5	
	What do you consider to be the best	Radio/TV.....1 Newspapers.....2 Publications.....3	

16	channels of communicating information?	Community Actions4 Elders/Parents.....5 Community Leaders.....6 Other (Specify.....7	
17	Is the education and information provided culturally appropriate?	Yes.....1 No.....2 Don't Know.....3	
18	Are there mechanisms for providing an input in the programme by the target beneficiaries especially the youth	Yes.....1 No.....2	
19	Do you consider these mechanisms adequate for effective participation in the programme by target beneficiaries?	Very Adequate.....1 Adequate.....2 Moderately Adequate.....3 Inadequate.....4 Very Inadequate.....5	
	How would you rate	Excellent.....1	

20	the strategies used by the local Health Centre to address youth concerns?	Very Good.....2 Good.....3 Fairly Good.....4 Poor.....5 Very Poor.....6	
21	Would you recommend that a different organization or organisations provide the services?	Yes.....1 No.....2	
22	How successful has the programme to target youth in your community been?	Very Successful.....1 Successful.....2 Moderate.....3 Unsuccessful.....4 Totally Unsuccessful 5	

APPENDIX II

FOCUS GROUP DISCUSSION GUIDE ON SEXUAL AND REPRODUCTIVE HEALTH SERVICES FOR YOUNG PEOPLE IN KABUSHI TOWNSHIP

What do you think are the major health concerns or challenges faced by the young people in your community?

Which organisation or organisations are addressing the health concerns of the young people in your community?

In your opinion is there enough communication between the community and the organisations in trying to address the health concerns of the youth in the community? _____

What activities are undertaken by local health centre in your Community to address health concerns of young people?_____

What do you think of the strategies and approaches that are used to address the health concerns of young people by the local Health Centre?

Do you think there are better strategies or approaches that could be used to address the issues of better health for young people?

What mechanisms are put in place for young people to provide an input in the planning, implementation and evaluation of activities by the local health centre in as far as they affect the youth who are the beneficiaries of the activities?

During the period that the local health centre has provided services for young people in your community what would say have been the major successes?

Has there been any major failure or failures? If yes, what are they?

What do you see as the way forward in the provision of services for young people?

What role would young people play in the effective mitigation of the sexual and reproductive health challenges that they face?

Would young men play different roles from those of young women? If so what would be the different roles?

What any other additional comments do you have on any aspect of what we have been discussing which may not have been covered in the items above?
