

# Communication strategies for fighting HIV/AIDS: A case Study of New Start Centre-Lusaka.

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Submitted in partial fulfillment of the requirements for the degree of Master of  
Communication for development offered by the Department of Mass Communication,

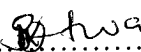
The University of Zambia

## DECLARATION

I declare that this Practical Attachment Report has not been submitted to another University.


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## **ABSTRACT**

The purpose of the study was to ascertain the communication strategies for fighting HIV/AIDS used by New Start Centre. It was sought to establish the nature of and extent to which communication strategies used by New Start are utilised in reaching out to the communities. The study also sought to establish whether the communication strategies are adequate to deliver the HIV/AIDS messages. It was sought to investigate the adequacy of the information received about HIV/AIDS. It also probed on the knowledge and understanding of clients of about HIV/AIDS as well as ascertaining how New Start Centre looked at the role of the media in the face of HIV/AIDS.

During the study, questionnaires were distributed to 110 respondents. 100 were clients that came for VCT and 10 were members of staff. These were believed to have knowledge about New Start activities in its fight against HIV/AIDS. Besides, the researcher held focus group discussions with workers and volunteers of the organisation. In depth interviews to workers and the Site Manager were also conducted. A statistical package for the social sciences (SPSS) was used to analyse quantitative data while qualitative data was analysed thematically.

The study is useful particularly to those organisations like New Start, its affiliated projects and other organisations dealing with the fight against HIV/AIDS. For these, the study will help them in arriving at the appropriate communication strategy for disseminating HIV/AIDS to the public.

The findings of the study revealed that the communication strategies used by New Start are radio television, brochures, magazines, newsletters, meetings workshops and other interpersonal strategies. In addition to these, mobile activities are also utilised in reaching out to the public.

The findings further established that New Start respects the role of the media in the fight against HIV/AIDS, because without the media, the fight would not be easily overcome. The organisation through the media, reach different communities using television, radio, film, the World Wide Web, music, CD's, newspapers, books, brochures and magazines and other media vehicles.

# DEDICATION

I dedicate this report to my husband John Munkombwe and my three sons Choolwe, Chileleko and Chabota who inspired me during my study. The report is equally dedicated to my older brother Miyanda for his uncompromising determination to achieve excellence in educating me.

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## **ACRONYMS**

<b>ABC</b>	<b>Abstinence, Be Faithful and Condom</b>
<b>ARV</b>	<b>Antiretroviral</b>
<b>AIDS</b>	<b>Acquired Immunodeficiency Syndrome</b>
<b>BCC</b>	<b>Behaviour Change communication</b>
<b>CIDRZ</b>	<b>Centre for Infectious Disease Research in Zambia</b>
<b>CHAMP</b>	<b>Comprehensive HIV/AIDS Management Programme</b>
<b>FAO</b>	<b>Food and Agriculture Organisation</b>
<b>FGDs</b>	<b>Focus Group Discussions</b>
<b>HIV</b>	<b>Human Immunodeficiency Virus</b>
<b>IEC</b>	<b>Information, Education and Communication</b>
<b>ILO</b>	<b>International Labour Organisation</b>
<b>MC</b>	<b>Male Circumcision</b>
<b>MTCT</b>	<b>Mother to Child Transmission</b>
<b>NGO</b>	<b>Non Governmental Organisation</b>
<b>NAPCIP</b>	<b>National AIDS Prevention and Control Programme</b>
<b>NASC</b>	<b>National Aids Surveillance Committee</b>
<b>OVC</b>	<b>Orphans and Vulnerable Children</b>
<b>PLHV</b>	<b>People Living with HIV/AIDS</b>
<b>PSI</b>	<b>Population Services International</b>
<b>SFH</b>	<b>Society for Family Health</b>
<b>SPSS</b>	<b>Statistical Packaging for the Social Sciences</b>
<b>STIs</b>	<b>Sexually Transmitted Infections</b>
<b>UNZA</b>	<b>University Of Zambia</b>
<b>VCT</b>	<b>Voluntary Counseling and Testing</b>
<b>ZDS</b>	<b>Zambia Demographic Survey</b>
<b>ZDHS</b>	<b>Zambia Demographic Health Survey</b>
<b>ZHECT</b>	<b>Zambia Health Education Communications Trust</b>
<b>ZSMP</b>	<b>Zambia Social Marketing Project</b>

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## **CHAPTER 1**

### **BACKGROUD**

#### **1.0 Introduction**

The old adage says “Knowledge is power”. Such knowledge-based power is becoming a reality in Zambia. Many Zambians now have access to information and are able to learn their HIV status. Voluntary Counselling and Testing (VCT) Centres are giving Zambians the power to take control and act on their HIV status. The opening of VCT Centres in various parts of the country has enabled thousands of Zambians to know their HIV status.

VCT has been shown in many countries to be an effective intervention that promotes positive and protective behaviour changes amongst those counselled and tested for HIV. Quality VCT services act as the link connecting Prevention, Care and Treatment programmes as clients learn their status and look for a plan for their future.

With support from United States Agency for International Development (USAID), the Society for Family Health (SFH) and 13 other agencies have implemented the “Zambia VCT Partnership”. Over the last three years, this partnership has improved the quality of VCT services, including pre- and post-test counselling; the test services themselves, and post-test referrals. Under this partnership, SFH has been implementing generic promotion campaigns to generate demand for counselling and testing.

New Start’s design is based on the findings of mystery client survey of existing VCT sites, and includes: full-time, dedicated VCT counsellors; posters, VCT signs and IEC material that are consistently available, visible and in the appropriate local language; an area dedicated to VCT that has its own reception and comfortable waiting area and is easy to find, but discreetly located; sufficient rooms available, dedicated to counselling only; and guaranteed privacy, including audio and visual privacy as well as freedom from interruptions.

Using a variety of outreach techniques, including community education and awareness campaigns and mass media communications, New Start encourages Zambians nationwide to seek VCT services and know their HIV status.

The New Start project generates messages that target sexually-active young people aged 16 – 25, young couples planning to marry or enter into a “serious” relationship, young couples planning to have a child, and men and women who frequently travel away from home. Since the inception of the programme, New Start has counselled and tested over 21,000 clients, well over double the anticipated client load and averaging more clients tested per month than any other VCT site in Zambia.

The centres strive to increase access to quality VCT services in Zambia and uses brand positioning to de-stigmatize VCT. They also aim at reducing stigma against those living with HIV/AIDS. HIV testing serves as a critical link between prevention, care and treatment. The New Start Centres offer pre and post-test HIV/AIDS counselling, rapid HIV testing, follow up psycho-social or HIV educational counselling, and referral for care and support services.

Client satisfaction surveys conducted at New Start in 2003 noted that the clients at New Start rated the services highly. About 96 percent of the clients were satisfied with pre-and post-test counselling services. Also, all the clients were satisfied with the privacy and confidentiality offered at New Start and indicated they would want to recommend the service to others.

The profile of New Start clients indicates that one third are youth aged 20-24, more than half (58.6 percent) are male and single (63.1 percent), and about one third have senior level secondary education (33 percent). New Start attracts clients from different socio-economic groups, as the price charged is very affordable. Almost 40 percent of the clients are either students or unemployed. The test results show that more female than male in all age groups test positive.

The expansion of New Start brings renewed hope for Zambians to help them know their status and act to protect themselves and those around them. Increased knowledge of one’s HIV status provides power to employ new strategies to live a long and full life.

As Dr. Peter Mijere, Copperbelt Province Director of Health stated recently at the opening of the New Start Centre in Kitwe, "The majority of Zambians are in fact HIV negative and VCT can help relieve the worry and fear."

The Emergency Plan has allowed SFH and the people of Zambia to make a new start together (<http://www.usaid.gov/zm/index.htm>)

Before reducing the risk and vulnerability to HIV, individuals and communities must understand the urgency of the epidemic. This can be achieved through distributing tailored health messages in a variety of communication channels. Hence, the coming of New Start centre and other counselling and testing centres in Zambia.

Communication has been identified as a crucial tool as we endeavour to fight against HIV/AIDS. Without proper communication, communities may not know what they need to do in order to avoid infection, what to do once they are infected, how to support and care for their beloved ones who are living with HI virus. The researcher analysed the communication strategies used by New Start Centre.

In all walks of life, information has proved to be a vital weapon in the fight against HIV/AIDS. The right information is essential to educate and raise people's awareness on how the HIV is transmitted, who is at risk and what can be done to prevent the spread of the disease. Without cure and vaccination to curb the spread of the virus, infected people can still live provided the relevant information is communicated to them.

Communication strategies have proved to give guidance and direction to organisations and individuals who are involved in the HIV/AIDS programmes on how they communicate to their audiences and on what they should communicate. Messages, audiences and channels that help to communicate effectively to the communities have been looked into.



### **1.2.0 Background of Zambia**

Zambia is a landlocked country in Southern Africa, covering an area of 752,612sq.km. It borders the Democratic Republic of the Congo to the north, Tanzania to the north-east, Malawi to the east, Mozambique Zimbabwe Botswana and Namibia to the south, and Angola to the west. Formerly Northern Rhodesia the country's name reflects the Zambezi River.

The country is located between 10 and 18 degrees latitude south of the equator. Zambia sits on a gently undulating plateau which is between 900 and 1,500 meters above sea level. This plateau is a mix of woodland and savannah regions interspersed with lakes, rivers, hills, swamps and lush plains. The most stunning geographical feature is the Victoria Falls, on the Southern border with Zimbabwe, and is one of the natural wonders of the world.

#### **1.2.1 Climate**

There are three distinguished seasons; A warm-wet season (Nov-April), a cool dry season, (May-August), and a hot dry season (Sept-October).The country's geographical location and high altitude are ideal for the country's sub-tropical vegetation and climate conditions.

Temperatures range from 15-33 degrees Celsius. The average annual rainfall in a normal season is 1000mm with the Northern parts of the country experiencing the highest rainfall averaging more than 1400mm annually.

#### **1.2.2 Population**

The population of Zambia is about 11,477,447 million with a growth rate of 3.5 per cent per year. It is highly urbanized, with well over half the population living in the four provinces along the rail line. The main urban cities are Lusaka in the Midlands, Ndola and Kitwe on the Copperbelt and Livingstone in Southern Province

The estimates for this country explicitly take into account the effects of excess mortality due to AIDS. This can result in lower life expectancy, higher infant mortality and death rates, lower population and growth rates, and changes in the

distribution of population by age and sex than would otherwise be expected [www.airninja.com.worldfacts](http://www.airninja.com.worldfacts) (July 2007 est.)

The movement of people from the rural areas into the towns was particularly marked after independence. Government efforts to reverse the flow have had only limited success.

Further, the estimated population below poverty line is 86 percent and unemployment rate of 50 percent exists. The population in each of the provinces greatly differs in terms of numbers and population density.

**1.2.3 AGE STRUCTURE**

0-14	years:	45.7%	(male	2,633,578	female	2,608,714)
15-64	years:	51.9%	(male	2,969,913	female	2,990,923)
65 years and over:		2.4%	(male	116,818	female	157,501)

**11,477,477:** population of Zambia (July 2007 estimates)

**1,100,000:** Estimated number of people living with HIV/AIDS by the end of 2005

**17%:** Percentage of adults (ages 15-49) living with HIV/AIDS by the end of 2005

**57%:** Estimated percentage of HIV cases that occurred among women (ages 15-49) by the end of 2005

**98,000:** Estimated number of deaths due to AIDS during 2005

**710,000:** Estimated number of children who have lost their mother or father or both parents to AIDS and who were alive and under the age of 17 by the end of 2005

**1.2.4 Political Information**

Provinces are run by political leaders who are appointed by the Republican President as Provincial Ministers. According to Davies (1971) Zambia widely recognised that there are social political and economic components of development. Major social problems include the processes and consequences of transforming the rural population from semi-subsistence to commercial way of life. It also includes combating the powerful drift of rural folk into shanty settlements around the major towns. HIV/AIDS fight is another major social problem Zambia is facing.

Zambia has had a lot of outside influence from either the socialist and capitalist ideals. The colonial influence on Zambia's people and its environment left a lot of gaps in its geographical resources development. Up to 1952, Northern Rhodesia (now Zambia) had a British protectorate status and was regarded as an annex to Southern Rhodesia. This was a colony that attracted European settlement. Industry developed in Northern Rhodesia with the exception of copper mining on the famous Copperbelt close to the Congo border. Southern Rhodesia proved more attractive to investors. Zambia's rural areas became suppliers of labour to the Copperbelt, Rand mines as well as to Southern factories. The geographical position of Zambia and its mineral wealth attracted the outside people to intervene in a lot of the country's stability and resource base utility.

Zambia became independent in 1964 and eight years later, a one party state was established. The first parliament had three parties but UNIP dominated and the reign of humanism was embarked upon.

### **1.2.5 The economy and the copper crisis**

During the period between 1975 and 1990 Zambia's economy declined by approximately 30 percent ([www.ageconsearch.umn.edu/handle/](http://www.ageconsearch.umn.edu/handle/) ).

The reason for this was that the Zambian economy was heavily dependent on the copper industry, which had previously been nationalised. During the 70's the price of copper sank drastically, resulting in a large deficit for the state owned enterprise. Another reason for the drop was Zambia's involvement in the neighbouring countries politics, and the consequent transportation problems. Zambia was actively in Zimbabwe's struggle for independence. This drained a lot of resources in terms of human and non human resources. On the other hand, Zambia incurred massive costs from the survival of white supremacy across the Zambezi. Following (Southern) Rhodesia's Unilateral Declaration of Independence (UDI) in 1965, the United Nations imposed sanctions intended to isolate that country, but these bore much more heavily on Zambia.

To deal with the crisis Zambia took big loans from the International Monetary Fund and the World Bank, hoping that copper prices would rise again soon, instead of issuing structural reforms. According to Kaunda (2006) the price of oil went up threefold in the 1970s. This greatly affected the national budgets and the immediate and long term impact on the whole economy was big. This was because Zambia had no control over events taking place in the Middle East and other oil producing areas of the world. Thus Zambia was very vulnerable.

The rise in oil price affected the cost of getting goods and services in all sectors. What worsened things for Zambia's economy was that while the price of fuel went up, the price of copper began to go down. This meant that Zambia could not easily proceed with the development programmes started in various fields just from independence. Zambia ended up borrowing from creditor governments and organisations, like International Monetary Fund (IMF) and World Bank in order to support development programmes.

The government embarked on an economic reform programme by 1991. It abolished foreign exchange controls, passed new investment laws and set up a stock exchange. The government also embarked on a privatisation programme, which at one point was dubbed by the World Bank as the best on the continent. All this led to Zambia being courted enthusiastically by aid donors. This led to a surge in investor confidence in the country reflected in a growing number of investors.

### **1.2.6 Culture**

Zambia is a country with diverse culture. Most of the people are indigenous Africans with small Asian and European minorities. English is the official language and is widely spoken throughout the country. There are seven main vernacular languages. These are Tonga, Bemba, Nyanja, Kaonde, Lozi, Luvale and Lunda. There are about 70 dialects spoken in Zambia. Each ethnic group has its own lifestyle, based on fishing, farming and cattle raising. The rich variety of traditional cultures gives Zambia a unique cultural heritage in the region ([www.inforplease.com/pa/](http://www.inforplease.com/pa/)).

Christianity is the major religion constituting 80 percent of the population with traditional religions, Islam, Hinduism and Buddhism making up the rest.

### **1.2.7 Place of study**

The study was carried out in Lusaka, urban district of Lusaka province at the New Start Centre-YWCA. The province is located in the central part of the country. It has an estimated population of 1 599 973 (Central Statistics Office, 1999) and most of the people live in Lusaka, the capital city of the country, particularly in the urbanised part of Lusaka.

### **1.2.8 HIV/AIDS IN ZAMBIA-AN OVERVIEW**

Nearly all of us have been affected, directly or indirectly, by the staggering scale of the HIV and AIDS pandemic. Zambia, with the population of about 11,477,477 million and an annual growth rate of 3.5 percent ([www.airninja.com](http://www.airninja.com)), is one of the Sub Saharan African countries worst affected by the HIV/AIDS pandemic. The country is currently experiencing the health, economic and social impacts of a mature, generalized HIV/AIDS epidemic; with a national prevalence rate of 16 percent among the 15-49 years age group (ZDHS 2002).

Overall, urban residents in Zambia are more than twice as likely to be infected as rural residents: 23 percent of urban residents were HIV positive compared to 11 percent of rural residents. The HIV prevalence rates vary significantly according to geography, with ranges from a low rate of 8 percent in Northern Province to a high of 22 percent in Lusaka province.

Women are overall 1.4 times more likely to be HIV-infected than men, 17.8 percent for women and 12.6 percent for men. Prevalence among women is highest between the ages of 30-34 and this could be as a result of high levels of vulnerability, inadequate access to information on prevention, low levels of negotiation skills, and unequal protection under statutory and customary laws and traditions (UNAIDS/WHO, 2006).

### **1.2.9 History of AIDS in Zambia**

Zambia's first AIDS case was reported in 1984. Only one year later 17.5% of hospital patients in the capital Lusaka were found to be HIV-positive. Within two years of the first report of AIDS in the country the National AIDS Surveillance Committee

(NASC) and National AIDS Prevention and Control Programme (NAPCP) were established to coordinate HIV/AIDS-related activities ([www.avert.org/aids.htm](http://www.avert.org/aids.htm) ).

In the early stages of the epidemic much of what was known about HIV prevalence was kept secret by the authorities under President Kaunda.

Senior politicians were reluctant to speak out about the growing epidemic (the President's announcement in 1987 that his son had died of AIDS was a notable exception), and the press did not mention AIDS (<http://www.avert.org/aids.htm>).

By the early nineties it was estimated that as many as 1 in 5 adults had been infected with HIV, leading the World Health Organization to call for the establishment of a National AIDS Advisory Council in Zambia. The Health Minister did not favour this idea; it was felt that the government was preoccupied with reconstructing the bankrupt economy and paying off the country's debt. According to Stephen Lewis, the UN's Special Envoy for HIV/AIDS in Africa, throughout the 1990s the government was 'disavowing the reality of AIDS' and doing 'nothing' to combat the problem.

In 2004, President Mwanawasa declared HIV/AIDS a national emergency and promised to provide antiretroviral drugs to 10,000 people by the end of the year; having exceeded this target, he set another to provide free treatment for 100,000 by the end of 2005. Additionally, government ministers and officials at all levels are now much more willing and able to talk about the epidemic. Even former president Kaunda has changed – he is now one of the most vocal and committed AIDS activists in the country.

#### **1.2.9.1 SOCIETY FOR FAMILY HEALTH**

Society for Family Health, a Zambian Non-Governmental Organisation was formed in the mid-1990s. It is affiliated with the international NGO Population Services International, and manages social marketing programmes in Zambia to help alleviate the burden of the disease in Zambian population. It does this both by motivating changes in behaviour and providing necessary health products and services at affordable prices at the point of demand.

### **1.2.9.2 VCT services in Zambia**

VCT services in Zambia commenced in the 1990s under the central board of Health as one of its strategies for controlling the spread of HIV/AIDS.

VCT is a process whereby an individual receives a half-an hour of confidential counselling prior to taking an HIV test (Dyk, 2003).

In March 2001, SFH entered into partnership with the Central Board of Health, Zambia Counselling Council, Zambia VCT services, International HIV/AIDS Alliance, Development Aid from People to People (DAPP) and USAID to improve the quality and scope of the VCT services in Zambia. Although VCT services are widely spread in Zambia, they are not widely utilised. SFH's role in the Zambia VCT partnership is to design and implement a promotional campaign as well as to develop IEC materials to increase the number of clients seeking VCT services and to improve the quality of the VCT services offered to those clients.

SFH targets urban and peri-urban male and female youth, aged 16-25; men and women aged 26-34, urban married men and women, commercial sex workers, truckers and military and uniformed personnel.

### **1.3.0 STATEMENT OF THE PROBLEM**

Thousands of people have lost their lives and many more thousands will face this same sad predicament. In the last couple of years, there has been an increase in awareness and commitment to combating this deadly disease, though challenges have remained high.

HIV/AIDS progression has aggressively devastated whole regions, impending national development, overstretching health services, soaring maternal and child mortality, collapsing essential public services and education systems, wiping out economic growth, deepening poverty, threatening national and household food security, enslaving women and weakening social cohesion.

In Zambia, on average one in every five adults is infected with HIV. About 84 percent of Zambians diagnosed with HIV are aged between 20 and 39, most of whom are enormously active and have young children to support. The HIV/AIDS is not only a disease; it has fatal consequences culminating in an economic

disaster. Yet the nation has not been as aggressive as AIDS has been in its impact on the nation.

More than seventy percent of the Zambian population falls below the poverty datum line and of ninety percent are women. HIV/AIDS is a serious public health, social and economic problem affecting the whole country to be addressed as a political, developmental and security national priority, requiring a multsectorial approach.

The devastating impact of HIV/AIDS on all sectors of the economy, on communities, households and at the individual level will continue to be enormous unless urgent interventions are put in place. Hence, New Start centres in Zambia engaged to fight this pandemic. This has been possible through their existing communication strategies used by the organisation to combat HIV/AIDS.

#### **1.4.0 RATIONALE**

HIV and AIDS affect everyone. Most people are either infected or affected. Nearly all Zambians have been affected, directly or indirectly, by the staggering scale of the HIV/AIDS pandemic. The most infected people are youths and women who are in their reproductive and productive age. They are often breadwinners. The country is currently experiencing the health, economic and social impacts of a mature, generalised HIV and AIDS epidemic. This has led to high levels of poverty, change patterns of household consumption, withdrawing of children from going to school because they have lost one or both parents due to HIV/AIDS. The majority of these orphans have to live with extended family members or neighbours with a possibility of them becoming street children while others live in orphanages.

Communication in Zambia plays a key role in combating HIV/AIDS and facilitating economic and social development. Communication is central to our lives and so good communication skills are necessary for effective participation in social life. Lack of good communication strategies will affect the development process leading to economic growth of our nation. Hence, the research project is of importance because it studies the New Start, under SFH, the coordinating body's communication strategies used to fight the HIV/AIDS. A successful fight against the pandemic relies on effective communication to shape people's response to the pandemic.



### **1.5.0 Aim of the study**

The study aims at strengthening the already existing network communication strategies within New Start and other organisations endeavouring to fight the HIV/AIDS pandemic

It is hoped at disseminating research findings on unheard stories in such a way that developmental policies can be influenced to enhance alternative holistic stories of attending VCT.

### **1.6.0 Objectives of the study**

The objectives of the study are to:

1. Establish the nature of and extent to which communication strategies used by New Start are utilised in reaching out the communities.
2. Establish whether or not the communication strategies are adequate to deliver the message
3. Investigate the adequacy of the information received about HIV/AIDS
4. Investigate the knowledge and understanding of clients about HIV/AIDS
5. Ascertain how New Start Centre looks at the role of the media in the face of HIV/AIDS.
6. Identify barriers that may hinder effective communication to the community

### **1.7.0 Limitations of the study:**

A sample of respondents comprising more than one district in Lusaka Province was desired. However, time and financial constraints could not permit a large sample even though the factor under study is very important.

## **CHAPTER 2:**

### **METHODOLOGY**

#### **2.0 Introduction**

The researcher used the triangulation approach suggested by scholars as ideal to take care of various concerns. The quantitative survey was used to gather data from representative sample of New Start staff and Clients and qualitative methods to gather varying opinions from the respondents.

#### **2.1 Research questions**

1. What communication strategies does New Start centre use in disseminating the information to the communities and how adequate are they?
2. How effective are the communication channels or strategies on their intended target?
3. Which strategy used for communication is thought to have yielded more behavioural change and for which audience?
4. How do clients view HIV/AIDS counselling and testing?
5. How does New Start centre look at the role of the media in the fight against HIV/AIDS?
6. What are the barriers that may hinder effective communication to the communities?

##### **2.2.1 Research Methods**

The researcher used a variety of methods in order to gather sufficient data representative of the situation. This included in-depth interviews, Focus Group Discussions (FGDs) participant observation and quantitative survey. Data collection through questionnaires was intended to evaluate communication strategies that are in use and how effective they are.

### **2.1.2 In-depth Interviews**

The In-depth Interviews were mainly for the Site Manager and VCT counsellors. The researcher conducted about 2 in- depth interviews. Purposeful sampling was used for in-depth interviews.

This was done to obtain people's inner feelings and views about communication strategies used by New Start.

### **2.1.3 Focus Group Discussion**

A group of 8 workers and volunteers at New Start Centre was involved. During the discussion, the researcher used a recording cassette to capture data.

### **2.1.4 Participant Observation**

The researcher participated in relevant activities that are carried out by New Start Centre. The researcher spent time with New Start, observing and participating in the day to day activities of the organisation. During the same time, the researcher also observed the interactions with each other within the organisation.

### **2.1.5 Quantitative Survey**

Questionnaires were used to collect data from the beneficiaries of New Start Centre and workers from the same organisation. Questionnaires were chosen because they accommodate behavioural questions which can measure attitudes, opinions, beliefs and motives. Above all, questionnaires allow for greater use of different questioning techniques such as open ended questions. These bring out a lot of information from the respondents. One type of questionnaire was administered to the New Start centre workers and volunteers and the other to the beneficiaries of New Start services. This included; youth, middle aged and the elderly. A total of 110 people were captured.

## **2.3 Sampling procedure**

The study was restricted to the New Start workers and volunteers, together with the beneficiaries (Clients). 10 respondents were randomly picked from the total population of the workers and volunteers. 100 respondents were drawn from the beneficiaries, using convenient sampling. The study was earlier targeting 150 respondents but only 110 were covered during the research.

The programme is more relevant to those engaged in the programmes of combating HIV/AIDS. One focus group discussion of about 8 people was conducted to both workers and volunteers. These are the implementers of communication strategies, and this was done to justify external validity.

## **2.4 Data analysis**

Qualitative and quantitative method of data analysis was used. The analysis was based on the SPSS. The researcher analysed data by use of tables, frequencies, percentages, charts and graphs, and other data summarising tools.

## CHAPTER 3

### 3.0 CONCEPTUAL AND THEORETICAL FRAMEWORK

This section focuses on conceptual and theoretical framework as used and applied in this research study of communication strategies relevant to the fight against HIV/AIDS. In addition, it states the main theories and their applicability to a study of this nature. The theories explain why particular communication strategies need to be used in particular situations to induce positive change, and also to explain reasons for certain communication strategies used in the fight against HIV/AIDS fail or succeed.

A conceptual framework is the definition of a concept by a set of other concepts. A conceptual definition simply states the distinctive characteristics of that which is being defined.

### 3.1 Communication

Communication in this study refers to the process of sharing of ideas, information and opinions through speech, writing, pictures, and other symbols. It is a sharing process where a source shares messages with a receiver via a certain channel in order to influence the receiver's thoughts and actions. *Elkamel (1986) pointed out that people engage in the communication process for a variety of purposes, for example, to obtain information, education, training, advice, rewards, to express feelings and emotions or to participate in entertainment.*

Infante et al, (1997) defines communication as when humans manipulate symbols to stimulate meaning in other human. This therefore entails that communication is fundamental to have everything done in our human circles.

#### 3.1.1 Mass communication

This communication process refers to the form of communication that takes place among large heterogeneous and physically scattered numbers of individuals. The communication that occurs between two persons or among a homogenous and physically small group is called interpersonal, or person-to-person, or face-to-face, or personal, or direct communication. (Elkamel, 1986).

In this type of communication, print and electronic media are used in form of newspapers, brochures, posters, radio, television, theatre to disseminate messages for HIV/AIDS.

### **3.1.2 Participation**

Participation is a process of equitable and active involvement of all stakeholders in the formulation of development policies and strategies and in the analysis, planning, implementation, monitoring and evaluation of development activities. To allow for a more equitable development process, disadvantaged stakeholders need to be empowered to increase their level of knowledge, influence and control over their own livelihoods, including development initiatives affecting them ([www.fao.org/participation/whoweare.html](http://www.fao.org/participation/whoweare.html)).

### **3.1.3 Participation in development**

In this study, the researcher defines participation in development as a process of equitable and active involvement of all stakeholders in the formulation of development policies and strategies and in the analysis, planning, implementation, monitoring and evaluation of development activities. To allow for a more equitable development process, disadvantaged stakeholders need to be empowered to increase their level of knowledge, influence and control over their own livelihoods, including development initiatives affecting them.

Participation in development is also seen as an organised effort within institutions and organisations to increase stakeholder access and control over resources and related decision making that contributes to sustainable livelihoods. Participation is furthermore viewed as an interactive process involving the continuous re-adjustment of relationships between different stakeholders in a society in order to increase stakeholder control and influence over development initiatives that affect their lives.

There are various levels or degrees of participation ranging from simple consultation to joint decision making to self-management by stakeholders themselves. The specific degree of participation of different stakeholders is determined through a negotiation process.

Ideally this means putting the beneficiaries at the centre of a development process that they will drive and continuously adjust, according to their own learning processes and needs ([www.farn.org.ar/docs/pp/en\\_index.html](http://www.farn.org.ar/docs/pp/en_index.html)).

### **3.1.4 Participatory communication**

In this study, the term participatory communication is used as a descriptive category that refers to the active involvement of a community or group in using media or group communication and to engage audience in critical reception.

The goal of participation is to empower communities to determine their objectives and take action to achieve them. Participatory communication aims to facilitate the expression of people's needs and priorities through effective communication processes.

According to Servus et al (1996) peoples' participation has historically been the ideological basis for a democratic society. Participatory communication is not new, it has been practiced and promoted for many decades in a variety of fields, and has received a considerable attention in industrialised countries in adult education, communication development, and development communication. In the fight against HIV/AIDS, the participation of communities or groups in using media will enhance the spreading of HIV/AIDS messages to societies and create sense of ownership in individuals. People need information as an integral part of development – information about their rights as citizens and about what has worked to promote inclusive development at the community level in the fight against HIV/AIDS.

### **Communication for development**

In this study, the term has been used to encompass many different media and approaches, for example, folk media and traditional social groupings, rural radio for community development, video and multi media modules and others.

Communication for development is based on dialogue, which is necessary to promote stakeholders' participation. Such participation is needed in order to understand stakeholder perceptions, perspectives, values, attitudes and practices so they can be incorporated into the design and implementation of HIV/AIDS fight and development initiatives. There is no universal formula capable of addressing all situations in the fight against HIV/AIDS and therefore it should be applied according to the cultural, social and economic context of a given area.

### **Development communication**

In this study, development communication refers to interventions that originate from outside the control of the community or target group and are delivered through government or international development institutions and NGOs.

#### **3.1.7 Interpersonal Communication**

This is face to face communication between two or more individuals. This takes the form of exchange agents that work in the area and people passing HIV/AIDS information amongst them. An interpersonal communication channel provides for two way interaction and feedback is more effective especially when the goal of communication is persuasion. Interpersonal communication is likely to cause attitude change (Melkote, 1991:29).

#### **3.1.8 Group Communication**

In this study, group communication is where people are put into small groups holding discussions. Like in interpersonal communication, one has an advantage of getting feedback immediately. The group is free to get clarified where it is due. White, (1994) affirms that small group communication can take the form of meetings, working lunch or breakfast and so on.

#### **3.1.9 Development**

Development is creating the conditions for the realisation of human personality. It is inevitably a normative concept, almost a synonym for improvement. The elimination of the HIV/AIDS epidemic is a development concern of our time.

Rodney (1972) defines development as increase in skill and capacity, greater freedom, self-discipline, responsibility and material well-being. Thus, we can say that development is the improvement of people's lifestyles through improved education, incomes, skills development and employment.

In this case, whatever is improved helps the individual to lead a better life. It therefore makes it difficult to precisely measure development because it is qualitative rather than quantitative. In cases where material push forward is involved, it is always accompanied by non-material improvements in the human life situation. Kasoma, (1994) states that, what is particularly important is the fact that this development, whether societal or individual, it is intended to answer or satisfy human needs or



wants. He further goes on to define development as the improvement of human life condition at individual and societal levels which is achieved through desired but fluctuating changes or adjustments in the environment. By this definition, environment means the sum total of all that which goes into making human life situation. It includes physical as well as psychological vicissitudes of the human condition.

### **3.10 Communication Strategy**

In this study, this refers to a well-planned series of actions aimed at achieving certain objectives through the use of communication methods, techniques and approaches. The strategy should be effective to make the best use of the available resources in order to achieve the set objectives and targets.

The purpose of designing a communication strategy is to address and solve problems at the grassroots level utilising communication methods, techniques and media. This should be done with the people, not just for the people ([www.comminit.com/planningmodels/plan.html](http://www.comminit.com/planningmodels/plan.html)).

## **3.2 MAIN THEORIES**

### **3.2.1 Introduction**

In communication, it is vital to ensure that the right information on any given issue is correctly transmitted by the use of the channel. In the fight against HIV/AIDS, communication becomes important. This may be promoting drastic changes in negative behaviours, cultures and traditions such as sexual cleansing (National AIDS Council communication strategy, 2005).

According to Infante et al. (1997), it is important to communicate because it helps us create cooperation and interaction with one another, promotes democracy, acquire information and entertain ourselves. He further adds that communication is important because without it, development would not be possible. To be aware that development has occurred, it has to be communicated to others.

Melkote (1991) quotes Diaz-Bordenave (1989) and says that communication is important because the need to think, express oneself, and belong to a group, be recognised as a person, appreciate, have some say in crucial discussions affecting one's life and so on, are essential to the individual as eating, drinking and sleeping.

Inaccurate, confusing or judgment information can lead to people making grave mistakes in the lives of those infected and affected by the HIV/AIDS epidemic. The researcher evaluated all information disseminated to people, how effective and accurate in order to bring about desired behaviour changes that will significantly reduce the prevalence rates, create a supportive environment for the treatment and care and support of programme.

### **3.2.2 Selective exposure, selective perception and retention, and shared interest:**

Klapper (1960) formulated several generalisations on the effects of mass media, which still stand. Initially, he investigated more than 1000 research reports, studies and essays on mass communications. He used 270 of these as a basis for his formulations, maintaining that the main tendency of the research findings is as follows: "Mass-media ordinarily does not serve as a necessary and sufficient cause of audience effect, but rather functions among and through a nexus of mediating factors and influences." That these mediating factors are such that they typically render mass-communication a contributory agent, but not the sole cause, in a process of reinforcing the existing conditions." On this basis, Klapper described the main mediating factors, which he considered responsible for the functions and effects of mass communications as: -

- (i) **Selective exposure-** is people's predisposition to expose themselves to those mass communications, which are in accord with their attitudes and interests.
- (ii) **Selective perception and retention** are people's predisposition to dispose the meaning of mass communication messages in order to bring these messages into accord with their already existing views.

First, the fact that people interact as members in social groups usually increases the reinforcing effect of the factors mentioned above. The group sees to it that the individual member does not deviate from its norm of behaviour. This group pressure reduces the effect of mass communication to a sort of accompaniment. The group context causes the individual member to be confronted by certain messages, but not by others, and also causes him or her to interpret the former in a group conformant way.

Second, the fact that people communicate with each other, influences their behaviour in many matters more than mass communication and, moreover, it influences them in favour of constancy and reinforcement.

Klapper's notions of selective exposure and selective perception were deepened by other researchers, notably in Sweden Cerha (1967) in an enormous sample of 50,000 adults; found that shared interests are the channels through which communication flows. People's interests control the flow of information in society. People communicate when they share an interest in a given topic.

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### **3.2.3 Diffusion of Innovation Theory**

One of the greatest pains to human nature is the pain of a new idea. It makes one think that favourite notions may be wrong, and firmest beliefs ill founded. Naturally,

therefore, human beings hate a new idea, and are disposed more or less to ill-treat the original person who brings it.

Everett Rogers (1994) defines diffusion as the process by which an innovation is communicated through certain channels over time among the members of a social system. Three elements that are present in the diffusion of innovation theory process are: (a) Innovation; an idea, practices, or object that is perceived as new by an individual or other unit of adoption, (b) Communication channels - the means by which messages get from one individual to another, (c) Time (innovation-decision process, relative time with which an innovation is adopted by an individual or group, and an innovation's rate of adoption and social system.

Innovations in most cases are generated to address some specific problems people are facing at a particular time, for instance, the HIV/AIDS pandemic.

### **3.2.4 CULTIVATION THEORY**

The researcher also employed the Cultivation theory (sometimes referred to as the cultivation hypothesis or cultivation analysis) as an approach developed by Professor George Gerbner, Dean of the Annenberg School of Communications at the University of Pennsylvania. He began the 'Cultural Indicators' research project in the mid-1960s, to study whether and how watching television may influence viewers' ideas of what the everyday world is like. Cultivation research is in the 'effects' tradition. Cultivation theorists argue that television has long-term effects which are small, gradual, indirect but cumulative and significant ([www.tcw.utwente.nl/](http://www.tcw.utwente.nl/)).

They emphasize the effects of television viewing on the attitudes rather than the behaviour of viewers. Heavy watching of television is seen as 'cultivating' attitudes that are more consistent with the world of television programmes than with the everyday world. Watching television may tend to induce a general mindset about violence in the world. Cultivation theorists distinguish between 'first order' effects (general beliefs about the everyday world, such as about the prevalence of violence) and 'second order' effects (specific attitudes, such as to law and order or to personal safety).

Gerbner argues that the mass media cultivate attitudes and values that are already present in a culture: the media maintain and propagate these values amongst members of a culture, thus binding it together. He has argued that television tends to cultivate middle-of-the-road political perspectives.

And Gross considers that 'television is a cultural arm of the established industrial order and as such serves primarily to maintain, stabilize and reinforce rather than to alter, threaten or weaken conventional beliefs and behaviours' (Boyd-Barrett & Braham 1987). Such a function is conservative, but heavy viewers tend to regard themselves as 'moderate'.

Cultivation research looks at the mass media as a socializing agent and investigates whether television viewers come to believe the television version of reality the more they watch it. Gerbner and his colleagues contend that television drama has a small but significant influence on the attitudes, beliefs and judgments of viewers concerning the social world. The focus is on 'heavy viewers'. People who watch a lot of television are likely to be more influenced by the ways in which the world is framed by television programmes than are individuals who watch less, especially regarding topics of which the viewer has little first-hand experience. Light viewers may have more sources of information than heavy viewers may.

Cultivation theorists argue that heavy viewing leads viewers to have more homogeneous or convergent opinions than light viewers who tend to have more heterogeneous or divergent opinions. The cultivation effect of television viewing is one of 'levelling' or 'homogenising' opinion. Gerbner and his associates argue that heavy viewers of violence on television come to believe that the incidence of violence in the everyday world is higher than do light viewers of similar backgrounds. They refer to this as a mainstreaming effect ([www.novaonline.nvcc.edu/eli](http://www.novaonline.nvcc.edu/eli)).

### **3.2.5 Agenda Setting Theory**

The agenda setting falls within the realm of powerful media effects. Agenda setting describes a very powerful influence of the media- the ability to ask what issues are important. The ability of mass media to effect cognitive change in the public and to

structure the public's agenda by controlling its awareness and information is known as the agenda setting function of mass communication.

As far back as 1922, the newspaper columnist Walter Lippman was concerned that the media had the power to present images to the public. McCombs and Shaw investigated presidential campaigns in 1968, 1972 and 1976. In the research done in 1968 they focused on two elements: awareness and information. In investigating the agenda setting function of the mass media, they attempted to assess the relationship between what voters in one community said were important issues and the actual content of the media messages used during the campaign.

McCombs and Shaw concluded that the mass media exerted a significant influence on what voters considered to be the major issues of the campaign. McQuail (1993) emphasises that the media simply by the fact of paying attention to some issues and neglecting others will have an effect on public opinion. For example, the mass media force attention on certain issues, build up public images of political figures, and constantly present objects suggesting what individuals in the mass should be thinking about.

Agenda setting is the creation of public awareness and concern of salient issues by the news media. Two basic assumptions underlie most research agenda setting: the press and the media do not reflect reality; they filter and shape it; media concentration on a few issues and subjects leads the public to perceive those issues as more important than other issues. One of the most critical aspects in the concept of an agenda-setting role of mass communication is the time frame for this phenomenon. In addition, different media have different agenda setting potential. Agenda setting theory seems quite appropriate to help us understand the pervasive role of the media in the fight against HIV/ AIDS. The idea that the media set the order of importance of issues seems fairly obvious. Issues that gain importance in public perception are generally those issues that the media determine to be important, such as HIV/AIDS issues. Somewhere between the function of informing (reporting the facts) and persuading (selecting certain facts that support a particular argument such as HIV/AIDS) is an area in which we find the agenda setting role of the press. Whether it is the coverage of HIV and AIDS or other issues, media tend to shift focus away from other relevant

issues and instead of disseminating useful information such as symptoms, methods of treatment etc, spread panic among audiences Hgel and Weiss (1989).

However, the information processing approach underlying the media priming approach gives HIV/AIDS knowledge a central place in how and when news information is stored and retrieved. Obviously different people can be exposed to the same HIV/AIDS message and yet perceive it differently, depending on their prior knowledge about the issue under consideration Allan (1998).

### **3.2.6 Persuasion Theory**

Persuasion is a process by which people use messages to influence others. While persuasion typically uses information, the emphasis in a persuasive message is on influencing the receiver (rather than merely providing information and letting the receiver make up his/her own mind). Persuasion attempts to change minds or get people to act. Persuaders seek change!

In the formal study of persuasion several common terms take on special, technical meanings different from their everyday uses. These terms can help persuaders analyse the rhetorical situation and become more effective in designing their messages (Ajzen, & Fishbein, 1980)

This theory was developed around 1960s by social psychologists. Persuasion according to Infante et al. (1997) is at its most basic level, an attitude towards a resource's proposal which has resulted from a message designed to alter beliefs about a recommended course of action. He further adds that an attitude is how favourably we evaluate something. He argues that if a persuader wants to influence a specific behaviour, he/she must use messages to create favourable attitude. By persuading a person to favour the new idea, the persuader provides justification for the receiver to choose to behave in a particular manner. In order to have persuasion and not some other type of influence, the receiver must be free and not constrained to choose. Thus, perceived choice is a distinguishing characteristic of persuasion.

The various mass media interpersonal communication theories were a good litmus test the researcher used to measure the context within which New Start programmes

operate. The researcher tried to see the extent to which the factors raised by the various theories came into play during dissemination of HIV/AIDS information to the public.



## **CHAPTER 4**

### **4.0 LITERATURE REVIEW**

In this chapter, the researcher discusses what other scholars have done on HIV and AIDS, communication and education strategy for prevention, as well as communication strategies among other areas that have been studied, in the world, including Africa and Zambia. In discussing issues of this chapter, the research used materials from Society for Family Health, National Aids Council, annual reports, strategic papers, thesis of previous MCD students, and above all, the researcher depended heavily on World Wide Web.

Awareness of HIV/AIDS has become universal in both rural and urban areas, 99 percent of men and women have heard about Aids, a slight increase from 96 percent record in 2000, Zambia sexual behaviour survey (2003).

The HIV and AIDS communication strategy (2005) aims to promote behaviours and policy measures in support of HIV/AIDS prevention, treatment, care and support. It sets out a comprehensive set of communication objectives aimed at improving knowledge, behaviour change communication for safer sexual practices, accessing voluntary counselling and testing, treatment, care and support services as well as to reduce stigma and discrimination.

It is further argued that despite some of the successes that have been demonstrated with HIV prevention efforts with small population like sex workers, many of these lessons have not been taken to scale for the general population to have an impact on overall incidence. The epidemic can only be reversed by intensifying communication strategies in scale and scope, so as to control the rate of new infections as the critical step to reducing the prevalence rate as the mortality rate falls and people with HIV survive.

Further, National HIV/AIDS/STI/TB report (2004), argues that behaviour change is a vital strategy in the response against HIV/AIDS in Zambia. Behavioural change is a process by which information and skills are shared and disseminated to people in a specific target audience with an intention of influencing them to adopt sustained changes in sexual behaviour or attitudes, or to engage in other health seeking behaviours.

Kenya national HIV/AIDS communication strategy, a wide body of research has also noted that significant and sustained behaviour change does not occur as a result of simply providing information about HIV/AIDS.

There is a wide range of communication design factors related to the types of appeals developed and their level of persuasion. Also to be considered are audience mediating factors such as socio-economic, cultural, spiritual and demographic factors that determine whether and how behaviour change occurs, how long it will take to occur, and whether it will be sustained ([www.stoptb.org/wg/advocacycommunication](http://www.stoptb.org/wg/advocacycommunication)).

Africa South of the Sahara is more heavily affected by HIV and AIDS than any other region of the world. An estimated 24.5 million people were living with HIV at the end of 2005 and approximately 2.7 million additional people were infected with HIV during that year. In just the past year, the AIDS epidemic in Africa has claimed the lives of an estimated 2 million people in this region. More than twelve million children have been orphaned by AIDS (WHO, 2007).

The extent of the AIDS crisis is only now becoming clear in many African countries, as increasing numbers of people with HIV are becoming ill. In the absence of massively expanded prevention, treatment and care efforts, it is expected that the AIDS death toll in Africa South of the Sahara will continue to rise. This means that impact of the AIDS epidemic on these societies will be felt most strongly in the course of the next ten years and beyond. Its social and economic consequences are already widely felt, not only in the health sector but also in education, industry, agriculture, transport, human resources and the economy in general.

Both HIV prevalence rates and the numbers of people dying from AIDS vary greatly between African countries. In Somalia and Senegal the HIV prevalence is under 1 percent of the adult population, whereas in South Africa and Zambia around 15-20 percent of adults are infected with HIV (HIV/AIDS Basic Handbook, 2006).

In four southern African countries, the national adult HIV prevalence rate has risen higher than was thought possible and now exceeds 20 percent. These countries are Botswana (24.1 percent), Lesotho (23.2 percent), Swaziland (33.4 percent) and Zimbabwe (20.1 percent).

West Africa has been less affected by AIDS, but the HIV prevalence rates in some countries are creeping up. HIV prevalence is estimated to exceed 5 percent in Cameroon (5.4 percent), Côte d'Ivoire (7.1 percent) and Gabon (7.9 percent).

Until recently the national HIV prevalence rate has remained relatively low in Nigeria, the most populous country in Africa South of Sahara. The rate has grown slowly from below 2 percent in 1993 to 3.9 percent in 2005. But some states in Nigeria are already experiencing HIV infection rates as high as those now found in Cameroon. Already around 2.9 million Nigerians are estimated to be living with HIV.

Adult HIV prevalence in East Africa exceeds 6 percent in Uganda Kenya and Tanzania. Overall, rates of new HIV infections in Africa South of Sahara appear to have peaked in the late 1990s, and HIV prevalence seems to be leveling off, albeit at an extremely high level. Stabilisation of HIV prevalence occurs when the rate of new HIV infections is equaled by the AIDS death rate among the infected population. This means that a country with a stable but very high prevalence must be suffering a very high number of AIDS deaths each year. Although prevalence remains stable, the actual number of Africans living with HIV is rising due to general population growth (UNAIDS/WHO, 2006).

The Joint United Nations Programme on HIV/AIDS (UNAIDS) has predicted outcomes for the region to the year 2025. These range from a plateau and eventual decline in deaths beginning around 2012 to a catastrophic continual growth in the death rate with potentially 90 million cases of infection.

According to NAC (2006), HIV/AIDS seriously affects adolescents throughout the world. One-third of all currently infected individuals are youth, ages 15 to 24, and half of all new infections occur in youth of the same age. More than five young people acquire HIV infection every minute; over 7,000, each day; and more than 2.6 million each year. Chifukushi (2007), states that, the number of new infections must be dramatically reduced in the next few years. This means that there must be a strong additional emphasis on reaching the youth of Zambia, including young children to reduce stigma and discrimination for the growing number of persons who will live with HIV.

About 1.7 million new adolescent HIV infections—over half of the world's total—occur in Africa South of Sahara. In fact, nearly 70 percent of people living with HIV/AIDS live in Africa South of Sahara, and over 80 percent of AIDS deaths have occurred there.

Although HIV/AIDS rates vary considerably throughout Africa South of Sahara — generally lower in western Africa and higher in southern Africa—the epidemic has had a devastating effect on most African youth who often lack access to sexual health information and services. In particular, unmarried youth have great difficulty getting needed sexual health services. At the same time, cultural, social, and economic norms and pressures often put young African women at excess risk for HIV infection (UNAIDS, 2006).

Experts estimate that half a million African youth, ages 15 to 24, will die from AIDS by the year 2010. In African countries with long, severe epidemics, half of all infected people acquire HIV before their 25th birthday and die by the time they turn 35.

(a) The epidemic means that African youth face a bleak future. In 1997 in Zimbabwe, half of all 15-year-old males could expect to die before age 50 compared to 15 percent in 1983. Between 1983 and 1997, 15-year-old females' risk of death prior to age 40 quadrupled from 11 to over 40 percent.

(b) Infection with a STDs, especially one that causes genital ulcers, such as herpes or syphilis, puts one at increased risk for HIV infection, and sexually active youth in sub-Saharan Africa are at high risk for STD infection. For example, 10 to 20 percent of the sexually active population of sub-Saharan Africa is infected with gonorrhoea (Dyk, 2003).

Other researchers indicate that half of all HIV infections worldwide occur in women in Africa. In seven of 11 studies in Africa, at least one woman in five, ages 20 to 25 was HIV infected; most HIV-infected young women will not live to age 30. In one city in South Africa, six out of 10 women, ages 20 to 25, were HIV infected; among youth in their early 20's, women's rates were three times higher than men's. In Malawi, HIV incidence in teenage women is six percent compared to less than one percent in women over age 35 (UNAIDS, 1999).

Throughout sub-Saharan Africa, HIV infection rates among teenage women are over five times higher than rates for teenage males. In Kenya, nearly one teenage woman in four is living with HIV, compared to one teenage male in 25.

The physical immaturity of younger women and women's lower status in society may contribute to disproportionate HIV infection rates. Women's lower status may prevent them from having control of their sexual relationships. For example, studies on women's first sexual experience show that over half of young women in Malawi and over 20 percent of young women in Nigeria experienced forced sexual intercourse.

UNAIDS (2004), indicate that young men and women need:

- a. Accurate and relevant information about sexuality and reproductive health, including full information about risk of acquiring STDs and how to avoid STDs.
- b. Access to information and services where they feel comfortable and accepted
- c. Communication skills to talk honestly with partners about sexuality as well

as negotiating skills to refuse unprotected sex.

UNAIDS/WHO (2006), also emphasises on the fact that generally gender inequality greatly hampers HIV prevention efforts.

In spite of large amounts of funding invested in information and dissemination activities around HIV-AIDS, the spread of HIV continues to progress at pandemic levels in many countries of the world. Although some progress has been achieved in specific country settings, the overall picture remains somewhat gloomy.

#### **4.1 Introduction to Aids in Zambia**

The republic of Zambia is a large country at the heart of sub-equatorial Africa. More than a quarter of its 11-12 million people live in two urban areas near the centre: in the capital Lusaka and in the industrial towns of the Copperbelt. The rest of Zambia is sparsely populated; particularly the west and the northwest, and the majority of people make their living as subsistence farmers.

In four decades of independence, Zambia has found peace but not prosperity. Today it is one of the poorest and least developed nations on earth. Around two-thirds of population lives on less than a dollar a day ([www.avert.org/aids-zambia.htm/](http://www.avert.org/aids-zambia.htm/) ).

Zambia's problems have since the mid 1980s been compounded by one of the world's most devastating HIV and AIDS epidemics. The statistics alone are shocking:

1. One in every six adults is living with HIV
2. 98, 000 people died of AIDS in 2003
3. Life expectancy at birth has fallen below 40 years
4. 710,000 children are AIDS orphans  
([www.globalhealthreporting.org/countries/zambia/](http://www.globalhealthreporting.org/countries/zambia/) ).

HIV has spread throughout Zambia and to all parts of society. It has worst hit those in their most productive years, and, as families have disintegrated, thousands have been left destitute (National AIDS Council, 2000).

Responses to HIV and AIDS in Zambia have for many years aimed to prevent HIV transmission; to care for those who are infected; and to reduce the personal, social and economic impact of AIDS. Since late 2002, the state has been engaged in an ambitious antiretroviral (ARV) treatment programme. Today HIV prevalence remains at a very high level. Reducing the number of new infections, while scaling-up the provision of treatment to so many thousands in need, poses a massive challenge to the government and the international community. Yet, it is a challenge that must be met if Zambia is ever to have a better future (Garbus, 2003).

There is only one weapon against HIV infection and AIDS and that is behaviour change. This means abstinence, mutual fidelity or condom use. It is unfortunately the most difficulty and complex weapon to use because people find it extremely difficult to change their sexual behaviour. Connor and Kingman (1988) said that, the disease that spreads with the help of sex is a formidable foe, because it is transmitted during intimate and compulsive of human activities.

One of the main educational functions of health care professionals is to encourage changes in unsafe sexual behaviour; meaning, failure to abstain, being faithful to one faithful sexual partner and consistent use of condoms. This is very difficult because sex comprises deeply pleasurable and meaningful acts that touch the very core of what it means to be a human being. Although people will never stop having sex, they can be taught to practice safer sex.

This entails practising abstinence, being faithful to one faithful sexual partner and correct and consistency use of a condom (Dyk, 2003). Good communication strategies can facilitate the achievement of this.

#### **4.2 People at high risk of HIV infection**

1. In sub-Saharan Africa, as in other regions of the world, a culture of silence surrounds most reproductive health issues. Many adults are uncomfortable talking about sexuality with their children. Others lack accurate sexual health knowledge.
2. Many Africans feel unable to discuss sexuality across perceived barriers of gender and age differences. Many Africans are also reluctant to provide sexually active adolescents with condoms.
3. In several African countries, some people believe that men are biologically programmed to need sexual intercourse with more than one woman. Polygamy is a central, social institution that reinforces this belief. Moreover, some men believe that this "biologically programmed need" makes high-risk sex unavoidable.
4. In some impoverished communities, high HIV infection rates may be partly explained by early sexual initiation, consensual or coerced. For example, in a survey of 1,600 urban Zambian youth, over 25 percent of 10-year-old children and 60 percent of 14-year-old youth reported already having sexual intercourse.

One study of adolescents in 17 African countries showed that those with more education were far more likely to experience casual sex and to use condoms for casual sex when compared to less educated youth. UNDP (2003) clarifies that, an increase in the flow of information is a key factor in the spread and smoothness of development. Information lubricates the very fabrics of society and contributes to the spiral of development. Given the important role information plays in development, the fight against HIV/AIDS would be easy.

A lot of organisations today are centering on disseminating information to fight HIV/AIDS. Mass media like radio, television, newspapers and brochures are mainly

used. This however, is indicated by McAnany that HIV/AIDS information drops sharply as one goes from urban areas to rural areas (McAnany, 1980).

The information does not reach where attitude and behavioural change is needed as already indicated above.

According to UNAIDS/WHO (2006) report on the global AIDS pandemic, it is said that communication strategies are very important for combating HIV/AIDS. The future generation can only be preserved through sensitisation on HIV/AIDS pandemic. It is also important to realize that most communication developmentalists share aim, attitude changes and gains in knowledge and skill, enhanced self ability to solve problems individually or through group action. If there is no change in people's attitudes toward sexual behaviours, then there will be no progress. All sectors of people need to be informed in order to realize the full benefit of behaviour change.

### **4.3 Women**

Gender inequality greatly hampers HIV prevention efforts. Traditionally in Zambia, as in many other parts of the world, men play a dominant role in most relationships, while women and girls are generally expected to be submissive. Females also have less access to education and mass media. As a result, women can lack the confidence, skills and knowledge necessary to negotiate safe relationships with men and to make independent lifestyle choices. Often a woman is taught that she must obey her husband and that it is wrong to refuse sex with him. Less than two-thirds of adults (of either gender) believe that a woman can refuse sex if she suspects that her husband has HIV.

Various aspects of traditional Zambian culture may make women more vulnerable to HIV infection. Among these is sexual cleansing - a not uncommon ritual in which a deceased man's relative has sex with his widow, in the belief that this will dispel evil forces; the HIV status of either person involved is not always taken into account. Various alternative, risk-free rituals exist, and are becoming more popular in some areas especially the Southern parts of Zambia ([www.avert.org/aids-zambia.html](http://www.avert.org/aids-zambia.html)).

Information flow to rural areas is needed where such practices are still rampant. However, to achieve this in Zambia is still a nightmare because even radios that used to be accessible in rural areas are now rare due to poor reception. The information



disseminated by HIV/AIDS activists does not reach all the intended people. Ganguli, (1988) states that information is power. Without rural areas receiving appropriate information, the fight against HIV/AIDS and development shall remain a myth in developing countries.

#### **4.4 Abused children**

Many of the most tragic stories connected with HIV transmission involve the sexual abuse of children. The high prevalence of HIV has increased the level of sexual violence and coercion, and not just because many of the victims are vulnerable AIDS orphans. Men are targeting increasingly younger sexual partners whom they assume to be HIV-negative, and the "virgin cure" myth (which wrongly claims that sex with a virgin can cure AIDS) fuels much of the abuse. An increased proportion of the abusers are HIV-positive and many transmit their infection to their victims.

Like most countries, Zambia does have laws against child abuse. However, orphans who inform against their guardians risk abandonment or violent punishment, and families will often go to great lengths to conceal what is going on. It is no surprise that the vast majority of perpetrators go unreported, unpunished and free to abuse again

#### **4.5 Impact of HIV/AIDS in Zambia**

##### **4.5.1 Impact on families**

The majorities of people who develop AIDS are in their productive years and are often the sole breadwinners in their households. When an adult falls ill, other family members - in particular children kept home from school - must try to raise money or tend crops as well as looking after their ailing relative. Much of the cash they are able to obtain is spent on medical care and, ultimately, funeral costs. When a parent dies, survivors can be left destitute.

People in need have traditionally been supported by their extended families, but the toll of the epidemic is now so great that family structures can no longer cope. Stigma compounds the problem, as many of those affected by AIDS become socially excluded. And to make matters worse, when the male head of a household dies it is

not unheard of for his entire property to be "grabbed" by his relatives (despite laws meant to prevent this), leaving his widow and children with nothing. Desperate people will inevitably turn to risky occupations or migration ([www.zambia-aids-prevention-care.html](http://www.zambia-aids-prevention-care.html)).

Thousands of children are abandoned due to stigma or to simple lack of resources, while others run away because they have been mistreated and abused by foster families. Many such children congregate in the big cities, where they live by begging, stealing and prostitution:

*"In the days before the full impact of the HIV and AIDS pandemic, street children were a very rare sight in Zambian cities and towns. Now they are everywhere sleeping under bridges, behind walls, and in shop corridors."* ([www.avert.org/aids-zambia.html](http://www.avert.org/aids-zambia.html)).

In 2005, it was estimated that 710,000 surviving children had lost at least one parent to AIDS ([www.avert.org/aidsorphans.html](http://www.avert.org/aidsorphans.html)).

#### **4.5.2 Impact on healthcare**

The crippling effect of AIDS on Zambia's healthcare system is perhaps the greatest problem the government faces. In some hospitals, more than 50 percent of beds are occupied by patients with AIDS-related illnesses. Not only has the epidemic increased the number of people seeking medical services, but it has also greatly increased costs as most AIDS-related conditions are especially expensive to treat. There is consequently less money available for other conditions.

Zambia's health system, having suffered years of under-investment, has now been brought to the brink of collapse. Almost all health facilities lack adequate personnel, drugs, and/or equipment, and physical infrastructure is deteriorating. Under such conditions, people who give care must struggle to cope with the rise in demand - just as their own number is being depleted by illness and AIDS deaths ([www.zambia-aids-prevention-care.htm](http://www.zambia-aids-prevention-care.htm)).

#### **4.5.3 Impact on education**

In 2001, a nationwide survey found that just two-thirds of primary-school-age children attended primary school, and less than a quarter of those aged 14-18 years attended secondary school. Twelve percent of all respondents said that a child in their own family did not attend school because a parent or guardian was suffering from AIDS or had died from AIDS.

Teachers have been disproportionately affected by the epidemic and are now in short supply; more than two thousand teachers died in 2002, while teaching colleges produced fewer than a thousand new graduates. Rural postings are unpopular, and those who accept them tend to move away when they become ill, so as to be closer to clinics.

Those children and teachers who are able to attend school face further challenges, as AIDS-related illness, stress and malnutrition make learning very difficult.

#### **4.5.4 Impact on the economy and food production**

The AIDS epidemic severely damages every sector of Zambia's economy. In the first place, employers bear the direct costs of absenteeism, medical care, funerals and extra recruitment; according to the Zambia Business Coalition, 82 percent of known causes of employee deaths are HIV-related and 17 percent of staff recruited is to replace people who have died or left because of HIV-related infections. But what is even more significant is that, as AIDS kills people in the prime of life, the workforce is stripped of valuable skills and experience, and there are fewer people left to teach the next generation. The result is that production costs rise, while at the same time consumer spending falls because people affected by AIDS have less money to spare. Zambia has been one of the world's poorest countries since the late 1970s, and AIDS has made a bad situation even worse ([www.addthis.com/bookmark.php](http://www.addthis.com/bookmark.php)).

Agriculture, from which the vast majority of Zambians make their living, is also affected by AIDS. In particular, the loss of a few workers at the crucial periods of planting and harvesting can significantly reduce the size of the harvest. AIDS is

believed to have made a major contribution to the food shortages that hit Zambia in 2002, which were declared a national emergency.

Negative trends in the economy and food production fuel the epidemic that helped to create them. Poor nutrition makes HIV-positive people more vulnerable to infections, and hastens the progression of AIDS; and when people are poorer they are more likely to turn to risky occupations, and are less able to pay for medical care or school fees. As Zambia's Poverty Reduction Strategy Paper acknowledges, "the epidemic is as much likely to affect economic growth as it is affected by it" ([www.arvert.org/aids-zambia.html](http://www.arvert.org/aids-zambia.html)).

#### **4.6 General VCT**

HIV Voluntary Counselling and Testing has emerged as a major strategy for the prevention of the infection in Africa. Apart from raising awareness about HIV/AIDS, many studies show that knowing one's HIV status is instrumental in effecting behaviour change and the adoption of safer sex practices (Mkaya-Mwamburi et al, 2000; Serima and Manyenna, 2000).

Availability of accessible and affordable VCT services is a problem that should be addressed by governments, especially in rural communities. It is also preferable to use rapid HIV antibody tests because distances from the clinic and a lack of transport often make it difficult for people to come back to the clinic for their test results. If VCT services do exist, the community should be well informed about such services. It should be widely advertised and health care professionals and VCT counsellors should be sensitised and trained in pre- and post test counselling.

According to Global Fund to fight HIV, TB and malaria (2005), the provision of voluntary counselling and testing is an important part of any national prevention programme. It is widely recognised that individuals living with HIV who are aware of their status are less likely to transmit HIV infection to others, and that through testing they can be directed to care and support that can help them to stay healthy. VCT provides benefits to those who test negative; their behaviour may change as a result of test. VCT could, and indeed needs to be made more widely available in most Sub-Saharan African countries.

#### **4.7 Stigma and discrimination**

Stigma related to HIV/AIDS appears to be more severe than that associated with other life threatening conditions. It also extends beyond the disease itself to providers and even volunteers involved with the care of people living with HIV.

The extent of HIV/AIDS related stigma has been widely documented. In a comparison of two studies conducted among similar samples, the proportion of the U.S population that harboured HIV/AIDS related stigma increased from 20.5 percent in 1991 to about 28.8 percent in 1997. However, a more recent Centre for Disease control and Prevention (CDC) study found a somewhat lower percentage of people who harbour HIV/AIDS related stigma (18.1 percent) (Annas, 1998).

HIV related stigma remains an enormous barrier to the fight against AIDS. Fear of stigma often prevents people from getting tested, seeking treatment and admitting their HIV status publicly. Since laws and policies alone cannot reverse the stigma that surrounds HIV infection, more and better AIDS education is needed in Africa to combat the ignorance that causes people to discriminate.

The fear and prejudice that lies at the core of HIV/AIDS discrimination needs to be tackled at both community and national level.

#### **4.8 ABC approach and HIV/AIDS**

Abstinence from sexual activity, Being faithful to a single partner, and correct and consistent Condom use are three key behaviours that can prevent or reduce the likelihood of sexual transmission of HIV, the virus that causes AIDS. The balanced promotion of all of these behaviours is commonly known as the “ABC” approach. ‘A’ stands for Abstinence, ‘B’ for being faithful and ‘C’ for correct and consistent condom use, especially for casual sexual activity and other high-risk situations.

An increasing number of countries including Uganda, Thailand, Kenya, Cambodia, Zimbabwe, India, Rwanda, Ethiopia, Dominican Republic and Haiti have experienced national or sub-national declines in HIV associated with the widespread adoption of AB or C prevention behaviours.

HIV prevention efforts are complicated by the fact that the global pandemic is rooted in different causes in different settings. To prevent the sexual transmission of HIV, the U.S Government, through the President’s Emergency Plan for AIDS relief (PEPFAR), supports the ABC approach because it can be used to target the sources of

the most new infections in a given population, while still being tailored to meet the specific needs of the most at risk or vulnerable individuals. Fundamental to this approach is the recognition that different settings will also feature different barriers to the adoption of ABC behaviours.

#### **4.8.1 Abstinence**

Abstinence can be for a long time or for a short time of your life, even if you have been sexually active in the past.

You may choose to abstain if:

- (a) you are unmarried
- (b) you are a couple and you do not know your HIV status
- (c) You are married and you travel or work away from your partner.
- (d) You are a couple and either you or your partner, or both of you have HIV.

The benefits of abstinence are that you avoid the risk of contracting HIV and other Sexually Transmitted Infections (STIs). You enjoy peace of mind. One also is assured of not having unplanned pregnancy. Moreover, one maintains his/her virginity and self respect.

#### **4.8.2 Being faithful**

To be faithful is to have sex with only one partner who is also faithful to you. One can only tell if the partner is HIV free after testing.

When traditional law tolerates polygamy, the partners involved should remain faithful to each other. This means that the husband should have sex only with his wives and his wives should have sex with him only.

The benefits of being faithful are that; it strengthens relationships by building trust, it avoids having children from outside marriage and it also helps plan for future.

There are however challenges of being faithful and these challenges are; being faithful to unfaithful partner. Family as well as community pressure to have children, cultural practices such as sexual cleansing, lack of sexual satisfaction in a relationship, among other things.

#### **4.8.3 Condoms**

Both male and female condoms can be used to practice safe sex. Condoms must be used correctly and consistently if they are to help reduce the spread of HIV and other STIs. If one is HIV positive, it is important to use a condom every time such a one has

sex to avoid infecting partner. If partner is also HIV positive, always use a condom every time you have sex to avoid being reinfected. Being reinfected can make it more difficult for ones body to fight infections. This weakens the body faster.

Condoms are available in: government hospitals and clinics, VCT centres, chemists, most supermarkets and many more places.

The benefits of using a condom are that, one can have sex and still be protected from HIV, prevents re-infection of HIV and it is a safe method for family planning.

If not used correctly and consistently, a condom will not provide the protection expected. Using condoms can also be embarrassing and difficult at first, this gets better with practice.

Condom use plays a key role in preventing HIV infection around the world. In Sub-Saharan Africa, most countries have seen an increase in condom use in recent years. In studies carried out between 2001 and 2005, eight out of eleven countries in Sub-Saharan Africa reported an increase in condom use. In most countries though, more information about condoms is needed. For instance, in Uganda between 120 and 150 million condoms are required annually, but less than 40 million were provided in 2005.

Relative to the enormity of the HIV/AIDS epidemic in Africa, providing condoms is cheap and cost effective. Even when condoms are available, though, there are still a number of social, cultural and practical factors that may prevent people from using them. In the context of stable relationships where pregnancy is desired, or where it may be difficulty for one partner to suddenly suggest condom use, this option may not be practical WHO (2007).

#### **4.9 Number of people living with HIV**

Zambia's reported Aids diagnosis in 1998 was followed by a rapid rise in HIV prevalence. By 1993, surveys of pregnant women had found infection rates of 27 percent in urban areas and 13-14 percent elsewhere. These levels have remained more or less stable ever since.

At the end of 2005, UNAIDS/WHO estimates that 17 percent of people aged 15-49 years old were living with HIV or AIDS. Of the above million adults mentioned

above, 57 percent were women. Young women aged 15-19 are around six times more likely to be infected than are males of the same age.

According to UNAID/WHO, nearly half of Zambia's population is under 15 years old. Estimates indicate that 130,000 of these children were living with HIV/AIDS at the end of 2003.

Unlike in some other countries, HIV in Zambia is not primarily a disease of the most underprivileged; infection rates are very high among wealthier people and the better educated. However, it is the poorest that are least able to protect themselves from HIV or to cope with the impact of AIDS.

Recent trends however indicate that, there is good HIV prevalence reduction among young Zambian women in the 1990s. The most notable finding concerns pregnant women aged 15-19 years surveyed in Lusaka. Among this group, the proportion living with the virus almost halved from 28.4 percent in 1993 to 14.8 percent in 1998. Over the same period, there appeared to have been a general decline in prevalence among young women in urban areas, and to a lesser extent among teenage women in rural areas (Sahu, 2004).

It is further argued that the greatest reductions were found among well educated women, while prevalence among the least educated remained stable or increased. It is thought that the falling prevalence levels indicate a drop in the number of new infections, possibly as a result of behavioural change. This stands to be an encouraging sign that efforts to educate young people about avoiding HIV have had some success.

The first 10 years of the AIDS epidemic, communication strategies designed saw a lot of fear being instilled: giving messages which were very blame-oriented. In the recent past, the discourse has been more compassionate. The communication discourse has to be engaging, involving and enlightening. People living with HIV can live longer life with communication focused more on prevention and care.

Information, education and communication are the main measures to make everybody understand HIV/AIDS and carry out measures to prevent the spread of HIV/AIDS.



The mass media and social organisations have the responsibility to join in the prevention and fight against HIV/AIDS infection.

The HIV and AIDS communication strategy (2005), aims at promoting behaviour and policy measures in support of HIV/AIDS prevention, treatment, care and support. It sets a comprehensive set of communication objectives aimed at improving knowledge, behaviour change communication for safer practices, accessing VCT and treatment, care and support services as well as to reduce stigma and discrimination.