An evaluation of communicating and managing responses of HIV and AIDS among youths at Solwezi Trades Training Institute and Solwezi Youth Alive

By

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DECLARATION

I, LUCKY **MUSONDA**, declare that this report:

(a) Represents my own work;
(b) Has not previously been submitted for a degree at this or any other university ;
(c) Does not incorporate any published work or material from another report.

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APPROVAL

This report of Lucky Musonda is approved as fulfilling the partial requirements for the award of the degree of Master of communication for Development by the University of Zambia.

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ABSTRACT

The study was carried out for the purpose of examining the effect of communicating and managing programmatic responses of HIV and AIDS among youths in a training institute and a nongovernmental organisation. The study focused on areas of management of HIV and AIDS and relevance of communications in order to understand the involvement and participation of youths in HIV and AIDS responses. A questionnaire, focus group discussions, interview schedule and documents analysis were used to collect data. The Sample size of 115 participants was chosen. A sample of 102 students was chosen from the training Institute by a stratified random sampling by sex. The purposeful sample was drawn by selecting 6 students; 4 social workers; 1 HIV and AIDS focal person and 2 Anti Aids Club members. The quantitative data were coded and analyzed using descriptive statistics with an aid of SPSS computer software. The data gathered from the document analysis, interviews and focus group discussions were also transcribed and reported in form of text.

The study found that they had been comprehensive HIV and AIDS campaigns done by many players. About 77.7% student youths indicated interpersonal communication as quite effective in responding to matters of HIV and AIDS. However, 83.0% of student youths felt HIV and AIDS programmes had been irregular. The study found that most HIV and AIDS programmes depended entirely on external funding implying that irregular programmes lacked funding. Managing and communicating HIV and AIDS responses have significant impact but has room for improvement, and many recommendations were derived from this study.

DEDICATION

To my two lovely sons Caleb and Joshua. Mum, Mrs Charity Musonda. My brothers and Sisters Ommy: Howard; Claire; Harton; Boyce; Kabuswe; Loreen; Mwape; Brian and Mukosa. My niece Mwimba.

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List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARRM	AIDS Reduction Risk Management
ARVs	Antiretroviral
HBM	Health Belief Model
VCT	Voluntary counselling and testing
ICTs	Information Communication Technologies
ILO	International Labour Organisation
MDG	Millennium Development Goals
MTCT	Mother to child Transmission
NASF	National Strategic Framework
NYP	National Youth Policy
SPSS	Statistical Programme for Social Sciences
TRA	Theory of Reasoned Action
UNAIDS	United Nations Programmes for HIV and AIDS
UNESCO	United Nations Education, Scientific and Cultural Organisation
UNGASS	United Nation General Assembly
UNICEF	United Nations International Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency on International Development
ZDHS	Zambia Demographic Human Survey

CHAPTER 1

Orientation to the Study

1.1 INTRODUCTION

Human Immune-Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) pandemics have remained complex and incurable and devastated individuals, communities and nations. Each and every continent is trying to overcome the adverse effects of HIV and AIDS. Although in some parts of the world HIV and AIDS had met reasonable success in reducing its prevalence, in others, it remains the biggest challenge.

This chapter gives a general introduction to the study and addresses the main problem related to the effectiveness of communicating and managing programmatic responses to HIV and AIDS. It provides the scope and assumptions for the study.

1.2 Background

This study explores the effectiveness of communicating and managing programmatic responses of HIV and AIDS prevalent among youth in an age group of 15-24 year olds; in a training institution and a non governmental organisation. It examines the role of a training institution and a nongovernmental organisation in communicating and managing programmatic responses of HIV and AIDS among the youth of 15-24 year olds as well as the levels of knowledge; attitudes and practices regarding the HIV pandemic and the effectiveness of forms of communications to fight the pandemic.

The data for the study was collected in Solwezi District, North Western Province of Zambia in July, 2012 to September 2012. The study was conducted with the help of various institutions including Solwezi Youth Alive (Z), Solwezi Trades Training Institute and Solwezi Urban Clinic (Ministry of Health).

The study aims to fill the gaps in knowledge concerning underlying factors crucial in the spread of HIV among youth, which has received little attention in the literature. Despite a growing interest in youth health matters, much remains unknown about the factors that enhance HIV

transmission among them. For example, according to the 2011 Millennium Development Goals (MDG) Progress Report, only 48% of youth (aged 15-24) had comprehensive and accurate knowledge of HIV and AIDS in Zambia (Chiwele & Syampungani, 2012). This is of concern and critical for Zambia's youth, who represent 68% of the population.

Yet again, they are few studies that have focused on how communications and management of programmatic responses of HIV and AIDS among youth are fully utilized. Understanding communications and management of programmatic responses of HIV and AIDS among youth requires exploration of social and pragmatic dynamics related to HIV and AIDS responses in institutions of learning or training and in non-governmental organisations. Knowledge of these aspects can help to develop communication approaches to control the spread of HIV and AIDS among the youth. This dissertation aims to provide insight and knowledge that is essential for everyone involved in policies and programs on sexual and reproductive health for youths in Zambia, and aims to assist in identifying effective approaches. This introductory chapter provides backgrounds to the global and national perspective of HIV and AIDS approaches to communication and trends in youths. The chapter ends with objectives of the research.

1.3 HIV and AIDS in a global perspective and Zambia

According to World Health Organization (WHO), United Nations Programme for HIV and AIDS (UNAIDS) and United Nations Children's Fund (UNICEF) , the global HIV statistics of people infected with HIV around the world by end of 2010 was estimated at 34.2 million which had an increase from the previous 32.9 million in 2009. Young people aged 15–24 years are at the forefront of the epidemic with 5 million [4.3–6.5 million] of them women and men living with HIV as of December 2010 (UNAIDS, 2011:63). However there was a decline in new HIV infections by the end of 2010 estimated globally at 2.7 million 15% fewer than the 3.1 million people newly infected in 2001 and more than one fifth (21%) fewer than the estimated 3.4 million in 1997. (WHO, UNAIDS, UNICEF, 2011:10).

Zambia is the seventh among the countries in sub Saharan Africa experiencing the effects of a mature generalized hyper-endemic. Everyone in Zambia is currently confronted with HIV and AIDS, either by oneself suffering from it, or having lost relatives, neighbours or friends from the

pandemic (UNAIDS, 2002). Zambia's report to the United Nations General Assembly Special Session (UNGASS) in 2012 report estimates that about 1,327,995 people to be living with HIV in Zambia.

Nonetheless, there were indications that the HIV epidemic had been reversed. A slight reduction in the percentage of the adult population infected with HIV from 15.6% in 2001-2002 to 14.3% in 2007. A significant reduction in the percentage of young women 20-24 years infected with HIV from 16.3 in 2001-2002 to 11.8% in 2007. However, there were some worrisome areas which included the increase in the percentage of infected among men 15-49 years in rural areas from 8.9 to 11.0 between 2001 and 2007, while it reduced in the rest of the population groups by sex and residence, and the very low percentage of 28.2 put on antiretroviral therapy among children aged 0-14 years compared to 90.0 per cent among adults 15 years and older.

The National tracking of progress on MDG 6 had shown that Zambia had actually met the MDG target on prevalence of attaining less 15.6 % by 2015 and currently, it stands at 14.3 %; the prevalence is higher for women (16 %) than men (12 %)(Zambia UNGASS Report, 2012).

However, the estimates in HIV and AIDS statistics had variations across regions. Not all regions and countries fitted the overall trends in the global decline of new HIV infections estimated at 2.7 million by end of 2010. In the Middle East and North Africa the annual number of people newly infected with HIV rose from 43 000 in 2001 to 59 000 in 2010. The badly hit region was sub-Sahara Africa with new HIV infections in 2001 estimated at 2.2 million. The trends reversed in that, by the end of 2010, sub Sahara Africa had 1.9 million of new HIV infections. That indicated a decline in the sub Saharan African region which had an overall peak between 1996 and 1998 (WHO, UNAIDS, UNICEF, 2011).

Therefore, HIV and AIDS remains extremely dynamic, growing and changing character as the virus exploits new opportunities for transmission. There is virtually no country in the world that is unaffected. Some countries that have let down their guard have seen a renewed rise in numbers of people infected with HIV and a reverse for those who experienced a high prevalence. Therefore, a global picture is made up of series of the HIV and AIDS epidemics with their own characteristics and dynamics.

1.4 Approaches to Communication and Management of HIV and AIDS

In the past, HIV and AIDS communication was focused on determining the knowledge, attitudes, and practices of individuals deemed at risk for infection. Therefore, approaches based on behaviour change of the HIV pandemic focused on providing correct information about transmission and prevention, relying on the theories that lack of accurate information about HIV transmission and acquisition was a primary catalyst for the spread of infections (Witte, 1998:423). However, such approaches fell short of producing the desired effect, and it became clear that more complex, multilayered strategies had to be developed (Becker-Benton A, Bertrand J, McKee N, 2004).

Thereafter, communication approaches took to understand and explain the role of environmental influences that is, the socio economic status; gender relations; cultural norms; spirituality and government policies. Such approaches are based on the understanding that beyond an individual's social network, they exit larger structural and environmental determinants that affect HIV and AIDS related behaviours. Those approaches to communication reflected a greater appreciation of the complexity of the HIV pandemic that emphasize on social groups and contextual factor than individual behaviour alone (UNAIDS, 1999).

HIV and AIDS communications has been managed in a holistic approach. It goes well beyond prevention. Besides prevention, care, support and treatment, it involves tools for the biological, psychological and social care of people living with HIV, their families and communities (UNAIDS 2008). They are also recognised as "combination prevention". These are methods that have included: communication strategies for behavioural change, political dialogue, condom use strategies, treatment of sexually-transmitted diseases (STIs), voluntary counselling, testing, safe blood supply, reducing mother-to-child transmissions (MTCT), and family planning counselling for HIV positive couples.

Communication and management of HIV and AIDS have been characterised by employing many different channels of communication, multiple stakeholders, with an increased emphasis on evaluation and evidence-based programming. It emphasizes more pervasive usage of mass media and a communication process in which participants create and share together. This shows that communication approaches are to be an integral component of an HIV and AIDS program

design, Krenn & Limaye, (2009). Therefore management of HIV and AIDS programmes have been managed coupled by various communication approaches.

1.5 Trends among youth

1.5.1 *Youth Perspective*

Zambia's total population constitutes 68%-70% of the youth, defining Zambia's population as young and of this about 6.6% are infected with HIV. The impact of HIV on young people is a severe and growing problem which requires serious attention by Government and affected stakeholders.

During the 2001 United Nations General Assembly Special Session (UNGASS) on HIV and AIDS, leaders from around the world drew up a comprehensive set of goals which among those included, 1) Reducing HIV prevalence among young people aged 15–24 by 25 per cent in the most affected countries by 2005, and by 25 per cent globally by 2010; and 2) ensuring that 90 per cent of young people aged 15–24 have the knowledge, education, life skills and services to protect themselves from HIV by 2005, and 95 per cent of them by 2010. Further, they went on to say that by 2005, at least 90 per cent, and by 2010, at least 95 per cent of young men and women aged 15–24 had access to the information, education, including peer education and youth-specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection (UNICEF, 2011). The goals were set due to the fact issues of HIV and AIDS had mostly involved adults and yet youths were found also to have been equally affected.

To ensure that goals were achieved, some indicators were included for HIV among youth to show they too needed to be involved in scaling down the prevalence of HIV and the Millennium Development Goals (MDG) considers that the prevalence among young people aged 15–24 needs attention. If the percentage of young people aged 15–24 had comprehensive correct knowledge of HIV which means that they needed to correctly identify the major ways of preventing the sexual transmission of HIV (using condoms and limiting sex to one faithful, uninfected partner, delaying in involvement of sex), reject the two most common local

misconceptions about HIV transmission and know that a healthy-looking person can have HIV. If the percentage of young people aged 15–24 used a condom at last higher-risk sexual activity which means that an indicator should show that if youths in their age are not married, non-cohabitating partner or sex with multiple sexual partners, the usage of condoms during higher-risk sex is a proxy for safe sexual practices (UNICEF, 2010).

Therefore, young people need accurate and relevant information about HIV transmission and an enabling and protective environment in their communities where they can talk openly about risk behaviours. There is also need to increase youth facilities for preventive interventions, which include voluntary counselling and testing, HIV education in schools, and prevention of sexually-transmitted infections.

The UNAIDS Report (2010) on the global AIDS epidemic indicates that among young people in 15 of the most severely affected countries in sub-Saharan Africa which among them is Zambia, HIV prevalence had fallen by more than 25% as these young people adopted safer sexual practices. Several of these countries with high HIV prevalence have experienced declines in risky behaviours, including the initiation of sex before age 15, sex with multiple partners and sex without condoms. Nevertheless, young people in the age group 15–24 still engage in unsafe behaviours and a significant number continue to be infected.

1.5.2 *Behavioural Change in Youths*

The question still remains, "To what extent does HIV and AIDS education and consciousness lead to behavioural change among the youth?" Because, sexuality, let alone changes in sexual behaviour, is very difficult to measure and information on this topic is seldom reliable. Moreover, emphasising sexual behavioural change suggests that sexual behaviour is static, while it is situational and personal.

Therefore, HIV prevention programmes are to combine information, life skills and behavioural change activities with actions to address the social issues that make adolescents and young people vulnerable to HIV and lead them to engage in risky behaviours. There is strong evidence that school-based sex education can be effective in changing the knowledge, attitudes and practices that lead to risky behaviour. However, there is need to establish whether the youth

really learns from HIV and AIDS education and whether this results in behavioural change (UNICEF, UNAIDS, UNESCO, UNFPA, ILO, WHO, 2011).

The truth remains that youth will still be part of multiplication of the HIV and in order to uproot the problems of HIV, it is very essential to curb its propagation amongst the youth. This is so because it is the youth who are the most active in activities of sexual relationships, drug abuse, prostitution, and reproduction. Therefore, in order to reduce the impact of HIV and AIDS, the young, irrespective of their gender, have to be prevented through the effective change in knowledge, attitudes and practices that lead to risky behaviour. Change of behaviour in youths impacts on society in that youths carry the mantle of adulthood so their responsive practices in sexual activities and will leave a mark that can live on to the coming generations (Campbell and MacPhail 2001).

1.6 Statement of the Problem

Youths (15-24 years) form part of a highly vulnerable group for HIV infection and according to data collected by WHO, UNAIDS and UNICEF (2011:63). However, it had been indicated that most countries are still unable to provide adequate statistical and empirical data specific to programmatic responses of HIV and AIDS prevalence among youths despite improved surveillance systems (Kalibala & Mulenga, 2011: 5). There is therefore need to identify appropriate means of communicating and managing programmatic responses of HIV and AIDS specific to the youth population. Motivation for more research to increase knowledge that address youth challenges in the area of HIV and AIDS is also required. In order to do so effectively, programmatic gaps in design and implementation of HIV and AIDS responses need to be identified and highlighted.

1.7 Rationale

Youths at Solwezi Trades Training Institute and those within the target of Solwezi Youth Alive Zambia or those from other sectors of society had been communicated to with matters of HIV and AIDS through many channels of communication. Youths within the age group of 15-24 years, are particularly vulnerable to HIV infection. Their vulnerability usually comes up due to the higher risks of engaging in risky sexual behaviours when under the influence of alcohol, responding to peer pressure, or lack maturity (Centres for Disease Control and Prevention, 2007).

The 2010 Population Census Report revealed that youths in Zambia constituted more than one quarter of the total population. The Report further revealed that many youths were sexually active and vulnerable to sexual abuse, pregnancy and sexually transmitted infections and multiple sexual partners because of lack of adequate information about sex, reproductive health and relationships (Chituwo et al, 2011:8). These inadequacies influence the likelihood of exposure to HIV and raise infection levels that are targeted to be at zero. However, empirical evidence of these important issues exists to a limited degree. Despite improved surveillance systems in communicating and managing programmatic responses of HIV and AIDS specific to youths (Kalibala & Mulenga, 2011: 5), youths are still not fully covered and recognized. Therefore identifying programmatic responses and design gaps specific to youths and implementing them will probably lead to youths making appropriate and responsible sexuality decisions that will empower them to avoid HIV infection.

1.8 Objectives of the Study

1.8.1 Main Objective

To examine effective approaches of communicating and managing of programmatic responses of HIV and AIDS prevalence among youth of 15-24 years of age in institutions of learning or training and in non-governmental organisations.

1.8.2 Specific Objectives

i. To investigate the role of institutions in regard to management of programmatic responses of HIV and AIDS prevalence among youth both male and female within an age range of 15-24 years old.

ii. To determine youth knowledge levels, attitudes and practices regarding the HIV pandemic within their age group ranging from 15-24 years in institutions.

iii. To investigate the effectiveness of various forms of communications institutions have in place in the fight against the HIV pandemic among youth in the age group ranging from 15-24 years.

1.9 Conclusion

This Chapter introduced the scope of the study. The research problem, the rationale and objective of the study were also highlighted. Chapter 2 discusses the methodology of the study.

CHAPTER 2
RESEARCH METHODOLOGY

2.1 INTRODUCTION

This study was conducted in order to examine the effective means of communicating and managing programmatic responses of HIV and AIDS prevalence among youths in a training institution and in a nongovernmental organisation. To be able to gather the necessary data, the researcher utilized the triangulation approach method, using both qualitative and quantitative approaches. Herein, the respondents were chosen by stratified random sampling and purposive sampling from a training institute and a non-governmental organisation. The survey, interviews, focus groups and existing record methods were the research instruments used for the data-gathering.

The students and employees of a training institute and a nongovernmental organization who had been chosen in this study completed a survey questionnaire, interviews and focus group discussions to examine the effective means of communicating and managing programmatic responses of the prevalence of HIV and AIDS among youths in a training institution and in a non-governmental organisation. The results of the survey were processed by coding, keying data into a database in a Statistical Package for Social Sciences software (SPSS) computer analysis system. For the in-depth interviews and Focus Group Discussion, data analysis involved developing a detailed description of each case. Relevant literatures were also used to support the gathered findings.

The credibility of findings and conclusions extensively depended on the quality of the research design, data collection, data management, and data analysis. This chapter was dedicated to the description of the methods and procedures done in order to obtain the data, how it was interpreted and the conclusion met.

Specifically, the chapter covers the following: Section 2.2, discusses the methodology used in the study and the rationale for its use; Section 2.3 details of participants in the study and the

selection criteria used; Section 2.4 overview of the data collection process; Section 2.5 discusses how the data was analysed; and Section 2.6 discusses the ethical considerations of the research and its potential problems and limitations.

2.2 Methodology

The study involved the triangulation approach. Triangulation is the use of mixed methods (Tashakkori & Teddlie, 2003) design, which is a procedure for collecting, analyzing and integration of both quantitative and qualitative data at some stage of the research process within a single study to understand a research problem more completely (Creswell, 2002). The rationale for mixing is that neither quantitative nor qualitative methods are sufficient by themselves to capture the trends and details of the situation, such as a complex issue of communicating and managing the prevalence of HIV and AIDS among the youths in a training institution and in a non-governmental organisation (aged between 15-24 years) within a context of their environment. Also if both methods are employed, each overcomes the limitations of the other.

Qualitative research was a process of inquiry to understand where the researcher developed an intricate, holistic picture, analyzed words and reported detailed views of informants and conducted the study in a natural manner (Creswell, 1998:15). In this approach, the researcher made knowledge claims based on the participants' perspectives. In a qualitative research, data was collected from those immersed in everyday life of the setting in which the study was framed. Data analysis was based on the values that participants perceived in their world.

2.2.1 Research Questions

i. What measures do training institutions and non-governmental organisations have in place to manage the prevalence of HIV and AIDS among youths?

ii. What communication channels do training institutions and non-governmental organisations have in place for disseminating HIV and AIDS information to youths?

iii. What tools do training institutions and non-governmental organisations utilize to measure knowledge, attitudes and practices about HIV and AIDS from youths.

iv. What form of support do training institutions and nongovernmental organisations have in order to effectively manage the prevalence of HIV and AIDS among youths?

v. What challenges do training institutions and nongovernmental organisations encounter in efforts of managing the prevalence of HIV and AIDS among youths in their institutions?

2.2.2 Methods

This study applied a mixed method designs used in educational research: sequential explanatory mixed methods design, consisting of two distinct phases (Creswell, 2002). The first phase used was quantitative were numeric data was collected first; using survey questionnaires relying on a stratified random sampling of students participants and the data was subjected to a discriminate function analysis. The goal of the quantitative phase was to identify potential predictive power of selected variables on distributed students at the training institute to allow for purposefully selecting informants for the second phase. In the second phase, a qualitative multiple case study approach was used to collect text data through selected individual in-depth interviews; Focus Group Discussion on selected participants and a review of the HIV and AIDS policy/program documents at the institute and at a nongovernmental organisation.

The qualitative approach helped explain why certain external and internal factors, tested in the first phase, were significant in examining appropriate means of communicating and managing programmatic responses of HIV and AIDS prevalence among youths on study sites. The rationale for this approach was that the quantitative data and results, provided a general picture of the research problem, that is, which communication measures are perceived as effective by students and management at the training institute and representatives of the nongovernmental organisation in regard to mitigating HIV prevalence among the youths; while the qualitative data and its analysis refined and explained those statistical results by exploring participants' views in more depth.

The priority in this design was given to the qualitative method, because the qualitative research represented the major aspect of data collection and analysis in the study, focusing on in-depth explanations of quantitative results. A smaller quantitative component went first in the sequence

and was used to reveal what were appropriate measures in communicating and managing the prevalence of HIV in training institutions and nongovernmental organisations with regard to the youth population within the study focus. The quantitative and qualitative methods were integrated at the beginning of the qualitative phase for developing the interview questions based on the results of the statistical tests. The results of the two phases were integrated during the discussion of the outcomes of the whole study.

2.3 Sampling

The researcher chose a sample from a population of five hundred and two (502). The Sample size of 115 participants was chosen being a quarter ($^1/_4$) of the population. It is argued that a major concept in sampling is representatives, (Bless & Higson-Smith, 2000:83) which involves selecting a group of people, events, behaviours and other elements with which to conduct a study. Therefore, a selected sample was chosen as it was not possible to include everybody from the population but only representatives.

The researcher targeted 102 students; 4 social workers; 1 HIV and AIDS focal person; 2 anti Aids Club members and 6 students as informants. A sample of 102 students was chosen by a stratified random sampling by sex. At first, the whole total sample of students was stratified, that is, dividing it into females and males (gender was a variable used). Secondly, a random sample was taken from each group, that is, a random sample of the required sample size from female and male students (Johnson & Christensen, 2007). Each Student in the selected sample was given a number which corresponded with the questionnaire numbering.

For the purpose of the second qualitative phase study, the purposeful sample was drawn implying intentionally selecting 6 students from the first phase, 4 social workers, 1 HIV and AIDS focal person and 2 Anti Aids Club members. This was to learn to understand the central phenomenon (McMillan& Schumacher,1994), of the effective means of communicating and managing programmatic responses of HIV and AIDS among youths in a training institution and a nongovernmental organization with regard to its prevalence. The idea was to purposefully select informants, who were best to answer the research questions and who had rich information (Patton, 1990, p. 169).

2.4 Data Gathering

A cross-sectional survey design, implying the data was to be collected at one point in time (McMillan, 2000), was used. The primary technique for collecting the quantitative data was self administered questionnaire, containing items of different formats: multiple choices, asking either for one option or all that applied. The survey questionnaire was physically delivered to each of the 102 participants selected for the study at Solwezi Trades Training Institute. An informed consent form was attached to the questionnaire were Participants checked in a box saying "I agree to complete this survey", thus expressing their compliance to participate in the study and complete the survey.

The survey instrument was pilot tested on the 5.0% randomly selected participants among the students at the institute. The goal of the pilot study was to validate the instrument and to test its reliability. All names from the eligible participants, identified in the database were entered into the Microsoft Excel computer analysis program. A random proportionate by group sample of 15 participants were selected. These participants were excluded from the subsequent major study. The results of the pilot survey helped establishing stability and internal consistency reliability, face and content validity of the questionnaire. Based on the pilot test results the survey items were revised. A week before the survey was available to the participants; Participants received a notification from the Institute Management about the importance of their input for the study. This helped escape a low response rate, which is typical for self administered questionnaires. The participants were given a time frame to complete their questionnaires and a maximum of three weeks was given with subsequent follow ups of one week each within the time frame.

The second, qualitative phase in the study focused on explaining the results of the statistical tests, obtained in the first, quantitative phase. The primary technique was conducting two Focus Group Discussions with 8 Participants (students of Solwezi Trades Training Institute); four in-depth interviews with representatives; 3 from a nongovernmental organisation (Solwezi youth Alive Zambia); 1 HIV and AIDS focal person from Solwezi Trades Training Institute Management Board and 1 from Solwezi Urban Clinic(Ministry of Health). The Interview Protocol included seven-eight open-ended questions, and was pilot tested. The content of the protocol questions were grounded in the results of the statistical tests and elaborated on them.

Debriefing with the participants was conducted to obtain information on the clarity of the interview questions and their relevance to the study objective. The participants received the interview questions prior to the scheduled calling time, and were informed that the interview was to be tape-recorded and transcribed verbatim. Respondents had an opportunity to review and correct the contents of the interview after it has been transcribed.

Literature was reviewed to understand the research problem. It was primarily to assist in resolving the research problem. Literature review was intended to help the researcher to position her study in addition to existing ones (Bless & Higson-Smith, 2000). In this regard, the researcher conducted literature review on policy and program documents being used in the training institutions and nongovernmental organisations in effective communicating and managing the prevalence of HIV and AIDS among youths.

2.5 Data Analysis

The data analysis consisted of examining the surveys for correctness and completeness, coding, keying data into a database in an Statistical Package for Social Sciences software (SPSS) computer analysis system, and performing an analysis of descriptive responses (in all categories of sections) according to frequency distributions and descriptive statistics. All incomplete surveys were discarded from the analysis.

For the in-depth interviews and Focus Group Discussion, Data analysis involved developing a detailed description of each case. During the analysis the researcher situated the case within its context so the case description and themes related to the specific activities and situations involved in the case (Creswell, 2002). The analysis was rich in the context or setting in which the case presented itself. Based on the analysis, the researcher provided a detailed narration of the case, using an elaborate perspective about some incidents, chronology and major events followed by an up-close description.

2.6 Ethical Considerations

Conducting research requires not only expertise but also honesty and integrity. Therefore to render study ethics, the rights to self-determination anonymity, confidentiality and informed consent were observed.

Written permission was obtained from the Management of Youth Alive Zambia, and Solwezi Trades Training institute (Appendix II). Consent was obtained from participants and anonymity, self determination and confidentiality were ensured during the administration of the questionnaires and report writing. This was done with the hope that this would promote trust between the researcher and the participants.

2.6.1 Limitations to the Study

The data collected from the 115 participants was adequate enough to carry on with this study. However, the study had limitations in that;

1. The study could not be generalized nationally due to the fact all participants were based in Solwezi. Hence, their perceptions were based on what they thought happened in Solwezi.

2. On the fact that the participants could have been biased in the answers they gave. They could have been biased in that they were trying to make Solwezi Youth Alive and Solwezi Trades Training Institute look good, rather than reporting on what the situation was really like.

2.7 Conclusion

This chapter discussed research methods, sampling and data collection and analysis processes. It also discussed ethical considerations and limitations to the study. Chapter 3 discusses concepts and theories to the study.

CHAPTER 3

CONCEPTUAL AND THEORETICAL FRAMEWORK

3.1 INTRODUCTION

This chapter focuses on the conceptual and theoretical framework that had a bearing on the problem researched. The following concepts were utilized:-

3.2 Conceptual Terms

Communication tools: These were channels of communication that were utilized at the training institute and in a nongovernmental organization. The channels used in communicating matters of HIV and AIDS to youths. These were drama, training workshops, interpersonal communication (face to face), and counselling, motivational talks, electronic media (Television and Radio).

Management These were plans and programs the training institution and the nongovernmental organisation had in place that enabled them follow through their activities in implementing HIV and AIDS programs/projects. These were policy and plan documents that governed their works in implementing HIV and AIDS programs/projects.

Non-governmental organisation this meant a non-profit organization which performed a variety of services and humanitarian functions. It had its source of funds from international fund agencies. It is a chapter of another in the district of Lusaka province. Its functions were organized around building the capacity of youths in the advert of HIV and AIDS in North Western part of Zambia. Almost all its programs and projects concerned the management of HIV and AIDS among the youth.

Preventive measures these were various tools and programs in place or distributed to help prevent the spread of HIV and AIDS among youth at the training institution and in a nongovernmental organization. These tools included; condoms, behaviour change programs and male circumcision.

Programmatic Responses these were various programmes responding to issues of HIV and AIDS among youths in a training/learning institutions and non-governmental organisation. For

example, the training institution had Anti Aids club as a programme responding to issues of HIV and AIDS among youth at the institute. The nongovernmental organisation had Behaviour Change communication programme to respond to issues of HIV and AIDS among youth in the community.

Training Institution this referred to a public community or technical college or a private vocational school licensed by educational coordinating board or the higher education coordinating board under the Ministry of Science Technology and Vocational Training. It trains youths in various skills of workmanship.

Youth this was understood as a looser concept, encompassing the age group 15 to 24 of individuals. Individuals aged 15 to 18 are thus included in the legal definition of children. In traditional African societies youth includes younger ages such as 12, and older ages up to 35. Attaining adulthood can mean the ability to support a household, or for males, the capacity to fight. Adolescence issues are not recognized in most cultures, some United Nations bodies, such as the United Nations Population Fund (UNFPA) defines youth as 10- to 19-years-old (National Youth Conditional Assembly, 2005).

3.3 THEORETICAL PERSPECTIVE

3.3.1 The health belief theory

The health belief model (HBM) was developed in the 1950s to predict individual response to screening and other preventive health services and their use. The HBM grew out of research by social scientists in the U.S. public health services to explain the reluctance of people to participate in disease reduction program. The HBM is based on value expectancy theory (Melkote & Steeves, 2001), which assumes that individuals will take preventive actions (risk-reduction behaviours) when they are susceptible to a disease (self-perception of risk) and acknowledge the consequences as severe; they believe that taking preventive actions will be beneficial in reducing the threat of contracting the disease.

Rosenstock (1974) discusses four constructs of Health Belief Model including: (1) Perceived Susceptibility, (2) Perceived Severity, (3) Perceived Barriers and (4) Perceived Benefits. More recently, the model has been expanded to include cues to action, modifying factors and self

efficacy. Majority of health communication campaigns are based on this model and it is equally useful in HIV and AIDS prevention programs.

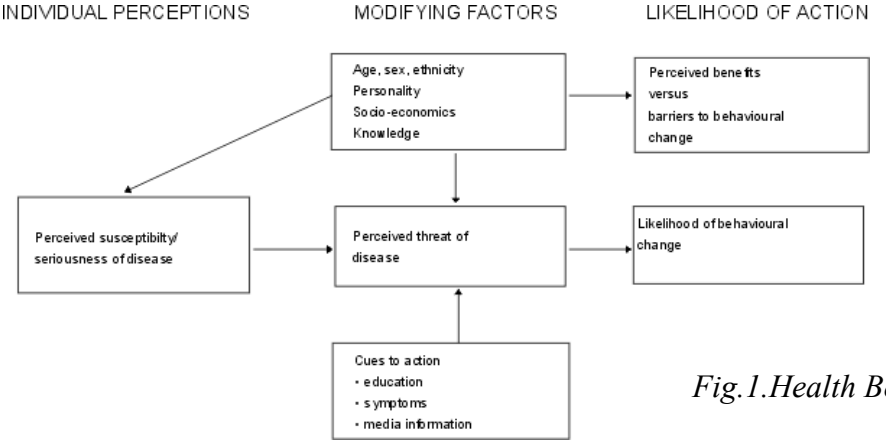


Fig.1.Health Belief Model

Perceived Susceptibility

Personal risk is one of the powerful perceptions in prompting people to adopt healthier behaviours. The greater the perceived risk, the greater is the likelihood of engaging in behaviours to decrease the risk perceived. It is logical that when people believe they are at risk for a disease, they are more likely to do something to prevent it from happening. This is in the case of introducing the uses of condoms to prevent HIV and AIDS to those engaging in sexual practices with people they do not know their HIV status. Unfortunately, this has not being the case always. When people believe they are not at risk or have a low risk of susceptibility, unhealthy behaviours tend to result. These are cases that have being occurring that even people who tested negative to the HIV virus, later on got infected.

Therefore, a perception of increased susceptibility or risk is linked to healthier behaviours and decreased susceptibility to unhealthy behaviours. Though this has not been the case in that, they can be a lot campaign massages on the severity of the disease, but they still be people contracting the disease even after listening to the messages.

Perceived Severity

When the perception of susceptibility is combined with seriousness, it results in perceived threat. If the perception of threat is to a serious disease which there is real risk, behaviour often changes.

This construct speaks to individual's belief about the seriousness of a disease. The perception of severity is based on information or knowledge on the disease or come from beliefs a person has about the difficulties a disease would create on their general life. Communication in matters of health plays a vital role in dissemination information on the serious conditions attach to a disease.

Perceived benefits

This is a person's opinion of the values of usefulness of a new behaviour in decreasing the risk of developing a disease. People adopt healthier behaviours when they believe the new behaviour will decrease their chances of developing a disease. An example is about one major driver of HIV which is having more than one sexual partner. This has been proven that they are benefits when one sticks to one sexual partner. They will not contract an HIV virus through sexual contacts with other partners if they maintain one. They change behaviour as soon as they prove from others about the benefits accrue from practicing the new one.

Perceived benefits play a major role in adoption of secondary prevention behaviours such as screenings. This is in cases of colon cancer screening, voluntary counselling and Testing (HIV virus) and female breast examination. When there is a detection of any disease in screening, treatment is management and less costly. If many people adopt behaviours of perceived benefits, chances of disease reduction are a lot. However, few people adopt behaviours of perceived benefits, in that with many campaigns to have an HIV test, they still many they have not taken a test because statistics of people gone for HIV testing are low as compared to a particular nation's population. HIV testing is viewed as only for those who feel they got involved in a risky sexual practice.

Perceived Barriers

Though the benefits perceived in adopting certain behaviours are good, change of behaviour is not something that comes easily to most people. This is an individual's own evaluation of the obstacles in the way of him or her adopting a new behaviour. This is a construct that is vital in determining change of behaviour.

A person needs to believe that the benefits of the new behaviour outweigh the consequences of continuing the old behaviour in order for a new behaviour to be adopted. When this is done, it enables barriers to be overcome and new behaviour is adopted. Even when the benefits are outlined, not all people adopt a new behaviour. For example the cases of Voluntary Testing and Counselling for HIV, there are still people who have not been tested for HIV in a targeted population. Perceived barriers include difficulty with starting a new behaviour or developing a new habit for fear of not able to cope with new habits.

Modifying Variables

The four main constructs of perception are modified by a number of variables. This depends on the environment in which the occurrence of the diseases is from. These variables include mentioning just a few such as culture, education level, past experiences, skill, and motivation. The modifying variables affect an individual's perceptions and thus indirectly influence health-related behaviour. Therefore in behaviour change campaigns, modifying variables are critical in that they help in tailoring messages that are for audiences experiencing those factors in involved in behaviour change.

Cues to Action

Behaviour is also influenced by cues to action. Cues to action are events, people or things that move people to change their behaviour. Examples can include an illness by one family member, media report, mass media campaigns (Graham, 2002), advice from others and a health warning labels on a product.

If one knows a fellow that is living with HIV or any other serious illness, this is an important cue to action for anyone to go for Voluntary Testing and Counselling for the HIV virus or any other steps. Cues to action motivate people to take action out of things they encounter from different sources.

The HBM Model is a rational-cognitive model that assumes a rational decision maker. The model has been used to explore a variety of health behaviours in diverse populations. For example the uses of seat belts in motor vehicles and sexual risk behaviours in HIV and AIDS

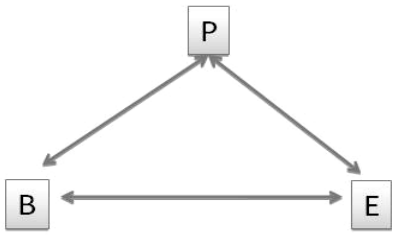
have applied the HBM model in dissemination information to the target audiences. The theory was applied to the research in helping respondents identifying perceived severity of risk behaviours.

However, in most health behaviours, for example in HIV and AIDS, some people do not seem to approach such issues from a logical perspective. They have a capability of discounting risks and optimistically perceiving themselves as invulnerable to harm. Therefore, the theory of reasoned Action predicts individual behaviour by another perspective.

3.3.2 Social Cognitive Theory

This theory is based on the assumption that individual behaviour is the result of interaction among cognition, behaviour, environment and psychology. Bandura (1991) pointed out that in order to achieve "self-directed change, people need to be given not only reason to alter risky habit but also behavioural means, resources and social supports to do so. It will require certain skills in self-motivation and self-guidance. (Bandura 1991).

According to Bandura, behaviour can also influence both the environment and the person. Each of the three variables: environment, person, behaviour influence each other. (p, be, e)



Bandura's theory is based on following three elements:

a. Self-efficacy

b. Social modelling

c. Self regulation

Self-efficacy refers to a person's belief in his/ her personal ability to affect a change, which determines what course of action that person will choose, how long it will be sustained in the face of resistance, and his/her resiliency to bounce back following the setbacks. *Self regulation* is when the individual has his own ideas about what is appropriate or inappropriate behaviour and chooses actions accordingly. There are several aspects of self regulation. *Social Modelling* is based on the principle that people learn vicariously by observing the actions of others. Moreover, people are likely to judge their own capabilities, in part, by comparing themselves with those who are in the similar situation as them. People look up to the models similar to them solving problems successfully which help them develop a stronger belief in their own abilities.

The virtue of self-efficiency may be effective only if the actors are confident of their ability to act. Social modelling has been used extensively in television campaigns in order to provide knowledge about HIV and AIDS, as well as strategies to cope with successful situations in sexual encounters. In short, the dual variables; self-efficiency and modelling have been used widely in campaigns on HIV and AIDS because of their holistic approach that provides knowledge, skill, and confidence to undertake preventive measures against HIV and AIDS (Melkote & Steeves, 2001, p. 133). However, the Social Learning theory is also an individual psychological model of behaviour change advocating the need to focus on collective efficacy.

The theory was applied to this research in that it identified the factor of social modelling in the matters of fighting HIV and AIDS among youth.

3.3.3 AIDS Risk Reduction and Management

The AIDS risk reduction and management (ARRM) model was provided in 1990. The model combines elements from health belief model and social cognitive theory to describe the process through which individuals change their behaviour and explains why individuals fail to change their behaviour regarding HIV and AIDS prevention. The ARRM identifies three stages in behaviour change and management (Catania, Kegeles & Coates, 1990).

Stage one

This *is* labelling high-risk behaviour as problematic, which incorporates the notion of susceptibility from health belief model. This involves knowing which sexual activities are associated with HIV transmission, believing that one is personally susceptible to contracting HIV, and believing that AIDS is undesirable.

Stage two

This is making a commitment to changing high-risk behaviour. This notion came from cognitive learning theory.

Stage three

This is seeking and enacting solutions that take steps to actually adopt the new behaviour than adhering to the previous one. This enactment is influenced by social norm and problem solving options, and may include seeking help (Melkote & Steeves, 2001. p. 134).

These stages provide useful diagnostic tool to determine at which stage a target group is situated, and, therefore, the most appropriate intervention. The model is extensively used in health communication campaigns. For instance, sex workers as a group are highly aware of the risk of unprotected sex as compared to group students in a training institute who do not recognize the risk. Therefore, this model identifies target audience that needs information as well as points out that behaviour change may not be achieved in a one-shot campaign.

However, it has limitations in that it is on individual focus which in cases those individual are said to be at high risk of contracting a disease. The risk felt in other individual is not due to their own fault but as a result of a partner. Therefore, the model needs greater consideration of the socio-cultural issues that influence or may limit an individual's behaviour choices and ability to take action.

3.3.4 Entertainment –Education for Behaviour Change

Edutainment is the use of drama and entertainment for educational purposes. Most often it is done by integrating instructive or best practices into a fictional narrative, often a radio drama or a

television series, and thereby communicating to the audiences how they can tackle specific issues, often health issues, in their everyday life. A large part of the entertainment value of the drama lies in the moral dilemmas and drama that are spun around the problems that are articulated by the health problem the characters may portray. In many countries, these radio drama and television series have obtained very high ratings, as they expose problems and messages that are to be communicated to the targeted audience (Tufte, 2002).

In spreading an HIV and AIDS message one must sell the message as selling of a product as to convince the audience to like it (Singh, 2006, para. 17). Messages about HIV and AIDS awareness have informative, educative and entertaining appeal. Entertainment-Education (equivalent to edutainment) plays an important part in communication for behaviour change in HIV and AIDs programs. The education of HIV and AIDS has to be done in a holistic manner without isolating or compromising educative or entertaining aspect.

In the 1970s the mass communication theory the *Minimal Effects Hypothesis lost* its appeal in that this theory believed that the mass media were not particularly changing opinions and attitudes of audience. However, the research in the area of *agenda -setting* showed that the mass media were very effective in increasing the cognition levels of audiences (Baran & Davis, 2003, pp. 311-314).

This however proved the usefulness of education and entertainment in that, between 1965-1995, the number of radio and television sets in developing countries by grew more than tenfold from 82 million to 997 million (Baran & Davis, 2003, pp. 261-263). This development increased the importance of entertainment-education through mass media in development perspective.

Unlike other communication theories, the Edutainment concept operates strategically within three interlinked units of change: the individual, the community and the broader society. As such, it reflects a holistic, multilevel and culture sensitive communication strategy which lies in line with the principles that is, it is not just as the overall recipe for communication strategies or in HIV and AIDS prevention but generally seen within communication for development. The Soul City Edutainment Model is among edutainment models adopted for edutainment, developed by 'Soul City – Institute' of Health and Development Communication (Tufte, 2002).

This theory was applicable to this research in that edutainment was a major tool identified for educating youths in matter of HIV and AIDS.

3.3.5 Social Marketing

Social Marketing is an organized approach in promoting the acceptability of a social idea. It was introduced in 1971 and involves a consideration of product, planning, pricing, communication, distribution, and marketing research (Melkote & Steeves, 2001, p. 137).

Baran & Davis (2003) highlights some features of the social marketing theory including;

(1) audience awareness regarding campaign topics, (2) Targeting messages at specific audience, (3) reinforcing messages, (4) cultivating images and impressions of people, product or services, (5) stimulating interests, (6) inducing desired decision making or positioning, (7) activating audience segments (pp. 303-305).

Social marketing is therefore an approach to promoting the acceptability of social ideas through mass media. Social marketing seeks to influence social behaviours not to benefit the marketer, but to benefit the target audience and the general society. It has been used extensively in international health programs, especially for contraceptives, HIV and AIDS prevention in condom promotion and oral rehydration therapy. It's well known for its four 'Ps' (product, place, pricing and promotion (USAID, 1999). For example, this has been achieved through commercial advertising and packaging of condoms, appropriate price and convenient locations (tuck shops, bars & hotels) resulting in dramatic increase in condoms sales in countries such as Zambia in particular. In Zambia, a package containing three condoms cost less than a US$.

Social Marketing has however being thought to target individual behaviour only which means reducing public health issues to individual problems (Guttman,1997). It is also said to be in product social marketing and little effort has gone into behaviour social marketing that is, using social marketing to change and maintain behaviour change.

The theory was well utilized and helped the researcher understand the distribution of condoms and male circumcision facilities at subsidised costs.

3.3.6 Diffusion of Innovations theory

Ryan and Gross proposed this theory in 1943, which traces the process by which a new idea or practice is communicated through certain channels over time among members of a social system. This theory explains the factors that influence people's thoughts, actions and the process of adopting a new technology or idea (Piotrow et al., 1997, p. 22). Rogers (1962) proposed a detailed model of diffusion of innovation and argues that it occurs in four stages: invention, diffusion (or communication) through the social system, time and consequences.

Information flows through networks. The nature of networks and the roles opinion leaders play in them determine the likelihood that the innovation will be adopted. Innovation diffusion research has attempted to explain the variables that influence how and why users adopt a new information medium, such as the internet. Opinion leaders exert influence on audience behaviour via their personal contact, but additional intermediaries called change agents and gatekeepers are also included in the process of diffusion. Five adopter categories are: (1) innovators, (2) early adopters, (3) early majority, (4) late majority, and (5) laggards.

This theory is also significant in health communication especially in HIV and AIDS prevention because it highlights the process of adoption of new ideas despite inconvenience, for instance, the use of condom for prevention of sexually transmitted diseases. The theory was utilized in the research when it came to the matter of Voluntary Testing and Counselling (VCT) for HIV. The program of VCT came as a new idea which was slowly being adopted through a social network with the influence of opinion leaders in the community. The continuation of VCT program was gaining increasing acceptance in the community.

The use of opinion leaders in helping to shape culturally appropriate strategies is a component of diffusion of innovation that offers possibilities in HIV and AIDS communications. However, it is said to be too linear and this is so because it has pro-innovation bias and widening the gap

between the 'information haves' and the' have not's. The gap between the innovators and the Laggards is said to be so wide in the social system.

3.3.7 Competence theory

The model was authored by Spitzberg & Cupach (1984). The model is often used to describe competence in the component model for a communicator. The Communication competence explains the ability to choose a communication behaviour that is both appropriate and effective for a given situation. Interpersonal competency allows one to achieve their communication goals without causing the other party to lose face.

The model includes three components (Spitzberg & Cupach, 1984);

Knowledge

Knowledge simply means knowing what behaviour is best suited for a given situation that is, recognizing what communication practice would be appropriate.

Skill

Skill is having the ability to apply behaviour in the given context or have the ability to perform a practice.

Motivation

Motivation is having the desire to communicate in a competent manner or to want to communicate in an effective and appropriate manner.

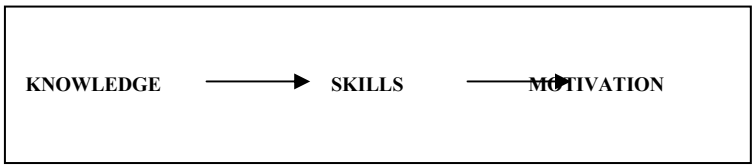


Fig. 3. *Component Model Three Parts of Interpersonal Communication Competence*
Source: Spitzberg & Cupach (1984)

The competence theory was applicable to this research in that, facilitators trained for behaviour Change programs for youths in issues of HIV and AIDS were made to utilized critical communication components in order for them to be competent communicators. They were to

recognize which necessary skills for training youths, to have those skills, and be properly motivated to use those skills.

However, the limitation of the model has been its focus on the three dimensions that the locus of competence is the individual communicating. Further, the notion of appropriateness and effectiveness place the locus of competence in the observer and not the communicator. The component model of competence has also been said not to be a theory about communication, but rather a model that sets the framework for what makes someone a competent communicator. Therefore, the component model has been used as the basis for many other models of competence because of its breadth. It can be easily applied to the criteria of effectiveness and appropriateness that make up a competent communicator where it has its strength (Tovstiadi, 2002, p.9).

3.3.8 Agenda Setting Theory

Agenda setting theory is a theory by McCombs and Shaw (1972) which says that the media (mainly the news media) aren't always successful at telling people what to think, but they are quite successful at telling them what to think about. It is a theory of strong media effects which suggests that with the passage of time the media agenda becomes the public agenda. The media highlights certain issues while neglecting the others thereby making the public think that those issues are more important than the others.

This theory is said to be good at explaining why people with similar media exposure place importance on the same issues. Although other people may feel differently about the issue at hand, most people feel the same issues are important. The theory also has some criticisms in that the media is said not to reflect reality in most of the issues brought to the public domain and through its editing function, it takes out what it thinks should not be brought to the public rather choose what the public should know (Jones& Baumgartner, 2005) .

However, the media steers people to understand the importance of the news issues in different ways. The media has being influential in informing people in matters of HIV and AIDS. It is through the media that people have learnt so many developments about the HIV and AIDS pandemic. Over 200 studies conducted in various parts of the world in over 25 years, show that

the media can have the power to increase level of importance assigned to HIV and AIDS related issues. Therefore, in applying the Agenda setting theory that makes a media agenda a public agenda, it is possible to feature HIV and AIDS related issues more prominently the issue worthy of discourse (Dearing and Rodgers, 1996).

The research made use of this theory in that, there was a local radio and Television station in the area that could learn to adopt the Agenda setting theory by featuring the HIV and AIDS related issues more prominently to make the issue a focus to the public. Therefore, Agenda Setting Theory is a theory of the press that can provide important implications for campaign messages and news coverage of the HIV and AIDs pandemic.

3.4 Conclusion

This Chapter discussed concepts used in this study. It's also briefly discussed the Health Belief theory; Social Cognitive theory; AIDS Reduction Risk Management; Entertainment-Education for behaviour change; Social Marketing; Diffusion of Innovation theory and Agenda Setting theory. Chapter 4 discusses the literature review for the study.

CHAPTER 4

LITERATURE REVIEW

4.1 INTRODUCTION

This chapter focuses on presenting the relevant literature which is appropriate for what is already known about and to examine existing research on HIV and AIDS among the youth. This is in order to acquire insight into the topic under investigation in this study. This chapter discusses the literature reviewed on the topic related to effective communicating and managing prevalence of HIV and AIDS issues and knowledge levels among the youth. It will also explore studies on the effectiveness of various forms of communications within the context of HIV and AIDS. The literature consulted was from local and international journals and books.

4.2 Management of HIV and AIDS

In the Zambian context there seems need for research on the effective management of the prevalence of HIV and AIDS among youth. When it is considered that 68%-70% (8.84million) make up a population of the young in Zambia, one recognizes that HIV and AIDS represent a devastating pandemic on the youth in Zambia (Oppenheimer, et al, 2011). Though Zambia's youth have seen a number of important successes in HIV and AIDS response (a significant 25% decline in HIV incidence between 2001-2009), the epidemic continue to have a huge effect on the country's youth that which leaves much more to be done to achieve an HIV-free generation (UNAIDS, 2011). Therefore in order to refuse further transmission of the HIV virus, information pertaining to the effective management of the HIV and AIDS prevalence among youth in Zambia (aged 15-24 years) may provide an important basis for preventative, as well as educational preventions.

A study by Wyk & Pieterse, (2006: 5) revealed that management of HIV and AIDS in training institutions may have a positive impact when a multipronged approach is utilized. Thus the Zambian government's response to the pandemic proved to be effective through the implementation of the National Youth Policy (NYP) of 2006 that provided key services necessary for HIV programming among the youth: STI care; training peer educators; providing

antiretroviral (ARVs); promoting young people friendly services; promoting life skills education; HIV information campaigns using print and electronic media and drama and sports; and providing HIV Testing and counselling (Kalibala & Mulenga, 2011:7).

A report by World Health Organisation (WHO), 2009, reviewed an approach to management of HIV and AIDS programmes. It suggested that the targeted interventions are to be aimed at offering services to specific populations within the general population. The best-designed HIV and AIDS programmes are to improve sexual and reproductive health and well-being among intended populations, and address general health concerns by reducing the harm associated with male and female sexual practices. Successful targeted interventions were not to stigmatize populations at risk that is, they were to respect their rights and endeavour to protect them. The researcher believed that the study will emphasize the issues of identifying specific programmes specific to youths in the study.

The researcher believed that the aims of the study will serve to increase levels of knowledge and at the same developing useful skills of the targeted audience. In this regard, the main objective was then to effectively be to encourage and promote a multipronged approach to management of HIV and AIDS amongst youths in the training institutions and those not. Through a multipronged approach of managing HIV and AIDS among youths, Zambia will significantly contribute to achieving the UNAIDS' vision of zero new infections, zero discrimination and zero AIDS-related deaths (UNAIDS, 2011). The researcher believed that the sure way to controlling HIV among youth is through an effective management of all interventions of HIV programmatic response that work (UNAIDS, 2000).

In a multi pronged approach of management of HIV and AIDS among youth, broad programmes are created within the area of prevention. In Zambia, a National AIDS Strategic Framework (NASF) in 2010 was created (NASF, 2010). The framework was a further consolidation of Zambia's National Youth Policy of 2006. In the framework, several issues were tackled concerning a comprehensive management of HIV and AIDS involving the whole population of Zambia. Within the NASF, programmes were created that could respond to HIV among the youth. In the framework, management of HIV and AIDs among youth involved;

(a) Learning Institutions providing life skills-based HIV education.

It was generally agreed that leaning institutions remain the best channel to reach the vast majority of youths with HIV and sexuality education since the traditional approach of teaching about sex through grandparents was not applicable to many families. Therefore, some NGOs work with the education sector to support life skills education in the classroom as well as through anti-AIDS clubs.

(b) Youth peer education, a widely used approach

Peer education has been used to reach young people in various locations including schools, health centers, communities, and other locations where the youth congregate. This has been a best approach as through their peers, youths get an influence to change behaviour either in a positive or negative way.

(c) Multi-media are a major approach used in Zambia to reach young people

Multi-media include TV and radio broadcasting, interactive radio, information and communications technology (ICT) as well as mobile phones.

(d) *Edu-sports and theatre provided by NGOs and CBOs are targeting young people and the General public*

Sports, has the advantage of enabling the youth to be involved in delivering the activity while simultaneously receiving information. The other advantage is that in communities where there are very little entertainment for young people, sports and dramas find a ready void to fill. However, the number of young people being reached by these services has largely not been documented and the evaluation of their impact was still limited.

(e) Abstinence-only campaigns are being conducted mainly by FBOs

The campaigns target all youths, either to restore their virginity for a secondary one if they have had sex before or not to have sex to those that have not till at the time they are older and ready.

(f) *Youth friendly health services are the mainstay of the health sector response to HIV among young people*

The NASF (2011–15 calls for the establishment of youth friendly services in all health facilities in the country offering all health services that would help youths have knowledge and indulge in health behaviours.

However, Kalibala & Mulenga (2011: 5) further reviewed that the programmatic responses to HIV among youth had been met with gaps and quite critical to those, was the major and overarching gap was the lack of systematic monitoring and evaluation of the programmes. The researcher reflected on this that it was vital in this study to consider issues of effective monitoring and evaluating HIV and AIDS programmes for the purpose of overcoming gaps or challenges.

Management of HIV and AIDS among the youth could be approached with extensive involvement of various behaviour change interventions. In the study done by Green, et al, (2006:335) it showed that there was a relationship between the various behaviour change interventions that were implemented in Uganda. Though the ensuing decline in HIV prevalence were complex and not completely understood, changes in age of sexual debut, casual and commercial sex trends, partner reduction and condom use all appeared to have played key roles in the continuing declines. It was also believed that HIV knowledge, risk perception and risk avoidance/risk reduction options ultimately led to reduced HIV incidence. However, the course of the epidemic in Uganda was said to have had a complex set of epidemiological, socio-cultural, political and other elements that likely affected it. The researcher looked at the relationship aspect in the study and applied it to the study on how youths intensified various interventions in behavioural change communication in reducing HIV incidences among them.

Initiatives to commit leaders in the fight against the HIV pandemic had in most times been called for. A report by World Bank, UNFPA & UNICEF (2007:42) on the Africa Regional Consultation with Youth on HIV and AIDS and Sexual Reproductive Health highlighted the need for increasing political and social attention on the African continent to address issues of the

HIV pandemic. Over 135 participants from 20 countries from Botswana, Burkina Faso, Cameroon, Ethiopia, Ghana, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Nigeria, Rwanda, Sierra Leone, South Africa, Swaziland, Uganda, Zambia, and Zimbabwe. These countries sent in representatives from government, youth, youth serving organizations and development partners working on youth HIV and AIDS and Sexual Reproductive Health matters to attend. Consultation sessions varied between plenary and group work and this allowed participants to actively engage and discuss relevant strategies and interventions on the basis of the technical knowledge that was shared in plenary sessions.

All the countries indicated to have had a good national initiatives from concerned stakeholders, that which emphasized the importance of reaching young people where they were that which included: (schools, religious institutions, out-of school, and work place interventions), VCT, life-skills and peer education (various youth friendly centres and youth networks), advocacy campaigns and communication for behavioural and societal change. Commitment of national leadership had influence in national work plans and policy that which included those that addressed youth initiatives.

In the consultation process, most of the countries also indicated to have had a National Youth Councils or Informal Youth Forums or networks, with specific practices such as youth parliaments, mock assemblies, capacity building and forums for participation in discussions on HIV and AIDS and Sexual Reproductive Health (SRH) strategic frameworks and implementation of interventions. Burkina Faso and Swaziland were recognized as good examples of that youth engagement. However, it was felt that the systematic engagement and participation of youth in national development frameworks, policy, programming and monitoring and evaluation was very inadequate. Packaging of youth issues and effective mobilization, in multi-dimensional ways, to systematically include their vulnerability issues into SRH and HIV and AIDS initiatives were also cited as gaps. Partnerships and communication of youth with key stakeholders (parents, teachers, social and governance and other structures) and among youth themselves to build youth confidence and capacity were reported as lacking or under-developed in many countries (World Bank, UNFPA and UNICEF, 2007:3-4,17).

Wyk & Pieterse (2006:5-6), reviewed a study of the Botswana University (UB). The UB profited greatly from committed leadership by the country's government and leadership. The UB's HIV and AIDS Policy were similarly dedicated, listed as a Policy Implementer. It was not only a host of persons in strategic positions but also involved all staff and students. Therefore, the obvious commitment from the university management and students' facilitated numerous HIV and AIDS activities on the UB campus. Besides, the manner in which HIV and AIDS Committees were constituted and empowered created a platform for dynamism and interaction across different field of specialization. However, even when they were several HIV and AIDS-related service provider's operative on campus, the study reviewed that, there was not yet been any suitable mechanism to coordinate, monitor and integrate all of these services.

The researcher believed that the study would indicate how an HIV and AIDS programmatic response at a training institute and in a non- governmental organisation could be participative to implement an inclusive HIV and AIDS policy.

4.3 Knowledge in HIV and AIDS

In Zambia, overall comprehensive knowledge of HIV prevention among youth had improved between 2002 and 2007. Knowledge of how HIV is transmitted has been crucial to enabling people avoid contracting the virus, especially the youth in the age group of 15-24 years who are at greater risks. Having knowledge of HIV and AIDS according to the CSO et al, (2009:212) by a survey with Zambia Demographic Health Survey (ZDHS) of 2007 means knowing that condom use and having just one HIV-negative, faithful partner can reduce chances of contracting HIV. Knowing that a healthy looking person could have HIV and rejecting the most common local misconceptions about HIV transmission (that HIV can be transmitted by Mosquito bites and by means of supernatural means). The survey reviewed that comprehensive knowledge among Zambian youths of age 15-24 was higher with 34 % females and 37% males. Comprehensive knowledge was found higher in urban areas than in the rural areas which the survey attributed to increases with level of education and wealth.

Further, a study by Wodi (2005:86), reviewed that they were fairly equal numbers of male and female respondents of 47% and 43% respectively with a median age of 19 in River States,

Nigeria who had heard about HIV and AIDS. Findings in the study by Ebeniro (2010:129) for universities in Nigeria found that the high levels of knowledge among youths were raised by lots of HIV and AIDS awareness campaigns in the form of billboards which advertise safe sex, abstinence and the deadliness of the disease. Also, provision of youth friendly centres and counselling centres helped spread the word across to some of the youths, and gave them the opportunity to test for STD's and HIV, as well as a place for them to be counselled.

A study identified misconceptions or myths about HIV and AIDS among youth. This was a study by Femmie (2011:70) confirmed that from the results of the study it was evident that students at the University of the Western Cape commonly engaged in lower levels of risky sexual behaviours than those informed in South African literature from national and international populations. That particular population revealed quite a high level of HIV-related knowledge and a reasonably high level of positive attitudes towards safe-sex behaviour. More than half of the sample (51.8%) did not find themselves effectively in relationships at that stage. That indicated that there was still an opportunity for them to be taught in a didactic way by means of role-play and group discussions how to continue incorporating a risk-free lifestyle.

However, despite high levels of knowledge, UNICEF, (2011), Ebeniro, (2010:129) and Wodi (2005:86), noted that levels of awareness did not necessarily reflect an understanding of how sexually transmitted infections (STI's) such as HIV could be transmitted or even prevented. They did not appear to improve misconceptions or translate into personal actions and precautions to avoid becoming infected with the virus. Kalibala & Mulenga (2011:20) further pointed out that the gap between high knowledge and personal action was attributed to underlying risk factors. The factors included poverty, inequitable gender norms, culture and lower levels of negotiations among girls. Therefore, the researcher believed that these factors constitute good media for educational intervention programs for youths.

4.4 Communication and HIV and AIDS

Communication is an important tool for promoting positive behaviour change, educating, informing, and motivating people to improve their health and the health of their families and communities. Communication in its various forms has been successfully used in resource-

limited settings to fight many of the drivers that fuel the HIV epidemic. However, only through persistent and well-conceived, comprehensive communications strategies, coupled with high-quality health services, can the tide of the HIV epidemic in the most affected regions of the world be reversed (Krenn & Limaye, 2009).

A large-scale impact at the national level, more pervasive use of mass media, and a communication process in which participants both create and share together are currently being emphasized. There is an ever greater push for communication to be an integral component of an HIV and AIDS program design and how it should be a primary consideration.

A study by Underwood el al (2006) was of a communication campaign program designed by and for youths aged 13-19 year olds in Zambia. Helping Each other Act Responsibly Together (HEART) was a media program with Television spots, radio spots and songs that were adapted to both rural and urban contexts. It was also accompanied by other materials such as posters, book stickers, exercise books, messages on buses, and music videos. The communication program was meant to encourage the youth population in Zambia to adopt risk-reduction practices (abstinence, a return to abstinence, or consistent condom use) to protect themselves from sexually transmitted infections (STIs) and HIV.

The study further indicated that the communication campaign had an impact in that, over a three-week period about 64% of urban respondents reported that they had seen all or some of the television spots, while approximately 14% of rural respondents saw one or more. Those who viewed the program were significantly more likely than non-viewers to mention abstinence as a way to avoid transmission of HIV. Also, viewers compared with non-viewers were more likely to mention condom use and having only one partner as ways to avoid HIV. Approximately 53% of viewers reported that they took at least one action as a result of having seen the campaign. Overall, respondents were more likely to say they chose to abstain than to report that they decided to use a condom as a result of seeing the spots. Viewers were significantly more likely than non-viewers to report primary or secondary abstinence.

The researcher believed that communication was an integral component of HIV and AIDS communication program design. Communication designed program contributed greatly to social

and behavior change in youth HIV and AIDS interventions. However as noted by Krenn & Limaye, (2009), Social and behavior change communication are such strategies that have to-date been underutilized, despite their proven effectiveness in many settings. The researcher concluded too that, apart from the quantitative research done on the HAERT communication youth campaign, there was need to include a qualitative research. This would be appropriate in order to understand how youth processed messages from the dramas televised or aired. To understand how they modeled words and actions either in conversations with friends and family through para-social interactions with the dramas.

Nonetheless, communication has emerged with the introduction of Information communication Technologies (ICT). Being a vital component of communication, ICTs are viable tools for communicating important points that may be difficult to communicate in face-to-face interactions. This is true when it comes to the teenagers' communication to the adults on issues related to sex education. Websites provides anonymity and has been effectively used for discussing important points and at the same time protecting the identities of the parties involved in the discussions. Kizito & Suhonen (2011:263) argued that existing approaches in developing countries could be enriched by including the following components to HIV and AIDS preventive educational environments: (1) set up an online environment where students could contribute their own ideas in preventive actions against HIV and AIDS spread in society using mobile technologies which most young people have access. (2) an online counseling service could be set up where HIV and AIDS counselors can attend to youths who are infected or affected (orphans) by HIV and AIDS epidemic, (3) computer games designed based on the contextual factors have potential for creating motivating and inspiriting technology supported solutions for HIV and AIDS preventive education.

A functional ICT infrastructure plays a vital role in dissemination information and ideas to youths in health issues especially of HIV and AIDS. Kizito & Suhonen (2011:270) reviewed an Internet program for teenage health education in Uganda. In there, a total of 500 teenagers participated in a cross-sectional survey of Internet use among adolescents in Mbarara, Uganda. The results showed that over one-third (35%) had used Internet to find information about HIV

and AIDS, and 20% had looked for sexual health information. Therefore, this indicated that the desire to use and the actual use of Internet is high among youth which in particular were these in Mbarara, Uganda. The researcher concluded that the Internet may be a promising strategy to deliver low-cost HIV and AIDS risk reduction interventions in resource limited settings with expanding Internet access.

However, Geers & Page (2007:25) reviewed in their study that three countries in southern Africa (Botswana, South Africa and Zambia) under study lacked sufficient numbers of professionals and adequately trained ICTs personals. These ICT professionals for both in rural and urban areas meant to manage Health facility information systems. Although expert systems are not to be considered for alternative training, uncomplicated ICT infrastructure were needed to be put in place and staff trained to manage the systems of ICTs. It was further noted that in Zambia, while Internet was growing rapidly, there was virtually no users among the disadvantaged rural populations. Even when available, the effective use of the Internet was impeded by low literacy rates, low education levels and linguistic barriers.

The researcher believed that if ICTs are to be a serious component of communication in the HIV and AIDS design programs, it is one aspect that has to be prioritized in planning.

4.5 Conclusion

This chapter discussed literature relevant to this study on youths in the age range of 15-24 years been involved in communicating and managing of programmatic responses of HIV and AIDS, their knowledge levels of HIV and various forms of communication utilized in HIV and AIDS interventions. This study will attempt to investigate how the level of knowledge among the youth influences their involvement and commitment in the programmatic responses of HIV and AIDS and as well as identify the vital role of various forms of communication in the prevalence of HIV and AIDS among the youth in a training institute and a non-governmental organisation. Therefore, there is a gap in communicating and managing programmatic responses of HIV and AIDS among youth in training institutions and non-governmental organisations that need to be improved. This study will attempt to make the necessary recommendation in this regard.

CHAPTER 5

RESEARCH FINDINGS: ANALYSIS, INTEPRETATION AND DISCUSSIONS

5.1 INTRODUCTION

This chapter contains the results of the statistical and empirical analysis of the data collected from the survey questionnaires, focus group discussions and interviews (**see appendices** III,IV, V) which attempts to meet study objectives like: to investigate the role of training institutions and non-governmental organisations in regard to communicating and managing programmatic responses of HIV prevalence among youth both male and female in ages of 15-24 years; to determine youth knowledge levels, attitudes and practices regarding the HIV pandemic; and the effectiveness of various forms of communications in place to fight the HIV pandemic.

The results are divided into three sections. The first section deals with demographic data and biographic details of the respondents by looking at gender, age, marital status and year of study. The second combines the qualitative and quantitative approaches. It will deal with the analysis, interpretation and discussion of data from the survey questionnaires (both closed and open-ended questions) and data from the interviews and focus group discussions.

5.2 DEMOGRAPHIC DATA/BIOGRAPHIC DETAILS

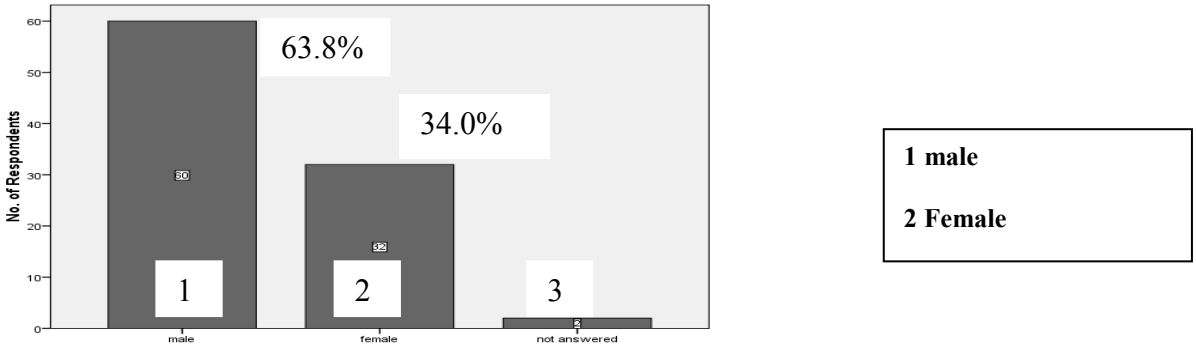
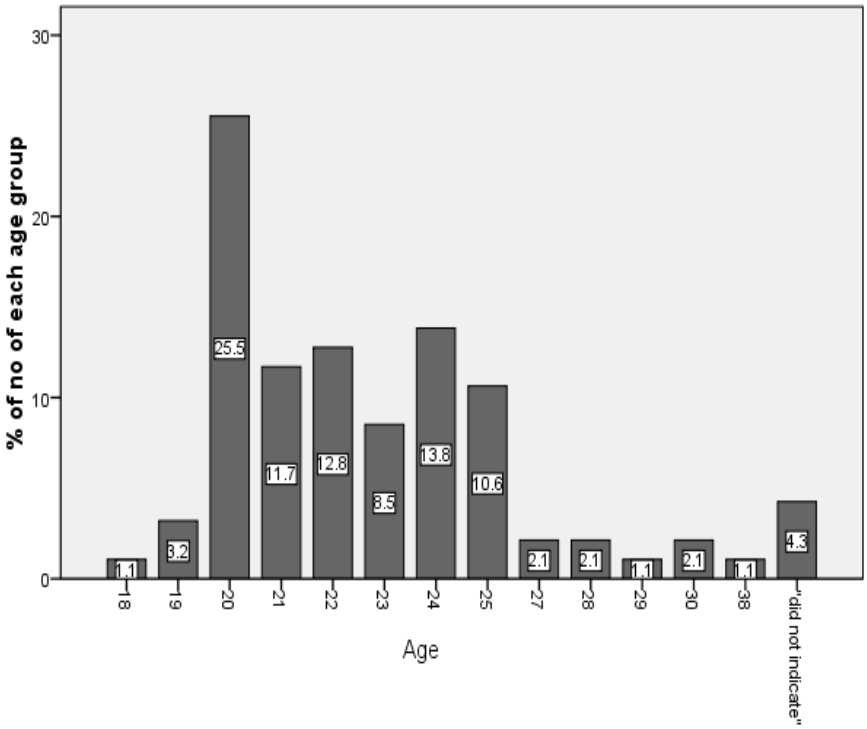


Figure 1: Gender Distribution

Figure 1 illustrates the gender distribution and the number of respondents (n=94) that participated in the surveyed questionnaire. Of this group of respondents, 63.8% were male and 34.0 % were female. This is an important observation for this study as men (males) are largely considered to be least in matters of HIV prevention, Care, Treatment and support efforts.

http://www.irinnews.org/pdf/.../Plusnews-Media-Fact-file-Men-and-HIVpd. The Lower participation of boys and men is well-documented in sub-Saharan Africa overall, "adolescent girls are 3 –4 times more likely to be infected compared to their male counterparts", reports (UNAIDS, 2003 in Wodi, 2005:1). The HIV and AIDS pandemic had mostly affected women or females hence seeing more attention to them than men or males.

Figure 2: Distribution of Age



18 year old-1.1%

19 year old-3.2%

20 year old-25.5%

21 year old-11.7%

22 year old-12.8%

23 year old- 8.5%

24 year old-13.8%

25 year old- 10.6%

Figure 2 reflects the age groupings of the respondents. Interestingly, the largest group in this study is the age group of 20 year olds, making 25.5% of the sample. Furthermore, 1.1% was younger and 18 years old; 11.7% were aged 21 years; and 12.8 % were 22 years; 8.5% were 23 years: 13.8% were 24 years; 10.6% were 25 years; 2.1% were 27 years; 2.1% were 28 years; 1.1% was 29 years; 2.1% were 30 years; 1.1% was 39 years and 4.3% did not answer.

The findings of the age group among the youth are in line with what the United Nations' Identity of a youth, (http://social.un.org/index/Youth/Youthflash.aspx). Therefore the findings in this

study indicate that the highest percentages of youths fall in the age group of 20s and these were in a training institution. However, the target group for a nongovernmental organization targeting youths was from 15-24 year olds and 9-14 year old. The nongovernmental organisation responses to HIV among youth includes those from primary, High school and training institutions which covers youths in the recommended age groups of 9-14 year olds and 15-24 year olds (Appendix VII)

Figure 3: Marital Status of Respondents

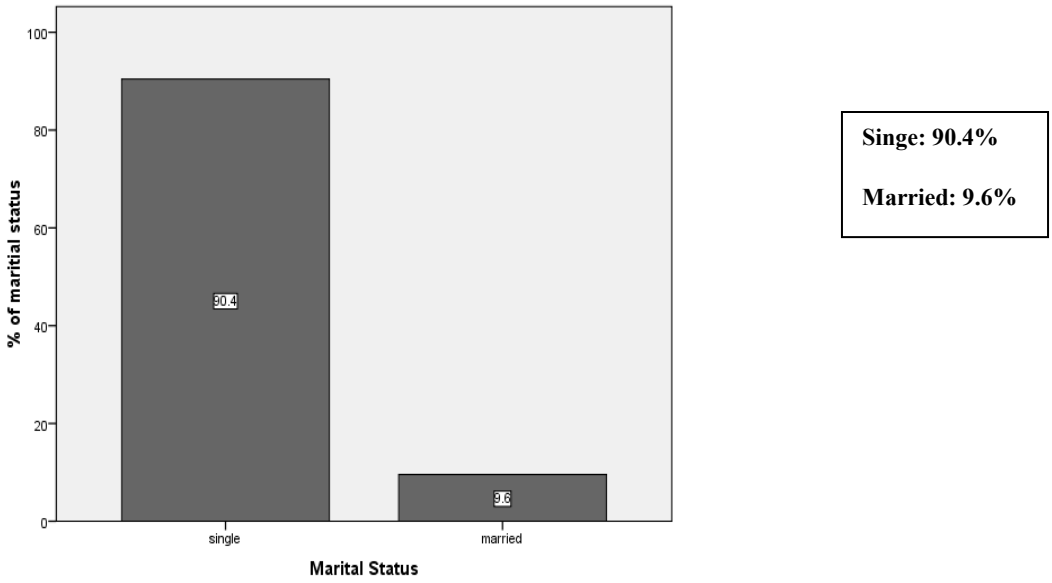
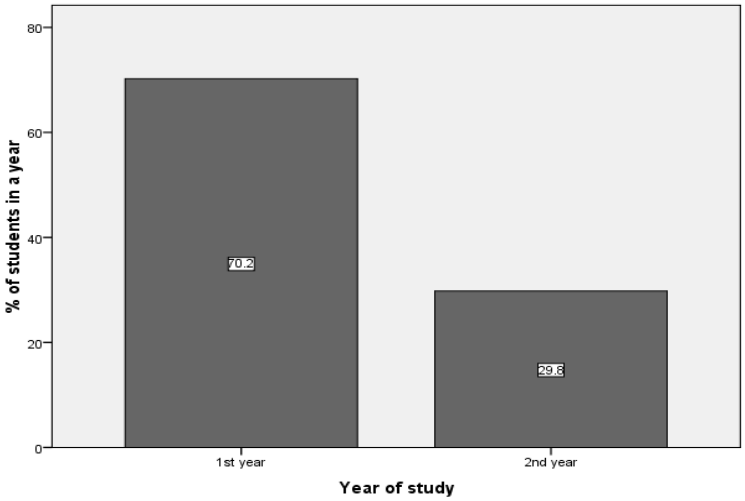


Figure 3, illustrates the status of respondents in the study. Interestingly, the largest percentage of the respondents was single and amounted to 90.4 % and those married constituted 9.6%. Generally, the findings suggest that most youths in their early 20s were still unmarried and not involved in family responsibilities. However, according to a study by Campbell and MacPhail (2001:1), Youths aged between 17-20 years old in Southern Africa, were 18.9% with high levels of heterosexually transmitted HIV infection while those aged 21-25 year olds had 43.1%. This indicates that youths in the ages of 17-25 years tend to be the active in activities of sexual relationships and need not only knowing that HIV exists but getting them to levels of changing behaviours. Therefore it's within these ages in youths that they too are supposed to be involved in programmatic responses to HIV in their localities.

Figure 4: Year of Study



1st year-70.2%

2nd year-29.8%

Figure 4, illustrates in percentage the number of respondents as Students in the 1st year at 70.2% and those in the 2nd year at 29.8%. Interestingly, respondents in the first year are the largest than those in the 2nd year. The variance of the students in each year cannot be explained but gives a background of information that the institute had a high response of students in the first year of enrolments. This gives a good reason that issues pertaining to HIV and AIDS among youth will have to be prioritized as youths form a considerate higher count to our population and need recognition in critical matters (Oppenheimer, et al, 2011:4).

5.3 ANALYSIS AND DISCUSSION OF RESEARCH FINDINGS

This section focuses on the findings of the study in relation to how it aims to address the main research objective: To examine the effective means of communicating and managing programmatic responses of HIV and AIDS prevalence among youth aged 15-24 years in a training institution and a nongovernmental organisation. As mentioned in section 2.1, the study combines the qualitative and quantitative approaches, an approach aimed at serving the purpose of triangulation (Creswell, 2002). Key results will further be compared with those of similar studies. A discussion will be done by the researcher by following a thematic approach instead of linking the discussion to each objective, the following will be discussed:

(i) Managing programmatic responses of HIV and AIDS

(ii) Knowledge and attitudes towards HIV-related issues

(iii) Communicating issues of HIV and AIDS

5.3.1 Analysis and discussions

5.3.1.1 Managing programmatic responses to HIV and AIDS

This study explored how programmes related to issues of HIV and AIDS among youth had been responded to in an institute of training or learning and in a nongovernmental organization. In as much as a training institute and a nongovernmental organization had a mandate to engage youths in matters of HIV and AIDS, a survey in this study showed that youths who where 29.8 % preferred provision of such matters be done by private Health care Workers among other services. The 28.7% showed a preference of not their close relations but distant. The 27.1% preferred a family planning services provider especially females. The 24.5% recommended Radio which is an electronic form of media and 22.3% print media which was in form of magazines and newspapers.

Table 5.0 which is preferred to provide matters on HIV and AIDS

	Count	Percentage
Nowhere	11	11.7
Government Health Care Worker (Doctor /Nurse)	1	1.1
Private Health Care Worker (Doctor/Nurse)	28	29.8
Community Health Worker	2	2.1
Family Planning/Clinic Provider	26	27.1
Lecturer	4	4.3
Other Relatives	27	28.7
Friends	6	6.4
Radio	23	24.5
Television	1	1.1
Newspapers/Magazines	21	22.3

Library	1	1.1
Community or public meetings	6	6.5
Missing	1	1.1

The findings in table 5.0 are in conformity with a study done by Kalibala & Mulenga (2011: 5) on which the National Strategic Framework (2010) consolidated best approaches of how the comprehensively youths programmes on HIV and AIDS are to be attained through Identification of various key programme components management by different key stakeholders in society. The findings in the study indicate that, managing and communicating responses of HIV and AIDS are integrated. They are to be managed in variety approaches and communicated through various channels of communication.

The study findings in an interview conducted to a Programme Coordinator were consistent as she asserted that their approaches to managing responses of HIV and AIDS among youths were integrated with various approaches. The nongovernmental organization had a program on Behaviour Change (BCP) were it trained Facilitators in facilitating behaviour change sessions conducted to Self Help Group members and the community. The target groups of this program were divided into three: the Primary target includes youths between the ages of 15-30years, the Secondary target group, had couples, parent and guardians and the third, the Tertiary target group which consisted of gatekeepers at community and institutional levels.

There was also a Behaviour Change Communication (BCC) programme which was synchronized with the BCP programme. The BCC programme had a target audience of youths aged 15-24 years old and children aged 9-14 years old. The programme used training manuals which were applied also in other behaviour change programmes meant for youths. The manual contained issues of behaviour change, life skills and behaviour formation. The programme in addressing needs of the target audience used Information Education Communication materials, brochures, fliers, and Drama and Life skills manuals.

IEC material: a T-shirt & a flier

Generally, the training manual had twenty-one chapters and objectives. Firstly, it was to empower individuals and communities with accurate basic information on reproductive health, HIV, AIDS, STDs and STIs. Secondly, to promote the identification and adoption of values, attitudes and behaviours that elevates a healthy state of mind, body and environment among individuals and communities. Thirdly, to prop up positive attitudes and behaviour change towards life as the best strategy in overcoming the HIV pandemic, also to sustain health values, attitudes and behaviours among the target group. Lastly, it was to enhance free discussions among individuals and communities on matters of sex and sexuality.

During a BCC/BCP program, a training workshop was conducted over a period of five days. In that, participants were taken through a behaviour change process of looking at the consequences of the present attitudes and behaviours. The training workshop described the start of the behaviour change process of the participants. The facilitators who were mainly the nongovernmental organization staff and others were trained with the community and guided the participants into looking at alternative behaviours and helpful attitudes without overlooking the obstacles that the new behaviour was going to bring.

The programme gave skills and helped participants overcome obstacles that were to be met. However, the programme did not assume that everyone needed to change. It recognised that in some cases, behaviour maintenance was needed.

At the time of the study, the organisation did conduct one training workshop that was to train trainers of trainers or facilitators for the BCC/BCP programmes for implementation of the training manuals in their community. The training workshop was facilitated by three staff members of the non-governmental organization and had 27 participants in attendance. Among

participants were health workers, primary and secondary school teachers, college lecturers, church leaders, community club members.

The training had to cover all the twenty-one topics in the training manual in five days of training. However managing the pace of all participants had been a challenge in that, not all of them had similar capabilities of perceptiveness. Therefore, at the end of the training not all the twenty-one topics were covered. The training managed in a way to tackle critical topics that were applicable to the participants and their community. These mainly were topics that were based on HIV and AIDS; abortion; behaviour change in youths; Sexually Transmitted diseases; Sexually Transmitted infection; drug and alcohol abuse; early involvement in sexual activities and the importance of communication skills. All in all, 13 topics where covered during the five day training period.

Nonetheless, drama was to be part of the twenty-one topics in the training manual, at the time of this training, it was not covered. However when the Programme Officer was interviewed for clarity, she furthered reviewed that the organization had its own drama group which they assumed took care of this topic. This aspect of not covering all the topics in the training manual meant that the non-governmental organization had challenges in that, their target of completing all the topics was not met. Therefore, it was concluded that he training manual was piloted or tested on rather an advanced participants or highly skilled participants who managed to cover all the topics in five day of training. This meant that the training manual had to be revised so as to be tailored to the capacity of participants.

The participants were to demonstrate skills of facilitation so as to qualify for award of certificate which meant that all participants had to facilitate one topic from the training manual. However, the training manual was in the English print language and some of the participants participated in a local language. Therefore, the training was to have another translation in a local language in order to ensure the full benefits of the programme to the beneficiaries. This was also noticed in the IEC materials distributed to the participants, these were T-shirts, Caps; and wrist bands. They were all printed in the English language which was presumed that all participants could read

when this was a different experience as some participants expressed themselves in their local languages during the training.

Moreover, the Programme Coordinator reviewed in an interview that the programme ran well on course but behaviour change had been the hardest thing to measure though beneficiaries through their testimonies helped them document success stories.

In conducting programs of BCC/BCP to the targeted audiences, the organization, incorporates them with others. The VCT program is one such. In a Behaviour Change Communication outreach, the VCT team's tents are mounted so as to provide VCT services to the community or target audiences. VCT helps people learn about how HIV is transmitted; practice safer safe; get tested for HIV and depending on the result and take steps to avoid becoming infected or re-infecting others. The organisation's response to HIV and AIDS programmes especially to youths had an integrated approach and this ensured that different issues related to HIV and AIDS were tackled in those programmes.

Further , an interview to one HIV Focal Person at the training institute agreed to the findings in table 5.0 as he said that it was not only from the training institution that the students were provided with issues relating to HIV and AIDS but it did so in partnership with others. Ministry of Health District Offices was one of them mentioned by the HIV focal Person and various Non-governmental organisations in the area.

However, the institute at the time of the study did not have an HIV Policy for youths/students that would guide them in matters of HIV and AIDS. The HIV policy document that was available at the institute was one that Technical Education, vocational and Entrepreneurship Training Authority (TEVETA) issued in 2004 and only dealt with staff and not students. Although clause 2.0 in the HIV/AIDS policy document mentioned that it would include, 'staff of the Authority and related parties', the students or youths at the institute are a reason why TEVETA exists and are not to be considered in their HIV and AIDS Policy as a related party. In conformity , an interview conducted to the Institute's HIV Focal Person agreed that it was one of the reasons why the institute lacked focus on how youths are to be mainstreamed in HIV and AIDS matters because they never had any policy in that line. Therefore it was a concern for the

institute that TEVETA authority needed a comprehensive policy or designing one particularly for students in training institutions. Nonetheless, without an HIV students' policy, the institute relied on external help as to the way it was to manage responses of HIV related matters among the youth at the institute.

The study findings in table 5.1 revealed that 53.2% had not found it easy to access condoms at the institute on which it further revealed that 71.3% (findings in table 5.2) said that the institute did not provide the condoms to the students. The 24.5% of the youth at the institute had easy access to condoms which meant they were well informed than the 53.2%. The issue of not affording to obtain a condom had a low rate at 3.2% which meant that the aspect of affordability in case of purchase was not a factor but availability. The theory in Social Marketing (Melkote & Steeves, 2001) is in conformity to these finding about affordability in that condoms in Zambia are distributed on a subsidised fee of less than a U$ or even at no cost to the beneficiary.

Table 5.1 Easiness to obtain a condom

	Count	**Percentage**
Easy	23	24.5
Not easy	50	53.2
Very easy	17	18.1
Did not know/not sure	4	4.3

Table 5.2 Reasons for not accessing condoms

	Count	**percentage**
Not available in the shop	3	3.2
Not available at the Institute or College	67	71.3
Unaffordable	3	3.2
Did not know/not sure	21	22.3

These findings agreed to a report by Kalibala & Mulenga (2011: 5) which reviewed that the programmatic responses to HIV among youth had been met with gaps as most lacked a systematic monitoring and evaluation of the programmes. The institute lacked a proper system to monitor how condoms were to be distributed. Nevertheless, a study done by Green, et al, (2006:335) indicated the impact of condom usage. A programme on non- HIV transmission had being positive in Uganda. In a demographic Health Survey, the increase of by women using condoms by 1% in 1989 to 6% in 1995 and males from 16% in 1995 to 40% in 2000 had an impact of the HIV national decline.

When an interview was conducted to the Programme Coordinator, the non-governmental organization further expressed their role in this that they had no mandate to distribute condoms as they were a Faith Based Organization (FBO) who only had a role to promote Christian morals among youth with approaches only in abstaining from sex before marriage and Behaviour change. However, youths at the training institute in a focus group discussion expressed the issue of lacking condoms as due to inconsistencies on the part of the institute management as they were connected to distributors of condoms within their authority. Nonetheless, a youth in the discussion further highlighted the point that they institute experienced a misuse of condoms when they distributed them in their right places. These were in toilets and common rooms. Each time a box of condoms was left in those places, they lasted only few days than expected which meant they lacked good care hence findings indicating poor accessibility. However the youths, committed themselves to looking into the matter and come up with lasting solutions.

5.3 Methods of teaching at the Institute

	Count	**percentage**
Nothing	3	3.2
Abstain From Sex	1	1.1
Use Condoms	68	72.3

Use Condoms with High-Risk Partners	1	1.1
Limit Sex to One Partner/Stay Faithful to One Part	57	60.6
Limit Number of Sex Partners	2	2.7
Avoid Sex with Prostitute	47	50
Avoid Sex with Homosexual	1	1.1
Avoid Injections	1	1.1
Stop Stigma	11	11.7
Avoid Kissing	1	1.1
Avoid Mosquito Bites	3	3.2
Seek Protection from Traditional Healer	2	2.1
Take Herbal Medicine	3	3.2
Did not know /not sure	0	0.0

According to the findings in table 5.3 youths themselves perceived the severity of the HIV pandemic as they believed certain behaviours had to be promoted to overcome perceived fears of contracting the HIV virus. This was consistent with Rosenstock's (1974) Health Belief Model, on the factor of perceived severity discussed on 3.2.1. The highest response that was thought to be critical and of much emphasis in providing health services to youths was a 72.3% of condom usage and was followed by 60.6% response to limiting sex to one partner. Avoiding having sex with a prostitute had a 50% response. Having nothing to be done had 3.2%; Abstaining from sex had 1.1%; usage of condoms with a high-risk partners had 1.1%; limiting number of sex partners had 2.1%; avoiding sex with Homosexual had 1.1% ; stopping stigma had 11.7%; avoiding kisses had 1.1%; avoiding mosquito bites had 3.2%; seeking protection from traditional healers had 2.1% and taking herbal medicines had 3.2%.

An interview with a Social Worker confirmed the perceived severity in the above findings in table 5.3 of the HIV pandemic that needed to enforce promotion of condom usage, limiting sex to one partner and avoid sex with prostitutes among youth. The Social Worker confirmed that there was need to increase such promotions on HIV matters in the area of the study and this was necessitated by the Town's increased mining activities. It was notable that an influx of people from all walks of life and different nationalities had overtaken the district/Town. This in turn resulted in overpopulation and brought about numerous social problems. There was an increase in the number of social vices including prostitution and a widened gap between the economically stable and poverty stricken persons. These did not leave out the youths who were part of the population hence their suggestion in the findings in table 5.3 to emphasize elements of condom usage, limiting sex to one partner and avoiding sex with prostitutes.

However, the research done by Wyk & Pieterse (2006) showed that youths elsewhere are to be involved in making policies of serious issues over HIV and AIDS because they had brilliant ideas as indicated in the findings in table 5.3. The study of Wyk & Pieterse (2006) was consistent in that there was commitment from the university management and students who facilitated numerous HIV and AIDS activities on the University of Botswana campus.

Table 5.4 Risk Students face of contracting HIV

	Count	**percentage**
No Risk at all	1	1.1
Medium risk	15	16.0
High risk	74	78.7
Did not know/not sure	4	4.3

The findings on table 5.4 further affix that 78.7% of youths at the training institution felt that they were at a high risk of contracting HIV as opposed to 16% who said it had a medium risk and 1.1% who said it had none. This was consistent with an interview to a Social worker and a focus group discussion that the youths were involved in transactional sex which was exchange of

favours of money for sex. The Social Worker pointed out that there was an Epi-synthesis report done by Ministry of Health (2010) that indicated that 9% of the 10-19 year old youth reported having traded sex for food or money, and the figure was higher among married youths.

The perceived feelings of youths being at high risk to the HIV pandemic indicated in the findings in table 5.4 was consistent with a report by WHO (2009) which suggested that the targeted interventions were to be aimed at offering services to specific populations within the general population. In the case of this study, youths are a specific population on it's on. Also the institution as discussed in a focus group discussion had been overwhelmed by the rapid growth of mining activities in the area. The institution at the time of the study experienced the abuse of alcohol by students/youth. Within their locality, the institute had in the recent past experienced the opening of drinking outlets and night clubs. These activities around the locality of the institute put them at a high risk and exposure to social vices that would lead them to risk of contracting the HIV virus.

In an interview conducted to a Psycho-social Counselor at the Urban Clinic, it was consistent in that the clinic saw the need of opening up a Youth friendly Corner services after an increase in a number of youths accessing Voluntary, Counseling and testing (VCT) services at the clinic. A report by Kalibala & Mulenga (2011: 5) is in support that Youth Friendly services were to be established in all health facilities in the country offering all health services that would help youths acquire knowledge and indulge in health behaviours. However, at the time to the study, the Youth friendly Corner at the Clinic did not have a full-time staff and the programme was found not quite active apart from the Clinic staff helping when need arose.

Table 5.5 Regular HIV and AIDS program at the institute

	Count	**Percentage**
No	78	83.0
Yes	11	11.7
Did not know/not sure	5	5.3

A study by Kalibala & Mulenga (2011: 3) on Zambia youth Assessment approved to regularity of an anti clubs in training or learning institutions as these remained the best channels to reach the vast majority of young people with HIV and sexuality education since the traditional approach of teaching about sex through grandparents was not applicable to many families. However, in an interview to the Programme Coordinator for the non-governmental organization, she further supported that their mandate had been to train youths in training or learning institutions especially those that were in Anti Aids Clubs to be facilitators of Behaviour change Programmes (BCP) among their peers. As part of the their objective of a Skill for life programme, the non-governmental organization trained within a period of three months 40 youths aged 15-24 years as facilitators in various learning institutions.

However, the findings of the study as indicated in table 5.5 were that, 83.0% of youths had not experienced a regular Anti Aids programme at the institute of which 11.7% said they had and 5.3% were not sure of anything. The findings were consistent with a study done by OSSREA (2008) that HIV and AIDS issues in higher learning institutions and colleges were considered as the prerogatives of HIV and AIDS committees and or anti-AIDS clubs. This was in conformity by a Focus Group discussion among the youths who expressed the institute's lack of commitment to have regular anti-AIDS. An interview conducted to the institute HIV Focal Person further agreed that in the past years, the institute had not been consistent with the HIV and AIDS programme at the institute.

5.3.1.2 Knowledge and Attitudes towards HIV and AIDS related issues

Knowledge

Levels of knowledge of HIV related issues influenced programmatic responses to HIV and AIDS in a training institute and a non- governmental organization. The findings in this study according to table 5.6 indicate that 89.4% had knowledge of what a person can do to prevent or avoid contracting HIV. While as indicated in table 5.7, 57. 4 % had known of a person who was living with the HIV virus and 91. 5% youths are very much aware that they were a population in Africa affected by HIV pandemic.

5.6 What a person can do to avoid HIV

	Count	percentage
No	5	5.3
Yes	84	89.4
Did not know/not sure	5	5.3

Table 5.7 Know someone with HIV

	Count	percentage
No	36	38.3
Yes	54	57.4
Did not know/not sure	4	4.3

The findings by CSO et al, (2009:212) for Zambia Demographic Health Survey (ZDHS) of 2007 were in conformity with the current study findings in that comprehensive knowledge among Zambian youths of age 15-24 was higher with 34 % females and 37% males. However, an interview conducted to the Programme Coordinator further indicated that although knowledge levels regarding HIV and AIDS were high among young people, most lacked consistent, accurate and correct information on the access to prevention and treatment of HIV and other sexually transmitted infections and unplanned pregnancies. A further study by Kalibala & Mulenga (2011:20) was in support that the gap between high knowledge and personal action was attributed to underlying risk factors.

Table 5.8 are youths most affected with HIV in Africa

	Count	percentage
No	4	4.3
Yes	86	91.5
Did not know/not sure	4	4.3

However the study findings in table 5.9 further indicated that youths were so much aware of programmes on VCT which had a rate of 53.0%, followed by Mother to Child Transmission. A low response of respondents was indicated in 5.3% condom usage; Reduction of many sexual partners 3.2%; 14.9% treatment with Anti-retroviral therapy and the ABC awareness 16.0%.

The findings by Ebeniro (2010:129) are in support of the current findings in table 5.9 in that the high levels of knowledge among youths were raised by lots of HIV and AIDS awareness campaigns. In a further interview to the Programme Coordinator, she said that though comprehensive HIV and AIDS campaigns had been done by many players, more was needed to be done to create awareness for HIV prevention and a demand for post test services.

Table 5.9 Aware with HIV and AIDS programs

HIV programs	count	percentage
Mother to child transmission	38	40.4
Condom usage	5	5.3
Voluntary counselling and testing (VCT)	50	53.0
Reduction of many sexual partners	3	3.2
Anti-retroviral therapy	14	14.9
ABC	15	16.0
Other	1	1.1

Attitudes

Generally, issues related to young people's attitudes towards HIV indicated that most would like people to be open about their HIV status. The findings as indicated in table 5.10 showed that 75.5% responded that someone's HIV status should be known and not be kept private and while 11.7 % responded that it should be kept private. However the findings of Meiberg A.E. et al, (2008:53) indicated that HIV and AIDS was a disease that was an epidemic of ignorance. This

Table 5.10 HIV statuses, Keep it private or tell others

	Count	percentage
Should keep it private	11	11.7
Should tell others	71	75.5
Others	5	7.4
Did not know / not sure	7	7.4

was indicated in the findings of this study in Table 5.11 showing that 28.7% of the respondents at the institute felt that stigma against the people living with the HIV virus or suspected to have the virus was still experienced. In accord with this, Kalibala & Mulenga's study (2011) was in conformity that a form of stigma raised vulnerability among young people. In an interview with a VCT programme Coordinator who said that in their mobile VCT programmes, a lot of apathy towards the services was usually experienced in urban centres which had a low turn up of people requiring the services unlike in rural areas. She further attributed the attitude of shunning attending VCT in public due to stigma associated with the HIV pandemic.

However, the nongovernmental organization had activities schedules that were specifically for VCT for learning or training institutions in the project framework. They offered VCT services in training or learning institutions especially during school festive celebrations. During sessions of VCT, a person was attended to in a full Counseling therapy process which gave an opportunity for counselors to offer a pre and post services on HIV and AIDS matters. Normal VCT Counseling sessions would take 45 minutes. However, at the time of the study, the normal VCT sessions of 45 minutes could only take place at the non-governmental formal established offices and when the VCT team was mobile; the sessions only lasted not more than 10 minutes. According to the findings at the time of the study, this was due to time frame and target of the number of clients the VCT project required in a month. Therefore, working to achieve the number of targeted clients was a factor than conducting a full normal 45 minutes VCT session. However, a full VCT 45 minutes was crucial in matters of the HIV and AIDS pandemic especially youths who were vulnerable.

VCT counselling Session

Table 5.11 Experience some form of Stigma

	Count	Percentage
No	32	34.0
Yes	27	28.7
Other	26	27.7
Did not know/not sure	9	9.6

Nonetheless, further findings in table 5.11 indicated that about 34.0% respondent did not experience any form of stigma. In support of this, the study by Meiberg A.E. et al, (2008) agreed to this that if attitudes changed towards HIV and AIDS then denial, stigma and discrimination may rapidly be reduced.

Table 5.12 Type of Stigma

	Count	Percentage
Bullying	6	6.4

Gossiping	53	56.4
Segregation	17	18.1
Did not know/not sure	18	19.1

In table 5.12, the findings further indicated that the respondent experienced gossip as the highest form of stigma at 65.4% and those who felt there was a form of segregation were 18.1% lower than the 19.1% who were not sure of stigma occurring at the institute. However the findings in the study by Mbonu N.C et al, (2009) is consistent and supported that if attitudes towards HIV related matters and even to people living with the HIV Virus were dealt with compassion, then it would result in effective social and Medicare services.

5.3.1.3 Communicating issues of HIV and AIDS

Communication

Responses to managing HIV and AIDS among the youth had been successful through uses of various forms of communication. The management of programmatic responses of HIV and AIDS among youths had been mainly through uses of communication tools as most programs are based on prevention messages and demand a use of a communication method or tool. The findings showing in table 5.13 had 64.9% as respondents having had access to a television with 31.9% having none and 3.2 were not sure of access to a television at the institute.

Table 5.13 Access to Television

	Count	**Percentage**
No	30	31.9
Yes	61	64.9
Did not know/not sure	3	3.2

Also a 53.2% of respondents as indicated in table 5.14, had access to a radio at the institute with 41.5% having none and 5.3% not being sure of accessing the radio.

Table 5.14 Access to Radio

	Count	**Percentage**
No	39	41.5

Yes	50	53.2
Did not know/not sure	5	5.3

Those that said had access to radio, were 83.0% who had accessed radio services through a personal cell phone and 13.8% was through a portable radio and 3.2% were not sure of the services of radio.

Table 5.15 Form of radio access

	Count	**percentage**
Phone	78	83.0
Portable radio	13	13.8
Did not know/not sure	3	3.2

In the current study findings, the people who had access to a radio or television at the institute, in two months were 30.9% having had seen an HIV youth program and 24.5% had seen none. The 60.6% had seen in two months an HIV prevention program and 18.1% did not while 21.3 had seen none.

Table 5.16 Seen on any media in two months about HIV

	Count	**percentage**
HIV youth program		
No	23	24.5
Yes	29	30.9
Did not know/not sure	42	44.7
HIV prevention		
No	17	18.1
Yes	57	60.6

Did not know/not sure	20	21.3

The findings in table 5.16 were consistent with the study of Underwood et al (2006) confirming that with over a three-week period about 64% of urban respondents reported that they had seen all or some of the television spots on campaigns of youths abstaining from sex, while approximately 14% of rural respondents saw one or more. Those who viewed the program were significantly more likely than non-viewers to mention abstinence as a way to avoid transmission of HIV. The findings in the current study of access to radio services through a mobile telephone are in conformity to an era of ICTs as in the study of Kizito & Suhonen (2011) who agreed that ideas in preventive actions against HIV and AIDS spreading in society could be utilized through mobile technologies which most young people had access to and internet services.

Further, an interview to the Programme Coordinator was in support of the findings when she was asked a question about how effective radio was in their programmes. Her answer to the question was,

> "*The radio is a very powerful and popular media in Zambia. Not everybody can afford a Television but every household and every young person have got a radio, even on the mobile phone. With using the radio the Youth Alive Zambia branches reaches a high number of listeners and extends the target group".*

The content of the radio programme varied a lot from one branch to the other. They used their air-time giving a typical Youth Alive Zambia-workshop vocally, giving an HIV and AIDS relevant information, they did a lot in the field of awareness and advocacy, conducted debates or informed listeners of important events. However, at the time of the study, there was no radio programme in the organisation's branch in Solwezi Town of North Western of Zambia were the study was been conducted.

Further, a study by Geers & Page (2007) was not consistent in that though the internet usage had an advantage to privacy in case of sourcing sexual information by youths, a country developing

like Zambia had fewer infrastructures for internet to meet a demand of a large population of youths. At the time of the study, the training institute had no computer laboratory that could serve for internet usage by the students. Also the nongovernmental organisation at the time of the study had only a Library facility for the public and did not have an internet facility.

Nonetheless, the Programme Coordinator interviewed in the study agreed that various forms of communication had been instrumental in their HIV and AIDS programs for youths. Most effectively, they relied much on Information Education materials (IEC); Fliers; Dramas/Sketches; Brochures; behavioural Change programme manuals and Life skills manuals.

Role play/drama in a community

However, youths interviewed at a Focus group discussion did not agree that many forms of communication had being effective at the institute in that, the institute lacked billboard displays and at the time of the study, the institute had no billboards or posters around the institute premises with HIV and AIDS promotional messages.

Billboards found available at Solwezi Trades Training Institute, July, 2012

The youths in the focus group discussion believed that such posters or billboard with HIV prevention messages would be effective in knowledge dissemination and behaviour change among the youth at the institute. They further said such displays around the institute would have lasting effects on a person's mind and impact change.

A billboard displaying an HIV and AIDS campaign message

A study by Chiwara(2012) agreed that billboards as a form of media, play a vital role in reaching large numbers of young people with HIV and AIDS information and prevention messages.

Table 5.17 Talked about HIV and AIDS to friends

	Count	percentage
No	16	17.4
Yes	73	77.7
Did not know/not sure	5	5.3

Nonetheless, interpersonal communications or face to face form of communication as indicated in the study findings in table 5.17 had a 77.7% as respondents having talked to their friends about issues of HIV and AIDS. The findings are in conformity to a study done by Kalibala & Mulenga (2011) on the Zambian youth assessment of approaching on the use of peer educators among the youth. This had been a best approach as through their peers, youths get an influence to change behaviour either in a positive or negative way.

Youth's interacting-an influence to Peer education

Further a Psycho-socio Counsellor when interviewed agreed that the Urban Clinics' Youth friendly Corner was opened due to an increase of a peer network of youths seeking health services at the clinic. A by Piotrow et al., (1997) is consistent in that information flows through networks. The nature of networks in them determines the likelihood that the innovation would be

adopted. Interpersonal communication and many other forms of communication had further been a major tool to fight many of the drivers that fuel the HIV epidemic as agreed by Krenn & Limaye, (2009) in their study.

The study findings at the nongovernmental organisation were also in support of the peer education among youths as an effective inter-personal communication tool. The organisation had a program called Mentoring school and community clubs. The school/community based initiative was an approach by the youths in empowering each other through role modelling in the adoption of positive attitudes and behaviours thus taking a step towards attainment of their dreams. This was to affiliate groups to promote peer to peer positive influences. It provided a platform of sustaining the newly adopted attitudes and behaviours and also to encourage open sharing on issues relating to the challenges of growing up into adulthood. The program was targeted on children in primary schools, community schools, and youths in secondary schools, tertiary education as well as community groups with non school-going youths. However, at the time of the study, the program was not operational and a Voluntary, Counselling and Testing (VCT) had been the most consistent program which was conducted both at the organisation's offices and mobile locations.

5.5 Conclusion

This chapter analysed, interpreted and discussed findings of data collected. The data analysis, interpretation and discussion was done according to the results from the surveyed questionnaire, in-depth interviews and focus group discussion indicated in the form of descriptive statistics; frequency tables; direct and indirect speeches. In chapter 6, the study will offer a conclusion and recommendations for future research.

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

6.1 CONCLUSION

In conclusion, the study explored matters of communication and management based on programmatic responses of the prevalence of HIV and AIDS among youth. This was based on exploring programmatic responses of HIV and AIDS among youth in a nongovernmental organisation and a training/learning institution.

Both the training institution and nongovernmental organisation are fully aware of their roles of ensuring that programmes intended to address the needs of youths concerning HIV and AIDS are on course.

The nongovernmental organisation had a number of programmes intended to address the youth population and a number of them had been implemented in the community. Most appreciatively was the programme for Voluntary, Counselling and Testing (VCT) that had been consistent at the time of the study. The VCT programme had in place an effective monitoring system though not very effective on evaluation so as to re-plan based on current findings. On each 25th day of the month, data was collected on each VCT location and submitted to its Head Office via a wireless network connection .By the end of the month data was published in each branch for reflection. They had a good programme of using radio as a way to sensitize youths and the local community on matters of HIV and AIDS. However at the time of the study, there was no running programme on the local radio. The findings in table 5.15 indicated that 83.0% students had access to the radio on their mobile phones which meant airing HIV and AIDS programmes on radio in a way would contribute to reaching youths in issues of HIV and AIDS.

The training institution as at the time of the study had fewer activities in regard to responding to matters of HIV and AIDS among the youths who were students at the institute. However, the findings in the questionnaire surveyed, focus group discussion and interviews explored the underlying factors. The institute had in the recent past operated and effectively communicated to students/youth programmes on HIV and AIDS matters.

The institute had in a recent past received funds for funding of an HIV and AIDS programme initiative for people living with disabilities in the sum of thirteen million kwacha (K13, 000,000.00). By the time of the funding, the institute had only one student with a disability. However, the funds were utilised even for those who did not have any disabilities as they had the same cause. The institute then managed to have in place a Video Cassette Recording (VCR) and a Television set which was used for filming HIV related films to the students. The films on VCR as reported by the HIV focal person had impact on the students as during the filming; they showed emotional reactions and the comments made after. However, by the time of the study, the institute no longer had the equipments as they had been run down or stopped functioning.

The institute used to have posters around its premises; however, at the time of the study, the posters were no longer there. As reported by the HIV Focal Person, the posters were removed when the institute was been renovated thereafter, they institute had not replaced them. The institute had no billboards around the premises with HIV and AIDS information or messages and the reasons given as reported by the HIV Focal Person were that, the Developer of the institute infrastructure had not allowed them to erect one. However, at the time of the study, the institute had two billboards erected that meant the institute had not planned for an HIV and AIDS billboard erection. Nevertheless, the students youth during the focus group discussion regretted the lack of a billboard and promised to looked into the matter and have it in place.

Further, the institute at the time of the study did not have in supply condoms in recommended locations that are, toilets and common rooms. However, when the HIV Focal Person was approached over the matter, he was found with plenty boxes of condoms in his office. The HIV Focal Person alluded to such a situation as due to lack of support from the Anti AIDS club committee members. However, the Anti AIDS club members when contacted gave a different view of the matter. They indicated that the condoms when distributed in their designated places lacked proper care from students or were misused. This meant that there was to be found a lasting solution of consistent distribution of condoms at the institute.

The institute relied and effectively utilized interpersonal communication in their methods of communicating to youths at the institute in HIV and AIDS matters. However, they found it very difficult conducting a session at the Anti AIDS club to their fellow youths. Their fellow youths shunned attending the programmes because they underestimated HIV information or messages coming from their fellow youth's representatives of the Club. This meant that the Anti AIDS club could be operated effectively if under the directive or leadership of people influential in the community or opinion leaders so as to have impact (Piotrow et al., 1997) in influencing their knowledge levels and attitudes.

The growing mining activities in the area had an effect on the youths at the institute in that, they institute had to deal with serious alcohol abuse by some youths. The institute had witnessed the opening of drinking places and night clubs in localities near to it. Therefore, it had been overwhelmed by issues of over indulgence in alcohol and prostitution among youths. In the focus group discussion, youths expressed their worries that the situation would put them at a high risk of contracting the HIV virus. This was because the new social places would be attractive to youths at the institute as they had a low income status and a lack of political power.

Weaknesses and Strengths of the Nongovernmental Organisation

However, the study also concluded that the two entities under this study had weaknesses and strengths in the way they managed and communicated responses of HIV among youths. A non-governmental organization communicated its programmes effectively. However this was made possible only when they were funded by external funders. The programmes were also implemented as stipulated by funders. The use of a training manual was such an example. The manual was printed only in English while some participants participated in their local languages. The training manual had twenty-one topics and only 13 were covered under a five day training workshop suggested by the funder. Depending on availability of funds, the programmes were confined to run according to what was laid down despite many challenges. Also, having the programmes run on funding from external sources, the organisation could not run other youth programmes due to lack of funding. Programmes found inactive at the time of the study were among them, Mentoring school and community clubs and radio programmes.

The nongovernmental organisation‘s financial strength had benefited a lot in the community especially youths who had been empowered with new skills and became change agents. However, the fully dependency on external funding is surrounded by uncertainties. The uncertainty is that, programmes are likely not to continue if funds are unavailable.

Weaknesses and Strengths of a training institution

The training institution had its strength on the willingness of youths/student and staff. However, it was further learnt at the time of the study that the programmes on HIV and AIDS ran smoothly at the institute only when they had external support with some form of funding. Therefore when support was discontinued, the willingness of staff, management and youths had gone down. The youths and staff after the discontinued external support lacked a volunteer or self sacrificing spirit in them. Therefore a willingness or volunteer spirit had to be bestowed in all the actors of HIV programmes at the institute as most programmes operated without external funding but internal.

6.2 RECOMMENDATIONS

In terms of programmatic responses to prevalence of HIV and AIDS among youth, the following recommendations are proposed:

- If a training institution had to be successful in communicating and managing its programmatic responses of HIV and AIDS among its youths, it is to be recommended that TEVETA address the need of incorporating youths/students in formulating an HIV and AIDS policy as youths are a reason of their existence. They policy should include issues of monitoring and evaluating programmes to ensure continuity and sustainability.
- The nongovernmental organisation implements its youth programmes depending on external financial funding which attracts participation from beneficiaries as they are given incentives. This however takes away a spirit of willingness, ownership and volunteerism. It is recommended therefore that the nongovernmental organisation aims

at engaging or mentoring youths as owners of youth programmes thereby promoting in them a spirit of volunteerism or self-sacrifice to ensure sustainability of the programmes.

- It is further recommended that training/learning institutions and nongovernmental organisations endeavour to strengthen partnerships. Partnerships in running HIV programmes especially in training/learning institutions are to be recommended as they offer forward and backward linkages. This was in the case of the training institution in the study that had failed to run some of its programmes due to discontinuation on partnerships both in finances and support.
- Communication channels or methods in both the nongovernmental organisation and the training institute had not be given serious attention as means in which most of HIV and AIDS programmes are implemented. It is therefore recommended that communication methods and channels are regarded as essential components in the fight against the HIV virus and require a communication plan when incorporated in a programme.
- For future studies, a study is recommended in the case of volunteerism among youth in communicating and managing programmatic responses of the prevalence of HIV and AIDS. The researcher further recommends that results of this study may be used to a large scale study to that the effective communicating and managing of programmatic responses of prevalence of HIV among youth are highlighted at a national level. This comes also on the background of inadequate programmatic statistical and empirical data specific to youths (UNAIDS, 2011:63).

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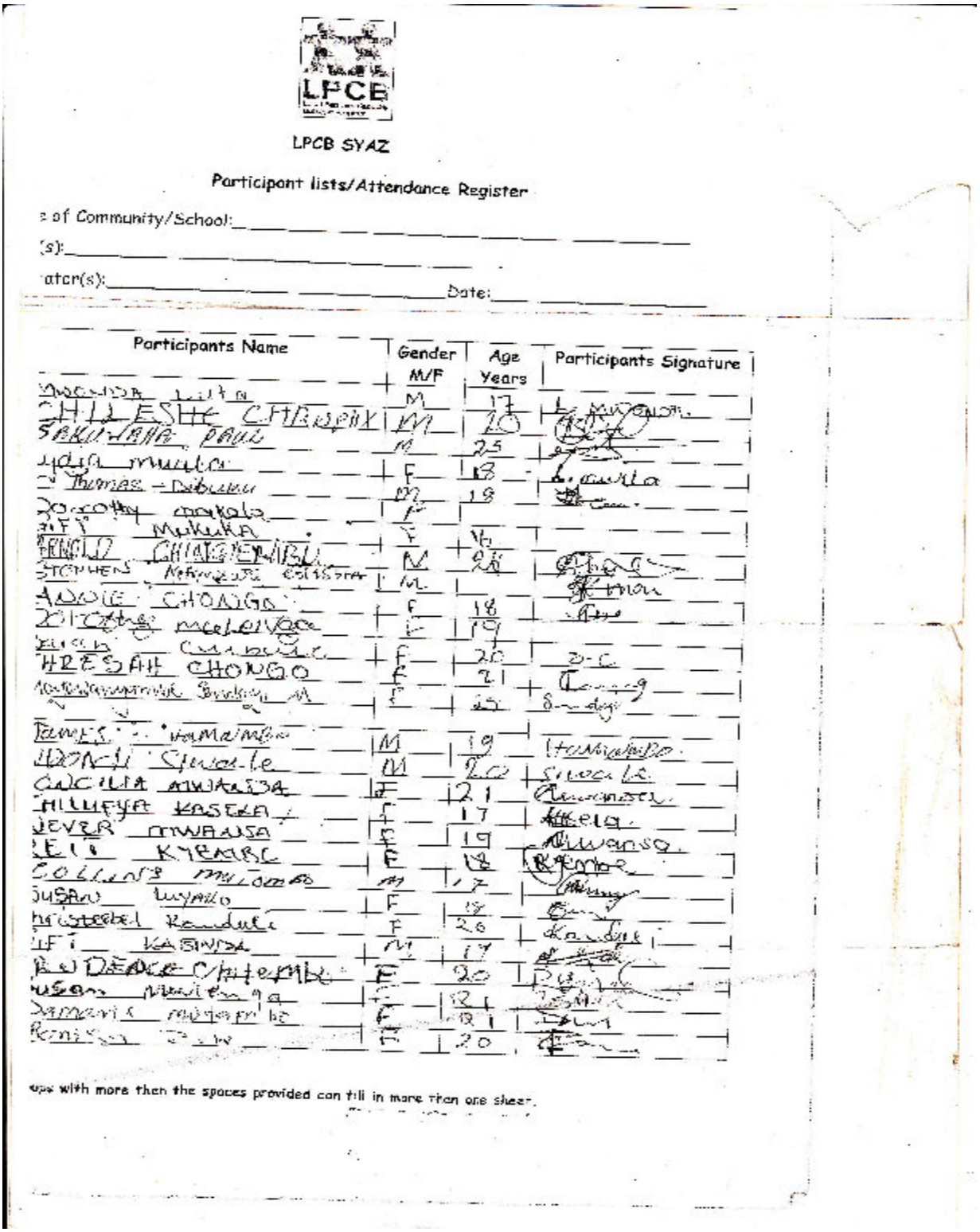
APPENDICES

***Ap*pendix I**



LPCB SYAZ

Participant lists/Attendance Register

e of Community/School:_____

(s):_____

ator(s):_____ Date:_____

Participants Name	Gender M/F	Age Years	Participants Signature
	M	17	
	M	20	
	M	25	
	F	18	
	M	19	
	F		
	M	24	
	M		
	F	18	
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	M	17	
	F	20	
	F	24	
	F	19	
	F	20	

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Appendix II

YOUTH ALIVE ZAMBIA

Private Bag RW 94OX Lusaka, Tel / Fax 21 – 293559
Email: yaz@zamnet.zm
Plot 6085, Chitulf Road – Northmead, Lusaka

1st August, 2012

The Principal
Solwezi Trades Training Institute
Solwezi

Dear Sir,

RE: **LUCKY MUSONDA**

Reference is to the above subject matter.

The above mentioned is our staff on attachment from the University of Zambia. She is pursuing her masters' degree in Communication for Development. Her research is under the title: **Managing Communications regarding the prevalence of HIV and AIDS among youths in training institutions.**

Kindly assist her for the purpose of her research.

Your assistance will highly be appreciated.

Yours faithfully,
Sr. Bibian Chilufya
Coordinator (SYAZ)

BIBIEN CHILUFYA (SISTER)
PROGRAM CORDINATOR

Appendix III

Questionnaire No _____

Date: Day __ Month ___ Year ___

THIS IS AN ACADEMIC QUESTIONNAIRE IN PARTIAL FULFILLMENT OF A MASTER DEGREE IN COMMUNICATION FOR DEVELOPMENT FOR THE UNIVERSITY OF ZAMBIA

RESEARCH TOPIC: COMMUNICATING AND MANAGING THE PREVALENCE OF HIV ANDAIDS IN A TRAINING INSTITUTE AND IN A NONGOVERNMENTAL ORGANISATION

QUESTIONNARE

PLEASE READ THE FOLLOWING STATEMENT CAREFULLY BEFORE SIGNING OR COMPLETING THE QUESTIONNAIRE.

Your participation on this survey is important to us and is completely voluntary. If you agree to complete the questionnaire, you will answer questions regarding yourself, your ideas, attitudes and behaviour regarding different aspects of HIV and AIDS prevention. Your answers will be kept confidential and only the researchers and study personnel will have access to this information. Completing the questionnaire will take between 15 and 20 minutes; the completed questionnaires will be collected by the research team representative and will be kept in such a manner as to guarantee your privacy.

Please mark with an X if you agree or not to complete the questionnaire.

I do not wish to complete the questionnaire ____

I agree to complete the questionnaire and do so in a completely voluntary manner. I understand that my responses will be kept confidential. _____

1	How old are you?	YEARS OLD _____ DOES NOT KNOW 98
2	When did you complete your high school?	.....0 1
3	In which year of study are you in?	1st Year .....0 2nd Year.....1 3rd Year 2
4	What is your marital status?	SINGLE .....0 MARRIED .....1 COHABITING.....2 WIDOWED.....3 DIVORCED .....4 SEPARATED 5
5	Sex:	Male .....0 Female.....1
6	Do you have access to television at the Institute?	NO .....0 YES.....1
7	Do you have access to a radio at the Institute?	NO .....0 YES.....1
8	How do you access radio services?	Phone: 0 Portable Radio……1
10	During the past two months have you heard or seen anything on the radio, television or newspaper, posters about the following:	YES NO a) Family Planning/Child spacing 1 0 b) HIV PREVENTION 1 0 c) HIV YOUTH PROGRAM 1 0
11	If you have a question about HIV/AIDS, who do you ask or where do you go to get	NOWHERE .....0 GOVERNMENT HEALTH CARE

	the information? Circle all the persons/places in the right column where you go to ask or find health information.	WORKER (DOCTOR /NURSE).....1 PRIVATE HEALTH CARE WORKER (DOCTOR/NURSE).....2 COMMUNITY HEALTH WORKER .....3 FAMILY PLANNING CLINIC PROVIDER.....4 LECTURER.....5 OTHER RELATIVES .....6 FRIENDS .....7 RADIO.....8 TV .....9 NEWSPAPERS/MAGAZINES .....10 LIBRARY..... 11 COMMUNITY OR PUBLIC MEETINGS...12 OTHER, SPECIFY_____ 97
10	How easy is it to obtain a condom when you need one?	Easy ..... .0 Not easy ..... 1 Very easy 2
11	What reasons do you have for not accessing condoms?	Not available in shop…….0 Not available at the college…….1 Unaffordable……..2
12	At the institute, do you have access to a VCT centre facility?	NO .....0 YES.....1
13	Do you know if there is anything a person can do to avoid getting HIV?	NO..... 0 YES..... 1

		DON'T KNOW 8
14	In your opinion what one can do to avoid getting HIV? Circle <u>all the answers</u> on the right column that you think would help a person to not get infected with AIDS. .	NOTHING ..... 0 ABSTAIN FROM SEX ..... 1 USE CONDOMS ..... 2 USE CONDOMS WITH HIGH-RISK PARTNERS ..... 3 LIMIT SEX TO ONE PARTNER/STAY FAITHFUL TO ONE PART. ..... 4 LIMIT NUMBER OF SEX PARTNERS ..... 5 AVOID SEX WITH PROSTITUTE ..... 6 AVOID SEX WITH HOMOSEX ..... 7 AVOID BLOOD TRANSFUS. ..... 8 AVOID INJECTIONS ..... 9 AVOID KISSING ..... 10 AVOID MOSQUITO BITES ..... 11 SEEK PROTECTION FROM TRADITIONAL HEALER ..... 12 OTHER _____ 97 (SPECIFY) Don't know 98
15	Do you think the college experience some form of stigma with students who are living with HIV?	NO ..... 0 YES ..... 1 DON'T KNOW…. 8

16	What type of stigma is common at the college?	Bullying …….. 0 Gossiping …….. 1 Segregation…….. 2
17	Do you know someone personally who has HIV/AIDS or someone who died from HIV/AIDS?	NO..... 0 YES……1
18	Do you believe that youths are the most affected group with HIV and AIDS in Africa?	NO..... 0 YES..... 1 DON'T KNOW 8
19	Have you ever talked about HIV or AIDS with your friend or regular sex partner or irregular sex partner?	NO..... 0 YES..... 1 NO REGULAR PARTNER..... 3
20	How much do you think students at the college risk of contracting HIV and AIDS? Would you say: no risk at all, medium risk or high risk?	NO RISK AT ALL..... 1 MEDIUM RISK ..... 2 HIGH RISK..... 3
21	Does the college have a regular HIV and AIDS program in place for all students?	NO..... 0 YES..... 1

22	Which HIV prevention programs are you familiar with? Circle in the right column all the places where you know that a person can obtain a condom.	MOTHER TO CHILD TRANSMISSION.....1 CONDOM USAGE .....2 VOLUNTARY COUNSELLING AND TESTING (VCT).....3 Reduction of many sexual partners .....4 Ant-retroviral Therapy .....5 ABC……6 OTHER_____ 97
23	During the past month, did you encourage anyone to use condoms to avoid HIV and AIDS and other sexually transmitted diseases?	NO .....0 YES.....1
24	If a person knows that he or she has AIDS or the virus that causes AIDS, do you think that he/she should keep it private or tell other people in the community?	SHOULD KEEP IT PRIVATE.....1 SHOULD TELL OTHERS .....2 OTHER, _____ 3 (SPECIFY) DON'T KNOW / NOT SURE 98
25	Do you think that the college is doing enough to sensitize the students as youths about dangers of HIV and AIDS?	NO..... 0 YES..... 1 Don't know _____ 2
26	Please write in the column in the right	NOTHING 0

	what things you think the college should emphasize in their methods of teaching students how to avoid getting infected with the HIV and AIDS virus?	ABSTAIN FROM SEX ..... 1 USE CONDOMS ..... 2 USE CONDOMS WITH HIGH-RISK PARTNERS ..... 3 LIMIT SEX TO ONE PARTNER. .....4 LIMIT NUMBER OF SEX PARTNERS ..... 5 AVOID SEX WITH PROSTITUTES..... . 6 AVOID SEX WITH HOMOSEX ..... 7 STOP PROSTITUTION ..... 8 STOP STIGMA……..9 AVOID KISSING ……10 GO FOR VCT ..... 11 SEEK PROTECTION FROM TRADITIONAL HEALERS ..... 12 TAKE HERBAL MEDICINES..... 13 BE FAITHFULL TO ONE PARTNER/ STICK TO ONE PARTNER……14 OTHER _____ 97 (SPECIFY) Don't know 98

THANK-YOU VERY MUCH FOR COMPLETING THIS QUESTIONNAIRE

APPENDIX IV

INDEPTH GUIDED INTERVIEW QUESTIONS

1) How do you manage your HIV and AIDS programs at the institute?
2) Do you think there is enough information on HIV and AIDS the institute offers?
3) Which methods of communication do you think are effective in sensitizing students about HIV and AIDS and do you use them in your program?
4) What preventive measures does the institute promote on issues of HIV and AIDS?
5) How do you think is the best way to manage HIV and AIDS issues in training institutions?
6) What behaviours do you think put youths at the of contracting HIV at the institute?
7) Do you face challenges in managing the HIV and AIDS program at the institute?
8) Do you have anything to add to this discussion?

THANK YOU

APPENDIX V

QUESTIONARE FOR BCC /VCT/BCP FOR SOLWEZI YOUTH ALIVE ZAMBIA

1. Who are your target audience for your BCC/VCT/BCP program?
2. What influences the choice of your target audience?
3. What communication tools do you make use of in the program?
4. How sufficient are the communication tools for the program?
5. Which risk behaviours do you focus on in the BCC/VCT/BCP programs?
6. How do you measure the outcome of the BCC/VCT/BCP programs (give an example of one success story?)
7. What challenges have you encountered in implementing the BCC/VCT/BCP programs?