Interpersonal Communication Networks in HIV and AIDS Prevention: What Works for Young Women from Low Socio-Economic Statuses in Rachuonyo North District in Kenya

BY

SILAS ODONGO ORIASO

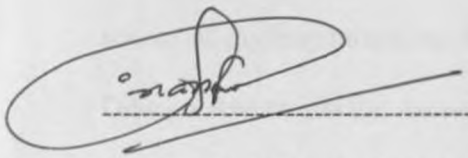
K90/92242/2013

A Thesis Submitted in Fulfillment of the Requirements for the Degree of Doctor of Philosophy (PhD) in Communication and Information Studies in the School of Journalism and Mass Communication, University of Nairobi

2013

Declaration

This thesis is my original work and has not been presented for a degree in any other university. Any work done by other people has been duly acknowledged. It has been examined by the Board of Examiners of the University of Nairobi.



22/11/2013

SILAS ORIASO ODONGO **DATE**

This thesis has been presented to the University of Nairobi with our approval as the supervisors.

R. White 23-11-2013

PROF. ROBERT WHITE **DATE**

M Wambui 22.11.13

DR. WAMBUI KIAI **DATE**

Dedication

This thesis is dedicated to my beloved father, the late Peter Odongo Awuor, my late brother Jack Omondi Odongo, whose struggles energized my innate convictions for socio-economic transformation through education and whose memories have been the source of my inspiration; my humble and dedicated mother, Mama Margret Odongo, the Odongo Awuor and the Awuor Mitoko families without whose commitment to God, hard work, education and discipline I would not have achieved any of my life dreams.

Acknowledgement

Special thanks go to my two supervisors Prof. Robert White and Dr. Wambui Kiai for their academic guidance in this thesis. Each of the supervisors contributed to this study in a different but in a collaborative and effective manner.

Prof. White helped me to structure and give focus to this thesis. I thank him for his critical reviews, consistent advice and openness in handling academic matters. He devoted enough time to discuss various models, theories and literature in communication with me. Apart from actively participating in all my defenses, he also held useful discussions with me and my other supervisor Dr. Wambui Kiai on the progress from where immediate feedback was relayed.

I want to specially thank Dr. Wambui Kiai for her encouragement during the PhD study. Like Prof. White, Dr. Kiai diligently helped me to address the key concepts which were critical for this study. I highly recognise her efforts to thoroughly scrutinize the overall structural layout and methodology of this study. Her politeness, humility, determination, firmness and professionalism in addressing academic issues energized me to complete this study. As the Director of the School of Journalism, I appreciate her efforts to provide all the needed time for my PhD as well as the administrative support for its successful completion.

I wish to thank my academic mentors: Dr. Hezron Mogambi from School of Journalism, University of Nairobi, Prof. Carol MacNeil from University of California, USA and Prof. Anne Neville Miller from University of Central Florida, USA for their advice and academic materials throughout this study.

Much appreciation also goes to Prof. Getinet Biley who was a visiting professor at the School of Journalism from the Antioch University in USA for reviewing my initial proposal and offering me the much needed academic support at that moment.

I also wish to acknowledge Dr. Muiru Ngugi (UoN), Dr. Wairimu Gichohi (UoN), Prof. Peter Kareithi (University of Pennsylvania, USA), Prof. Keyan Tomaseli (KwaZulu Natal, SA), Prof. Eliza Govender (KwaZulu Natal, SA), Dr. Joseph Mbindyo (UoN), Dr. Guantai Mboroki (UoN), Dr. Ndeti Ndati (Multimedia University, Kenya) and Mr. Polycarp Ochilo (UoN) for their academic commitment and emotional support.

Much appreciation also goes to all the people who contributed to the success of this study, my colleagues in the PhD class such as James Oranga, Samuel Kamau, Charles Owino, Pharaoh Ochichi, Dorothy Omollo and Samson Osanya who made this work to succeed. I notably thank Moses Araya, Stephen Oguttu, Isaac Ragama, Anne Wathome, Fronica Monari and other colleagues from the School of Journalism, and the entire University of Nairobi community for all their support and encouragement.

I humbly appreciate the support from all the officers from Rachuonyo North District who assisted me in building the sample frames and identifying the respondents. I also salute my very able research teams throughout this study including George Wachira, Felister Muthoni, Fiona Indasi, Joel Mitoko, Richard Allan, Keith Ambundo, George Akong'o; and Dan Okoth for editing this thesis. Lastly, sincere thanks go to the Odongo Awuor family for their encouragement throughout my education, and to the Almighty God for all support, life and tolerance. Thank You Very Much!

Abstract

The high HIV and AIDS prevalence among women in sub-Saharan Africa has raised a lot of concern with the effectiveness of the communication approaches used in promoting attitudes and behaviour change (Govender, 2010; Fishbein and Joseph, 2006). Some existing literature suggest that high risk persons are able to initiate programmes and give direction to each other through interpersonal communication (Govender, 2010; Rogers and Kincaid 1981; Freire 1972), contrary to the linear communication approaches which most studies indicate as mainly responsible for creating awareness (Mulwo, 2008; Govender, 2010). Using the Convergence Model and Social Cognitive Theory, this study focuses on the role of interpersonal and group communication networks and strategies in promoting attitude and behaviour change leading to avoidance of high risk behavioural practices. It also focuses on the ways by which high risk women explore mechanisms of coping with and avoiding situations of high HIV and AIDS risks. Using a multi-method approach, involving life story interviews and focus group discussions with eight groups of changed and two groups of unchanged low status women purposively selected from Rachuonyo North District in Kenya and in-depth personal interviews with a total of twenty key informants, the findings concur with the literature that the linear approaches are not very effective in promoting behaviour change, but are mainly responsible for high awareness creation. The findings also reveal that forms of interpersonal communication that integrate all stakeholders in HIV and AIDS communication as well as encourage participation and involvement, empowerment, local creativity, social consciousness raising, reliance on local culture, local innovations and primitive social learning processes where communication lead to sharing of ideas in a horizontal open-ended communication networks in the community are effective. The study concludes that both the linear and interpersonal communication perform different but complementary functions in HIV and AIDS behaviour change process and that interpersonal strategies are the most important in bridging the knowledge-behaviour gap to promote attitude and behavior change necessary to avoid risky sexual practices associated with HIV/AIDS.

Abbreviation

AIDS	Acquired Immune Deficiency Syndrome
AIS	AIDS Indicator Survey
ARH:	Adolescent Reproductive Health
ART:	Anti-retroviral Therapy
ATI:	Access to Information Initiative
BCC:	Behaviour Change Communication
CAAC:	Constituency AIDS Advisory Committee
CBOs:	Community- Based Organisations
CHAK:	Christian Health Association of Kenya
CRS:	Catholic Relief Services
EGPAF:	Elizabeth Glazier Pediatric AIDS Foundation
FBOs:	Faith-Based Organisations
GoK:	Government of Kenya
HIV	Human Immune-deficiency Virus
IEA:	Institute of Economic Affairs
IEC:	Information, Education and Communication
KAIS:	Kenya Aids Indicator Survey
KANCO:	Kenya AIDS NGOs Consortium
KDHS:	Kenya Demographic and Health Survey
KNASP:	Kenya National HIV/AIDS Strategic Plan
KNBS:	Kenya Nationals Bureau of Statistics
MOH:	Ministry of Health
MSM:	Men Who Have Sex with Men
NACC:	National Aids Control Council
NASCOP:	National Aids and STI Control Programme
NASSEP:	National Sample Survey & Evaluation Programme

NDO:	Netherlands Development Organisation
NGOS:	Non-Governmental Organisations
PLWHAs:	People Living With HIV and AIDs
PMTCT:	Prevention of Mother to Child Transmission
SABC:	South African Broadcasting Corporation
SCC:	Social Change Communication
SCT:	Social Cognitive Theory
STI:	Sexually Transmitted Infections
TB:	Tuberculosis
UFI:	Upendo Foundation International
UNAIDS:	United Nations AIDS Programmes
UNDP:	United Nations Development Programmes
VCT:	Voluntary Counseling & Testing
WHO:	World Health Organisation
WSW:	Women Who Have Sex with Women
WVIPA:	World Vision Integrated Pala Area
ZNBC	Zambia National Broadcasting Corporation

Definitions of Terms

Young Women: Refer to the women within the 18-35 age brackets from Rachuonyo North District (Upendo Foundation International, 2008) either married or single.

Low Socio-Economic Status: Refer to the women in the social grade E (At the lowest level of subsistence e.g. widows and casual workers with no income (Institute of Practitioners and Advertising, 2006; KNBS, 2009).

High Risk Women: those who engage in risky or unprotected sexual behaviour or practices and who are often the target of HIV message. They were targeted by the study.

Behaviour Change: Adoption of new behaviour that reduce the risk of HIV infection such as avoidance of unprotected sexual practices and casual sex (Warren Parker, 1999).

Risky Sexual Practices and behaviour: includes behaviour that exposes women to HIV risks such as unprotected sex, casual sex, alternative sexual partnering and trans-generational sex (Warren Parker, 1999).

Table of Contents

List of Figures

List of Tables

The Organisation and Structure of the Thesis

This thesis has six chapters. Chapter one provides the background and justification, the study context, problem statement, research objectives and questions, significance of the study, scope and limitation and the conceptual framework.

Chapter two contains the literature review and theoretical framework of the study with the philosophical orientation and the theories guiding the study. It analyses the literature on the trends of HIV and AIDS communication and role of interpersonal communication in HIV and AIDS behavior change communication. It also highlights the nexus between literature and theories as well the study gaps.

Chapter three details the research methodology, focusing on the research design, population, sample size and strategy, instruments, data collection and analysis methods

Chapter four presents the research findings, analyses them and gives interpretations of the findings in both narrative and case study formats including data summaries in tables based on the research objectives.

Chapter five is the discussion of findings within the context of existing literature and theoretical framework, and

Chapter six is the summary of key findings, conclusions and recommendations. It reviews the objectives followed by the key findings, study conclusions, the contributions to theory and research, and study recommendations.

Chapter One: Introduction and Background to the Study

1.0 Introduction

The general objective of this study was to find out the most effective forms and strategies of communication in promoting a reduction of risky behavioural practices associated with HIV and AIDS prevalence among young women aged 18-35 years from low socio-economic status in Rachuonyo North District, Kenya. It was based on the fact that many HIV and AIDS communication interventions have been used by the Government of Kenya, local NGOs and international bodies to promote reduction in risky sexual practice which is the leading predisposing behaviour for the high HIV and AIDS prevalence in the country (NACC, 2008/2010; KAIS, 2007/2009; NACC, 2012).

The HIV and AIDS infection rate among women still continues at an alarming rate especially averaging at about seven percent per year in Kenya, despite the communication interventions in place (KAIS, 2009; KDHS, 2009; NACC, 2012). This suggests that the forms and strategies of communication used so far have not been very effective in promoting the needed change in attitudes and beliefs of the high risk young women, which has consequently exposed the women to more HIV and AIDS risks.

Many studies have identified the high poverty level, old traditional cultural practices, rigid religious beliefs and low levels of HIV and AIDS awareness among women as the major predisposing factors for high rate of AIDS prevalence (Castaneda, 2005; Tessler, 2006; Tanja, 2008; Agadjanian, 2008). A critical analysis of the relationship between these factors, on one hand, and HIV and AIDS prevalence among women, on the other hand, has suggested that it is the communication variables that have immense impact

(Chandler, 2008; Agadjanian, 2008; Fishbein & Joseph, 2006; Ndati, 2012). For instance, when the effectiveness of some forms of communication was tested in a pilot study, the results showed that some young women reported that they had changed their behaviour while others reported that their behaviour remained unchanged hence they got infected by the HIV and AIDS pandemic (Fishbein & Joseph, 2006). The implication of this is that there might be certain forms of communication which are more effective in promoting preventive attitudes and behaviour than other forms of communication (Fishbein & Joseph, 2006; Govender, 2010). This provided a major justification for the present study to find out these forms and strategies of communication and to further test their effectiveness.

This chapter presents the background and justification of the study with a brief description of the global forms of communication employed in HIV and AIDS behaviour change communication. The chapter then narrows down to HIV and AIDS communication in Kenya, followed by a situational analysis of HIV and AIDS problems and communication in Rachuonyo North District. The chapter also presents the statement of the research problem, research objectives, research questions, and study assumptions, significance of the study, the scope and limitations of the study, the conceptual framework and conclusion.

1.1 Background and Justification of the Study

Since the discovery of HIV and AIDS and its subsequent declaration as an international disaster close to three decades ago, approaches to address the rate of this incurable infection have seen a dramatic metamorphosis from the bio-medical to bio-psycho-social remedies being used in the world to control the scourge (Schiavo, 2007).

The latter, being a communication-based approach, has seen numerous health communication strategies developed and employed in what seems to be a relentless search for effective interventions to address the pandemic. In this endeavor, the HIV and AIDS pandemic have received considerably higher and more exhaustive communication attention compared with other pandemics in the world. A lot of communication research has been conducted leading to different strategies being tested based on the assumption that only communication can control the HIV and AIDS prevalence and impact (Airhihenbuwa & Obregon, 2000; Kiai, 2009; Kunda & Tomaselli, 2009; Govender, 2010).

The first approach utilised the linear models of communication. This model involves informational and educational strategies developed from the understanding that communication is a vital tool in development and HIV and AIDS prevention (Govender, 2010; Fishbein & Joseph, 2006). The linear communication strategies are based on the need to 'modernize' the traditional ways of developing countries to the modern ways of the developed countries. From the linear perspective on development, the main catalyst is an individual whose negative attitudes, beliefs and behaviours must be changed through mass media and some forms of public campaigns (Govender, 2010; Kiai, 2009).

Many scholars indicate that most linear approaches have failed to impact people because the social and cultural contexts of HIV and AIDS in Africa are not considered and their cultural values are blamed rather than taken as an advantage (Freire, 1972; Campbell, 2003; Singhal & Rogers, 2003; Rice et al, 2003; Govender, 2010). The linear approach assumes that individuals are rational beings who are capable of taking rational decisions if persuaded by communicating safe sexual choices (Govender, 2010), which

has not proven to be very effective in attitudes and behaviour change from several communication programmes.

A linear approach assumes that communication is a process of transmitting knowledge of the experts to uneducated people by use of mass media, persuasion and advertizing because media has powerful influence on individual attitudes and behaviour (Hovland & Janis, 1953). This assumption has been cited as the cause of the failure of the Love Life Campaign in South Africa (Govender, 2010). The Love Life project was launched in 1999 to promote sexual responsibility among the youth and link them to counseling and clinical services. The campaign used branding as an instrument of change without taking into account variants like culture, religion, belief systems and socio-economic contexts of the youth in South Africa (Govender, 2010). It also assumed that young people were motivated by individualistic aspirations to consumption since it linked HIV and AIDS prevention to a lifestyle of consumerism, not considering the fact that most of the targeted youth were from lower income brackets. Since the project did not involve the youth it was viewed as exogenous and lacked in-depth knowledge of the true challenges of youth in the developing countries (Govender, 2010; Kunda and Tomaseli, 2009).

In Kenya also, the linear model has been employed to disseminate messages and experiences on causes, effects and control measures of AIDS through radio and television at prime news time, during entertainment sessions like *the Beat* on National Television (NTV), in between soap opera programmes, during youth-focused programmes like *Vijana wetu on KBC* radio as well as on *Epuka Ukimwi* billboards placed in most vantage places in urban areas and along highways, focusing on the youth in schools, colleges and

universities and women and the key messages include abstinence from sex, use of condom and being faithful to sexual partners (KAIS, 2007/2009). The model has also witnessed the introduction of peer education, group discussions and anti-HIV and AIDS clubs in schools, colleges and universities as well as the mainstreaming HIV and AIDS at work places and in other social gatherings (KAIS, 2007/2009; NACC, 2008)).

The second approach is the behaviour change communication (BCC) model. This model developed because in linear models, as exemplified by the Love Life campaign, strategic planning for HIV and AIDS communication focused on determining the knowledge, attitudes, and behaviours of individuals, which were deemed risky (Govender, 2010; Kiai, 2009). In the process of designing a communication strategy, the variables contributing to behaviour were identified, and then a theory was developed to explain how these variables were linked together. An intervention was then designed to influence these variables with the goal of producing a desired effect on the behaviour of an individual. As a result, approaches to behaviour change in the early years of the HIV and AIDS pandemic focused on providing *correc*t information about transmission and prevention based on the theory that lack of accurate information about HIV and AIDS transmission was a primary catalyst for the spread of the infection. This approach has been used in Uganda, South Africa and Kenya in such activities as social marketing of condoms and the implementation of ABC strategies among the youth; which has not been very effective in promoting the adoption of desired attitude and practices (Kiai, 2009; Govender, 2010; Melkote, et al, 2000; Mulwo, 2008; Nzioka, 1994; Ndati, 2012).

The utilization of the behaviour change communication approach marked the beginning of the application of the participatory approach to communication intervention

and shifted the focus to local dialogue and social change where participatory strategies and interactive solutions are based on interpersonal communication (Govender, 2010). Behaviour Change Communication is premised on the belief that the urgency of the AIDS pandemic necessitates a steady focus on individual behaviour and thus tries to encourage people to make informed choices. It involves promoting a particular behaviour or social norm through communication interventions which rely on mass media and social marketing techniques (Govender, 2010; Fishbein and Joseph, 2006).

The behaviour change model has been used in Kenya in mass media and public campaigns that promote increased condom use; delay of sexual debut; promote abstinence; avoidance of extra-marital sex; avoidance of casual and unprotected sex; HIV status knowledge; HIV status disclosure and the reduction of sexual partners (KAIS, 2007/2009; NACC, 2008). The major flaw of the BCC approach is that it gives primacy to behaviour transformation, neglecting other important factors in the process of change like socio-cultural contexts and community involvement and participation. It is also argued that BCC are mere replications from western countries and contexts which need to be modified to create impact in sub-Saharan Africa (Govender, 2010; Kiai, 2009).

The perception among some communication scholars that both linear and behaviour change approaches are susceptible to failure (McQuail, 2005; Freire, 1972; Morris, 2003) has necessitated the need for a paradigmatic shift in HIV and AIDS communication intervention. This has culminated in the development of the social change and advocacy models. These models result from the integration of linear and BCC models to include other key factors that influence change such as participation by

members of society in local networks utilizing forms of interpersonal communication (Rogers & Kincaid, 1981; Rice and Atkins, 2003; Govender, 2010). This approach requires the redefinition of HIV and AIDS to be a medical, social and developmental problem that requires the efforts of the entire community to mitigate. The integrative approach has not been effectively utilised to inform communication intervention strategy that addresses HIV and AIDS problems in many parts of Africa (Govender, 2010; Campbell, 2003; Kunda & Tomaselli, 2009; Kiai, 2009; Ndati, 2012; Okigbo, 2002).

1.1.1 Analysis of HIV and AIDS Prevalence and Communication in Kenya

The current surveys on the rate of HIV and AIDS infection in Kenya indicate that young women are highly infected by AIDS at 8.4 percent among those in their productive ages of 18-35 years, compared with their male counterparts at 5.6 percent or less among the latter in some areas (KAIS, 2007/2009; KDHS, 2008/2009; NACC, 2012). This increase has occurred against what seems to be highly intensified communication efforts by the government, local and international AIDS NGOs, civil society and the community members to reduce the infection among this most high risk group (NACC, 2008; NACC, 2009/2010).

In Kenya, HIV and AIDS communication interventions have focused on the youth and women through mass media campaigns, social marketing and educational strategies which inform, persuade and motivate change in behaviours like unprotected sex which expose them to the HIV and AIDS risk (KAIS, 2007/2009; NACC, 2010)). The campaigns have been highly intensified in regions perceived to have high rates of HIV and AIDS infection like Nyanza, Nairobi, Western, Rift Valley and Coast provinces

(NACC, 2010; KAIS, 2007/ 2009; KDHS, 2008/2009; NACC, 2012), using both sponsored and public mass media like radio, television, cinema and video, outdoor media and some community activities sponsored by the AIDS NGOs (NACC, 2010; KANCO, 2011).

Most of the studies conducted on the correlation between HIV and AIDS awareness and behaviour change (KDHS, 2008/2009; NACC, 2010; Ndati, 2012) reveal that HIV and AIDS awareness among the general population is relatively high with an average of over 80 percent due to the mass media campaigns. However, the corresponding behaviour associated with reduction of the spread of the pandemic is very low. This disparity has raised a lot of questions concerning the effectiveness of the forms of communication being used to change attitudes and behaviour of youth and women. Many people have argued that the present communication interventions have been ineffective and they have even suggested other non-communication strategies like quarantine (KAIS, 2007/2009; NACC, 2010). The criticism of the current communication intervention in promoting behaviour change has challenged the application of the linear approach for attitude and behaviour change (McQuail, 2005; Freire, 1972; Muturi, 2008; Morris, 2003).

Some scholars who propose that non-linear models of communication are effective argue that attitude and behaviour change ought to involve the entire society, their needs, interests, values and the collective potential of all participants in the change process rather than perpetual over-reliance on linear models that focus on discrete elements of communication (Schiavo, 2007; Rogers & Kincaid, 1981; Campbell, 2003; Morris, 2003). According to Rogers and Kincaid, the source-message-channel-audience approach to

communication has led to the failure of some communication approaches because the common meaning of the HIV and AIDS pandemic is not shared by all participants in the society as a communication system. This is what results in the failure of some communication efforts in contributing to the positive impact on attitude and behaviour, especially among young women in low socio-economic status in rural areas in Kenya.

There is an urgent need to address the problem of HIV and AIDS among the urban and rural Kenyan population because HIV and AIDS has severely threatened the development agenda of Kenya: the loss of human capital; disrupted societies and the use of massive expenditure on medicine leading to the depletion of Kenyan resources (NACC, 2010; Okigbo, 2002; Melkote, 2000; Kiai, 2009). There is an urgent need to create the platform for people to change their belief systems, attitudes and consequently behaviour like engaging in unprotected sex, wife inheritance and transactional sex, which are associated with the high risk of contracting HIV and AIDS (UNAIDS 2005).

In order to provide the Kenyan population with effective information on HIV and AIDS, the National AIDS Control Council (NACC), which is a government agency, was created in 1999 in the Office of the President to work with strategic plans in carrying out its activities aimed at controlling the HIV and AIDS prevalence (NACC, 2008). So far there have been two strategic plans in force, both integrating communication as their core business. The linear approach to communication and its related strategies (informational, educational and behaviour change models) utilizing mass media to communicate awareness and create the need to change attitudes, beliefs and behaviour of the Kenyan population, especially the youth and women concerning AIDS have been applied. The

third strategic plan is to be implemented in the 2013-2016 period (KAIS, 2007/2009; NACC, 2008).

A review of the success of the implemented communication strategies reveals a huge disparity between HIV knowledge and behaviour change considering what appear to be intensive communication campaigns launched by the government, NGOs, civil society, faith-based organisations and other community based groups in the last two decades to address HIV and AIDS pandemic (Ndati, 2012). These communication endeavors culminated in the development of the National HIV and AIDS Communication Strategy for the Youth in 2008 to address HIV among the high risk groups (NACC, 2008, NACC, 2010, KAIS, 2009).

According to the modes of transmission survey reports (KAIS, 2007/2009; KDHS, 2008/2009; Upendo Foundation, 2008), risky sexual behaviour has been reported as the leading cause of HIV and AIDS prevalence among the youth and women at 94 percent compared with other causative factors. The studies also reiterate that there have been more deliberate communication intervention efforts for the female population than the male population about HIV and AIDS. Among other things, the affirmative action and the interest of many NGOs in the development of the girl-child have increased to promote the welfare of women, specifically in the area of HIV and AIDS (Institute of Economic Affairs, 2008). However, most young women still engage in casual sex, transactional sex and trans-generational sex at a higher rate, with infected persons, with people who do not know their HIV status and with the married *sugar daddies* (Upendo Foundation, 2008; KAIS, 2007/2009).

In order to confirm the assumption that communication efforts so far implemented have not been very effective due to their linearity and that most young women still engage in casual or unprotected sex, this study adopts the case of young women of low socio-economic statuses in Rachuonyo North District for analysis. Prior to the actual study, a pilot or exploratory study was conducted between November and December 2011 in order to gain familiarity with the community and useful data were gathered to augment the information available in the literature. The information received on the forms of communication which some young women reported led them to change their risky sexual behaviour as well as the communication efforts that some young women reported did not contribute to changing their behaviour was documented, in order to establish the relationship between forms of communication used and behaviour change noted. It was believed that this would form an important first step in determining the forms of communication which were most effective and those not adequately effective in promoting HIV and AIDS behaviour change among young women from low socio-economic statuses so as to recommend a model of effective forms of communication for this group of women in Kenya.

1.1.2 Profile of Rachuonyo North District

Rachuonyo North is a relatively new district which originated from the division of the former great Rachuonyo District into Rachuonyo South and Rachuonyo North districts in 2010 for administrative reasons (GoK, 2007). It is a rural district located about 350 kilometers from the capital city of the Republic of Kenya in Nairobi city. It borders Lake Victoria to the East, North East, North, North West and South West. It also borders Homa Bay town to the South, Homa Hills to the West and Kendu Bay town to the East. It

is mainly occupied by the Luo Community, popularly known as Luos from South Nyanza. It is a relatively dry district, with only one rainy season between March and July every year. The crops grown here are mainly maize, sorghum, beans and groundnuts for subsistence, although cotton is also grown for commercial purposes on small scale. Most people especially women engage in fish selling business in small scale for subsistence, while men mostly work in stone quarries. Some few men engage in artisan jobs like shoe repairs, basket weaving, mat weaving as well as working as casual laborers in cotton farms for the few rich people. Most employed or salaried people are primary and secondary school teachers and the local provincial administrators. There are few public service employees and few pensioners or retirees (KNBS, 2009; Upendo Foundation, 2008; Institute of Economic Affairs, 2008).

Generally, Rachuonyo North is a poverty-stricken district, with some natural resource prospects remaining unexploited (Upendo Foundation, 2008; IEA, 2008). These include the fish business, geothermal power, solar energy, un-irrigated fertile soil, un-conserved wildlife, among others.

The district, probably, has the poorest physical infrastructure in the entire Homa Bay County. This is evidenced by poor road networks, few health facilities, poor water and sewerage systems, limited electricity supply, very few tertiary colleges and universities, lack of incentives for large business and entrepreneurship activities, few dilapidated social amenity facilities, few schools and teachers, poor security systems and poor standards of living (KNBS, 2010).

Poverty and illiteracy levels in the district are very high and it is estimated that 56 percent of an approximated two hundred thousand (200,000) people are completely illiterate with women comprising of about 80 percent of this statistic (KNBS, 2010; UFI 2008). This is because of adverse weather and climate in the district, which has not promoted the growth of sustainable agriculture and livestock farming to reduce poverty in the district.

1.1.3 Status of HIV and AIDS in Rachuonyo North District

According to the reports of NACC Districts HIV and AIDS prevalence (2010), the consolidated Constituency AIDS Advisory Committee (2010) and Upendo Foundation (2008), more women than men are infected and affected by HIV and AIDS in Rachuonyo North District. There is a high death rate in the district associated with HIV and AIDS (Upendo Foundation; MOH Rachuonyo District, 2010; NACC, 2010; KAIS, 2007/2009; NACC, 2012).

The most affected parts of Rachuonyo North District in terms of HIV and AIDS prevalence are believed to be in the northern side especially along the beaches of Lake Victoria, in trading centres, around stone quarries, near dam sites as well as in the interior parts of the district (Upendo Foundation, 2008; NACC, 2010; NACC, 2012). In these areas it is believed that at least one member of the family is infected and that at least one member of the family has succumbed to the disease (NACC, 2010; KAIS, 2007/2009). The district is one of the areas in Kenya where women in stable marriages have almost become extinct because girls drop out of schools due to poverty and join the fish selling business or migrate to live in urban areas (Upendo Foundation, 2008). Some of these women get infected with HIV and AIDS and unwanted pregnancies where the latter

results in a high population of children who eventually either become orphans or succumb to the HIV and AIDS pandemic. The number of women is relatively higher than that of men in most affected parts of the district due to low lifespan as well as the low immunity level of most men due to the physical or menial work they do in the quarries as the women engage in the fish business (IEA, 2008). The rate of HIV and AIDS prevalence is 14 percent in South Nyanza region and 26 percent in other districts along Lake Victoria such as Homa Bay, Nyakach , Rarieda, Suba and Kisumu (NACC, 2012; GHPC, 2012; CSIS, 2013).

1.1.4 HIV and AIDS Communication in Rachuonyo North District

There have been massive communication campaigns in Rachuonyo North District over the last two decades among the youth and women to change risky sexual behaviours in order to control HIV and AIDS prevalence (Upendo Foundation, 2008; NACC, 2012). This communication has been spearheaded by the government, local and international non-governmental organisations, faith-based organisations and many other kinds of the civil society in the district. The campaigns have aimed at disseminating HIV and AIDS information, promoting individual behaviour change from questionable cultural norms like wife inheritance, casual sex, unprotected sex, marrying off young women in exchange for dowry to rich men and discouraging young women from education (NACC, 2010).

In this district, HIV and AIDS communication efforts have involved mass media campaigns, public communication campaigns, lobbying by civil society, entertainment education in schools, social places and in churches, through organised community voluntary counseling and testing, condom education, condom promotion and distribution,

prevention of mother to child transmissions, promotion of anti-retroviral therapies, home based care, building of youth initiatives through forming outreach groups, training of youth and women in life skills, encouraging male circumcision through campaigns and incorporating HIV and AIDS in schools' and religious curricula (Upendo Foundation, 2008; NACC, 2010; NACC, 2012).

The government's efforts have been seen in the dissemination of information in both vernacular and national broadcast media such as the radio stations: Kenya Broadcasting Corporation in Kisumu and Mayienga FM in Nairobi. Private and community media have also been used to deliver information. Such media include Ramogi FM, Radio Lake Victoria, Radio Nam Lolwe, Radio Sayari and Gulf FM with many programmes focusing on HIV and AIDS. Most of these media stations collaborate with the ministries of Medical Services, Public Health and Sanitation, Youth, Gender and Sports and Special Services (Upendo Foundation, 2008; NACC, 2008). Government agencies like NASCOP, NACC, KAIS, KDHS and Constituency AIDS Advisory Committee (CAAC) have also been used to dispatch information. The Ministry of Information and Communications has also been instrumental in coordinating communication between government and its agencies as well as non-governmental bodies through the public media. Most of the campaigns against HIV and AIDS through the mass media have been for the general public, although some programmes have targeted specific high risk audiences like the youth and women (NACC, 2008; Upendo Foundation, 2008).

According to information from the Kenya AIDS NGOs Consortium (KANCO, 2011) the major non-governmental organisations which are very active in the district

include the World Vision Integrated Pala Area (WVIPA), APHIA Plus, the Christian Health Association of Kenya (CHAK), the Catholic Relief Services (CRS) and Elizabeth Glazier Pediatric AIDS Foundation (EGPAF). Some of these organisations have existed in the district for more than a decade to support government initiatives aimed at reducing HIV and AIDS prevalence. They have also formulated and implemented communication programmes to promote behaviour change, encourage HIV testing, promote status disclosure, ensure adherence to anti-retroviral therapy, promote positive living with AIDS and encourage an AIDS-free district. Most specifically, they have promoted the welfare of girls and women in a culture associated with strict traditional norms, high HIV and AIDS burden, poverty and illiteracy.

The pilot or exploratory study conducted among young women aged 18-35 years attached to the above organisations had suggested that forms of communication currently used for HIV and AIDS behaviour change were not very effective for women from low socio-economic statuses in this district, which the present research sought to study in detail to ascertain the most preferred communication model associated with change. From the pilot study, the young women who reported to have changed and those who reported not to have changed from risky sexual practices were asked to state the kinds of communication which impacted or failed to impact on their behaviour and a summary of responses was used to justify the main study.

1.1.5 Organisations Giving HIV and AIDS Information Services in Karachuoyo

The organisations in this district which provide HIV and AIDS information and other support services to young women at high risk of AIDS include APHIA Plus, the

Christian Health Association of Kenya, World Vision IPA, the Catholic Relief Services and the Elizabeth Glazier Foundation.

APHIA Plus is located in Homa Hills Center. They serve young women in the cosmopolitan Rawi, Kobiero, Ongoro, Mainuga, Remo, Lwasi, Miti Mbili, Kojwang and Doho beaches of Lake Victoria which are associated with casual and transactional sexual practices (KANCO, 2011). They also address the economic and communication needs of infected and uninfected young women using a team of health outreach campaigners who deliver information to all social places to promote attitude and behaviour change.

The Catholic Relief Services (CRS) has a new branch set up in the district by the Catholic Church to fight AIDS among young women. Located in Kendu Bay town, its key objective is to use effective communication to eradicate AIDS or change risky behaviour among church members (KANCO, 2011). Since 2009, young women in the location have benefitted from AIDS communication provided by members of the church. They work with teams of outreach social workers to transmit HIV and AIDS information. They also offer guidance and counseling services through priests, fathers and nuns. They rehabilitate women from beaches by giving them moral and financial support. The Elizabeth Glazier Foundation (EGPAF) is located in Got Oyaro divisional headquarter to serve the entire Kokoth, Kauma and Kakdhimu villages. It is affiliated to CDC and USAIDs. They have started a communication programme dubbed 'pamoja' which includes PLWHAs in teaching women positive life skills and behaviour change to avoid contracting or spreading AIDS (Upendo Foundation, 2008).

The World Vision Integrated Pala Area (WVIPA) is an NGO situated in Pala Market and it deals with AIDS communication among high risk low socio-economic status women and the youth. It is affiliated to the Chinese community and World Vision International. It also uses teams of outreach workers to support women, give them guidance and medical support. The Christian Health Association of Kenya (CHAK) is located in Gendia Mission Station of the Seventh Day Adventist Church in Kendu Bay area. It integrates HIV and AIDS issues in religious teachings besides using outreach workers to teach the faithful (World Vision website; Upendo Foundation, 2008; Christian Health Association, 2010).

The most important factor which is common to these organisations is that their coordinators and workers are trained health practitioners as well as part of members of the community who are HIV positive. They understand the HIV and AIDs communication strategies, predisposing behavioural practices and the challenges that the high risk persons in the district face due to the HIV and AIDS pandemic. They are also privy to the statuses of women regarding attitude and behaviour change to reduce the HIV and AIDS prevalence in the district. For this reason, they proved very useful in giving the preliminary and general information on the status of women and forms of communication for behaviour change to reduce HIV and AIDS prevalence.

The coordinators of the above HIV and AIDS organisations also purposively selected two groups of women for the pilot study. These were those who reported they had changed from casual and unprotected sex and those who reported they had not changed. A two-stage interview was conducted with them and these comprised of an

open invitation to tell their story and then expanded on the forms of communication used to promote attitude and behaviour change.

The young women in the low socio-economic status who reported changing their casual or unprotected sexual behaviour indicated that they got information from their school teachers; experience with infected relatives; informed by doctors who treated their relatives; from discussions in churches and hospitals; family meetings; through radio programmes; peer group discussions; from church leaders; local provincial administrators; conferences; from NGO coordinators in the area; from role models; church-endorsed behaviours like singing in church choirs; membership to church organisations; informal discussions; through sponsorship by the church; enrolment of their friends in faith; through counseling; visual murals and stop AIDs messages.

Conversely, the young women who had not changed their casual or unprotected sexual behaviour indicated numerous reasons for their continued unprotected sexual relationships: the lack of accurate information; illiteracy; engagement in fish business full time; they lacked radios and television for awareness; peer pressure; engaging in alcoholism; attending discos; had informally mediated sexual relationships; did not attend women or chief's meetings; received the health practitioners messages in dispensaries as well as relying on information from NGOs during the time of assistance only.

Another group of relatively older women reported that they believed they had messed their lives beyond change; some felt that HIV and AIDS' messages were boring; most of them reported having been ridiculed for their casual sexual behaviour; some of them indicated that the celebrities used to pass messages were a group of 'special people'

who were far removed from the daily challenges affecting the high risk women; most of them reported they were maligned by friends; some lacked past experience with AIDS to learn from; some feared stigma from the community; some of them blamed the confidential or secret testing of HIV; some attended churches preaching against protected sex; some kept multiple sexual partners; some tested negative even after sexual intercourse with HIV positive people and some indicated that the formulation and implementation of HIV and AIDS communication programmes did not involve them.

In summary, the findings of the pilot or exploratory study had certain implications that provide more justification for in-depth study to be conducted in the present study. There was an assumption that the disparity between HIV and AIDS communication and actual behaviour change depended on the forms of communication used. For instance, young women who reported to have changed their behaviour seemed to describe very different communication strategies from those that women who had not changed their behaviour described. This confirmed the present study's central hypothesis that some forms of communication are more effective than others in the process of behaviour change. It, therefore, appeared from the pilot study and available literature that forms of interpersonal communication were more effective than the mass mediated or public information campaigns, the central notion that this study sought to determine.

1.2 Statement of the Research Problem

From KAIS (2009), KDHS (2009) and NACC (2012), the national rate of HIV and AIDS infection among women is 8.4 percent, while in Rachuonyo North District, the rate is 14 percent , which are relatively higher than that of men at 5.6 and 7.2 percent

respectively, despite the deliberate communication efforts by all the stakeholders skewed in favor of women and the youth which have raised awareness of these high risk groups.

The first group of scholars who have attempted to explain the disparity between high HIV and AIDS awareness and behavior change have suggested poverty, low education, personality traits, environmental constraints and questionable cultural practices as the factors for the continued risky sexual practices associated with the high HIV prevalence (Egesah, 2002; Oloo, 2005; Nzioka, 1994; Agadjanian, 2008; Tessler, 2006; Markos, 2010).

The second group of scholars has pointed out attitudes and behaviour as the variables which can be impacted more by some forms or strategies of communication than other forms (Fishbein & Joseph, 2006; Kohler, 2002). Most of these scholars have suggested that forms and strategies of interpersonal communication are more effective in promoting attitude and behaviour change than the linear approaches. They observe that most of the previous HIV and AIDS interventions have utilized the linear communication strategies which have not been effective in promoting attitudes and behavior change (Kohler, 2002; Muturi, 2008; Karim, 2005; Kiai, 2009; Govender, 2010; Ndati, 2012; Kunda & Tomaseli, 2009). This has been corroborated by the pilot study.

The implication of the second position is that the factors like culture, poverty and low education are mere predisposing factors which have no serious impact where there is appropriate and effective forms and strategies of communication. The purpose of this study therefore is to investigate the forms and strategies of communication which are effective in promoting attitude and behavior change to reduce risky sexual practices

associated with HIV infection among young women from low socio-economic status in Rachuonyo North District where the rate of HIV is all-time highest. This will consequently fill the wide knowledge-behaviour gap in HIV and AIDS communication for change.

1.3 Research Objectives

1.3.1 General Objective of the Study

This study investigated the most effective forms of communication in promoting attitude and behaviour change to reduce risky sexual practices associated with HIV and AIDS prevalence among young women from low socio-economic statuses in Rachuonyo North District in Kenya.

1.3.2 Specific Objectives of the Study

The study was guided by four specific objectives, which include:

1. To find out the knowledge level of young women of low socio-economic status in Rachuonyo North District on the HIV and AIDS predisposing behaviour

2. To investigate the forms or strategies of communication used in the previous and current HIV and AIDS interventions among young women in the low socio-economic statuses in Rachuonyo North District

3. To investigate the preferred or most effective forms and strategies of communication in promoting attitude change to reduce risky sexual behaviour among the young women who reported to have changed their behaviour in Rachuonyo North District; and

4. To determine the preferred or most effective HIV and AIDS communication model for young women from the low socio-economic class in Rachuonyo North District.

1.4 Research Questions

This study investigated the most effective forms and strategies of communication in promoting attitudes necessary for promoting avoidance of risky sexual behaviour among women from low socio-economic statuses in Kenya, and was grounded on an over-arching research question: *what are the most effective forms and strategies of communication in promoting attitudes and behaviour change to reduce risky sexual practices among young women in Rachuonyo North District?*

The thesis answers this overall research question by addressing four specific questions regarding the effective forms of communication for behaviour change:

1. What are the knowledge levels of young women of low socio-economic status in Rachuonyo North District about HIV and AIDS predisposing behaviour?

What forms or strategies of communication have been used in promoting attitude and behaviour change to control HIV and AIDS prevalence young women in low socio-economic statuses in Rachuonyo North District?

3. What forms or strategies of communication are the most effective in promoting attitude and behaviour change to control HIV and AIDS prevalence among young women in the low socio-economic status who reported to have changed their risky behaviours in Rachuonyo North District?, and

4. What model of communication is most preferred or effective in promoting attitude and behaviour change to control HIV and AIDS prevalence among young women from the low socio-economic status in Rachuonyo North District?

1.5 Assumptions of the Study

The study was guided by four study assumptions:

1. That young women in Rachuonyo North District have relatively high knowledge of the HIV and AIDS predisposing practices and behaviours

2. That most of the previous and current HIV and AIDS behaviour change interventions among young in Rachuonyo North District are based on the linear model of communication utilizing mass media and public campaigns which have not been very effective in promoting reduction of risky behaviours

3. That forms of interpersonal communication are more effective in promoting attitude change necessary for the avoidance of risky sexual practices among young women from low socio-economic statuses than the linear forms and strategies and

4. That the community-based interactive model of communication which encourages participation, social interaction and learning, the creation and sharing of information for mutual understanding, using community media to raise consciousness and culture-sensitive informal discussions was more effective than forms of communication based on the linear model in promoting the avoidance of risky sexual practices.

1.6 The Significance of the Study

The fight against HIV and AIDS has received considerable financial, communication and collective attention in the local and international circles to reduce its adverse impact on development (WHO, 2010; UNDP, 2007; UNAIDS, 2008). However, the communication efforts used so far with young women from low socio-economic statuses have not been very effective in promoting behaviour change to reduce risky behaviours associated with AIDS. There is a widespread belief that significant change in risky sexual practices through strategic communication can only be realised when the most effective forms and strategies of communication are used (Govender, 2010; Fishbein and Joseph, 2006).

This study is meant to assess the effectiveness of the convergence model and interpersonal forms of communication in promoting preventive attitudes and behaviour to control the HIV and AIDS prevalence among young women of low socio-economic statuses in Kenya. Specifically, the study aimed at proposing the most effective communication model, forms and strategies to be used by the organisations or institutions providing HIV and AIDS communication support services to the low status women. It is also meant to contribute towards getting appropriate communication response to be used at the local, regional, national and international levels in reducing risky sexual practices that expose women to high HIV and AIDS prevalence especially those women and youth in low socio-economic statuses who are disadvantaged in the fight against AIDS.

At a theoretical level, this study is meant to add to the existing body of knowledge valuable information on the forms, strategies and model of communication which would be more effective for health interventions among women. It has been noted that most

behaviour change communication interventions rely on investigations of communication effects which target the individual elements in communication with little significant change in attitudes and behaviour. These strategies also rely on mass media and other behaviour change techniques like social marketing with little or no impact. This study aimed to test a different communication model in promoting attitude and behaviour change that would promote attitude and behaviour change to control the HIV and AIDS prevalence among women (Govender, 2010; Morris, 2003).

1.7 Scope and Limitations of the Study

The study was restricted to Rachuonyo North District because of its high HIV and AIDS prevalence over the last two decades among young women from low socio-economic statuses (KAIS, 2007/2009; KDHS, 2008/2009; NACC, 2012). A lot of communication interventions have also been used in this district to promote attitude change associated with avoiding risky sexual activities which led to the spread of HIV and AIDS. This district also has numerous organisations focusing on the development and HIV and AIDS control programmes for young women from the low socio-economic status group.

The study respondents were drawn from these organisations and their environs using purposive strategy because the coordinators had information on the status of young women's attitude and behaviour change. The study targeted young women who were classified into two different strata, based on whether they had reported having changed their attitudes and behaviours or not. Also targeted were experts in HIV and AIDS communication, representatives from organisations dealing with AIDS communication

and members of the public with specific information about HIV and AIDS. The study was conducted in the entire district covering the two divisions.

The study was limited to investigating the most effective forms of communication in promoting attitude change to reduce risky sexual behaviour to control HIV and AIDS prevalence among young women from low socio-economic statuses in Rachuonyo North District. The study was not, therefore, meant to investigate the effective forms of communication for promoting behaviour change among younger or older groups than those covered by 18-35 age brackets. It would not also be naturally assumed that the effective forms of HIV and AIDS communication for attitude and behaviour change among young women of 18-35 years in the low socio-economic statuses would also influence such change among men of the same age and status in the ordinary circumstances. In the latter case, therefore, another study would be necessary.

The study was restricted to Rachuonyo North District in Homa Bay County and the findings are more applicable to this context than other contexts, although there is a possibility of applying it to other environments with similar features to those of this rural district and not to urban environments of same status. Since this study is meant for academic fulfillment, it is not be possible to directly utilise the findings to initiate actions, but the theory generated from it or utilised in this study can directly or indirectly be used for action as well as in future studies related to the subject and issues under the study.

1.8 The Conceptual Framework

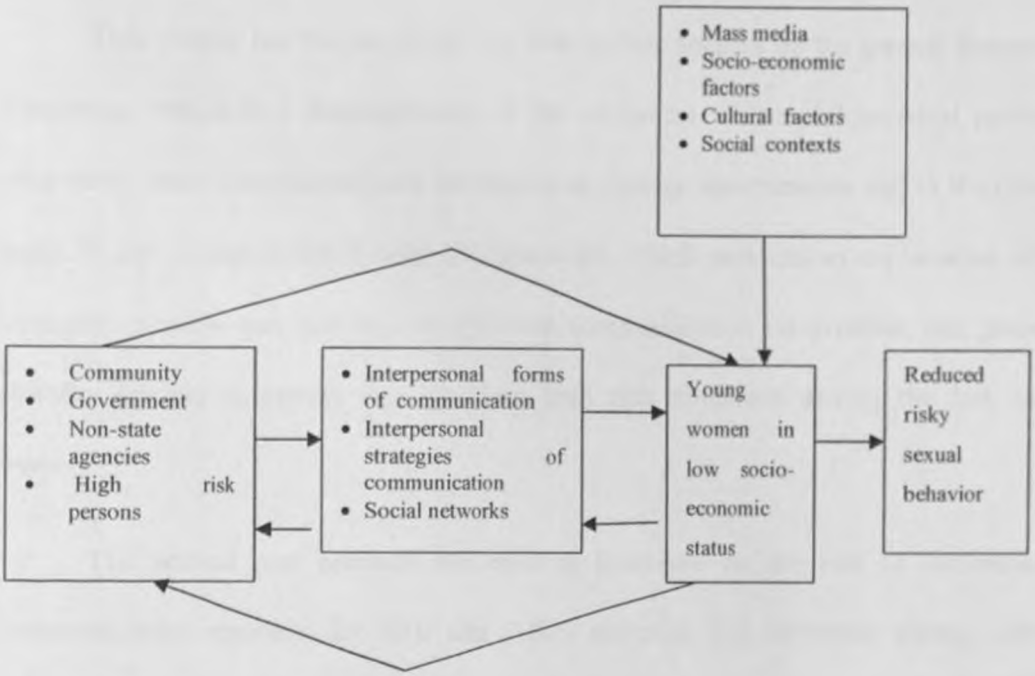
A conceptual framework is a representation of the relationship of the research variables, which explain the present state of affairs as well as outline the possible solution to the problem being investigated (Kombo, et al, 2004).

In the present study, the independent variables include forms and strategies of interpersonal communication, whereas attitude and behaviour change to reduce HIV and AIDS prevalence is the dependent variable. The mass media, socio-economic and cultural factors as well as the learning contexts are the intervening variables.

The three groups of variables combine into a group of factors which together form the conceptual framework for the study. Together, they lead to the development of a comprehensive outline of the elements of the effective model of HIV and AIDS communication for the young women. From the model, communication involves the production and sharing of information among all stakeholders in HIV and AIDS behaviour change intervention such as the government, the community and the non-state agencies, using the interpersonal strategies to influence attitude and behaviour of the young women in the low socio-economic status to promote responsible sexual behaviour to reduce HIV and AIDS prevalence. Factors like mass media, socio-economic, cultural and learning contexts are intervening variables.

Figure 1.1: The Diagram of the Conceptual Framework

Source: Researcher, 2012



1.9 Chapter Summary

From the discussion, there is evidence that the HIV and AIDS prevalence among young women in villages has continued unabated despite the communication efforts put in place because the forms of communication used have not been very appropriate and effective. It has also been noted that the women who form the highest percentage of the high risk groups have not been targeted using an appropriate communication approach. The present study which is based upon women in Rachuonyo District intends to find out the most effective forms and strategies of communication that could make behaviour change possible; and this is assumed to be possible when forms of communication which are non-linear are used. This would lead to the identification of effective model.

Chapter Two: Literature Review and Theoretical Framework

2.0 Introduction

This chapter has two sections. The first section focuses on the general theoretical foundation, which is a demonstration of the evolution of the philosophical positions adopted by many communications for behaviour change interventions and in the present study. It also discusses the theoretical framework which provides an explanation of the strategies, process and structure of effective communication intervention that promote attitudes leading to coping and avoiding high risk situations among the low status women.

The second part presents the existing literature on the role of interpersonal communication approach for HIV and AIDS attitudes and behaviour change among women. It begins with an overview of the transition from the linear approaches to interpersonal approaches in HIV and AIDS communication. This is then followed by the socio-cultural and interpersonal communication approaches, where an analytical perspective has been taken in demonstrating how effective communication occurs in the various studies through participatory, empowering, consciousness raising, social learning and localised forms of communication. This demonstration uses the theoretical framework in explaining the process of communication for behaviour change. The chapter also demonstrates the role of the integrative communication approach. The chapter ends by providing a general conclusion and the research gaps filled by the thesis.

2.1 General Theoretical Foundations for the Study

This study is driven by the philosophical assumption that an effective communication approach for HIV and AIDS attitude and behaviour change needs to involve the entire social environment of a person, where participatory and culture-based interpersonal communication involving group networks, as well as utilizing local techniques and resources are used. The basis for this position is that most of the behaviour change communication efforts which have been used have targeted individuals as complete communication entities, yet literature suggests that a change in attitudes and behaviour is associated with change in entire social norms and cultures of all members of the society (Rogers & Kincaid, 1981; Morris, 2003; Freire, 1972).

Most of the previous and current communication interventions and research have been anchored on the traditional communication models. The earliest of such communication models was proposed by Aristotle who specified the speaker, the speech and the audience as the main elements of a communication act or process. Most communication scholars and practitioners today also conceive communication in a manner influenced by Lasswell (1948) where communication consisted of "who says what, in what channel, to whom, and with what effect" (Rogers & Kincaid, 1981; Freire, 1972; McQuail, 2005). Shannon and Weaver (1949) also developed a model where communication was defined as "all the procedures by which one mind may affect another", which was used to explain electronic or technical communication in their mathematical model. Slightly later, Osgood, et al (1957), Wesley and MacLean (1957) and Barlo (1950) also developed similar models all of which specify a series of components implying a linear sequence in the communication act, where an active source

seeks to influence attitudes, belief and behaviour of passive receivers. All these are attributes of communication anchored on the linear or traditional model of communication (Rogers and Kincaid, 1981; Morris, 2003).

The major assumption of the linear model is the existence of one-way causality of communication process; but empirical evidence suggests that not all communication processes run linearly. Most scholars have used this 'effects approach' in communication research where they gathered data from receivers about the effects of communication on their knowledge, attitudes or overt behaviours (Rogers & Kincaid, 1981; Hovland & Janis, 1953; Griffin, 2009). In studies utilizing the linear approach, the source, message, channel and receiver variables are manipulated as independent variables to relate them to the dependent variable of communication effects, where individual receivers are the units of analysis. For instance, the 'source credibility' studies by Janis & Hovland in 1953 which found that source characteristics like expertise, experience, trustworthiness, authority and attractiveness determined their persuasiveness (Rogers and Kincaid, 1981; Tan, 1985; McQuail, 2005).

After some time in the development of communication research, the linear models began being heavily criticized by their own proponents. Barlo (1977) criticized his own model indicating that it only showed the communication process in persuasion and propaganda. It was also claimed that linear models were simply audio-visual aids to stimulate people to recall the communication components. It was also believed that such communication did not account for significant differences in people's lives. Barlo, therefore, proposed the 'communication-as-exchange' model while Bauer (1964) proposed the transactional communication models, which were all different from the

linear models. Rogers (1962) came up with the diffusion of innovations theory which indicated that communication involved a number of participants developing and distributing ideas and innovations among themselves in a complex non-linear fashion (Rogers & Kincaid, 1981; Morris, 2003).

According to Bateson (1972) and Kincaid (1979), the linear model of communication was based on certain misleading mathematical or epistemological assumptions: that communication is a linear one-way act rather than a cyclic two-way process; that there was lack of dependency among elements in the communication act; that there was focus on the object of communication as simple and isolated; that there was focus on messages 'per se'; that there was focus on the intent of communication as persuasion rather than mutual understanding and collective action; that there was a tendency to concentrate on the psychological effects of communication on separate individuals rather than on social effects and relationships among individuals within networks; and lastly, that there was the belief in one way causation rather than in mutual causation in the human systems that are fundamentally cybernetic (Rogers & Kincaid, 1981; Morris, 2003).

The convergence communication position taken in this study is borrowed from the development concept and hypothesis of Freire (1972). Paulo Freire indicated that when communication is perceived as one-way and vertical and when one takes the point of view of sources as subjects who use communication to produce a change in receivers as objects, bias toward psychological effects and mechanistic causation are created. Hence human communication should be viewed as collective acts in a social system. Freire affirms that communication scholars ought to study relationship between or among

individuals in groups or networks rather than as individuals to overcome individual biases. This cybernetic or social systems position is important in rationalizing the most effective model for HIV and AIDS communication among young women of low socio-economic statuses in Kenya, which is the focus for the present study.

2.2 Theoretical Framework for the Study

The study mainly utilised the Convergence Model from the systems and interpretive traditions as the central theory, although certain dimensions of Social Cognitive Theory also proved useful. This implies that an eclectic approach was used to explain how women, through interpersonal processes, create and share information which promotes adoption of avoidance behaviour as well as explore local solutions to their problems. The utilization of the Convergence theory (Rogers & Kincaid, 1981) and Social Cognitive theory (Bandura, 1977,1986,1991,1994 and 1997) was important in developing a model of effective forms of HIV and AIDS communication appropriate for changing sexual behaviour of low status young women in rural Rachuonyo North District.

2.2.1 Conceptualizing Collective Actions through the Convergence Model

The central theory used to explain collective action through interpersonal communication networks among women is the Convergence Model by Everett Rogers and Lawrence Kincaid (1981). Perceived from a convergence standpoint, communication is a continuous process where participants create and share information with one another in order to reach a mutual understanding and engage in a collective action. In this way communication is a means of relationship building which makes individuals within a

social system to converge over time due to sharing of information through interpersonal networks, participation and social consciousness raising processes.

According to the convergence perspective of communication when individuals interact with their environment, they develop mutual agreement or consensus due to the common interpretation of the meaning of their social problems and then engage in social and collective activity or action that benefits the entire group. Rogers and Kincaid, who are the proponents of this theory, also define convergence as the tendency for one or more individuals to move towards one point or for one individual to move towards another, and to unite in a common interest or focus through a series of non-linear forms of interpersonal communication in groups or social networks. The implication of this is that successful communication intervention is that which occurs in contexts of social systems made up of social norms, values, beliefs and cultures. For instance, communication for HIV and AIDS behaviour change in an individual involves a change in values and norms of the entire environment of the targeted individuals, which linear model proponents fail to appreciate (Govender, 2010; Freire, 1972; Morris, 2003).

The convergence theory of communication is one of the many theories within the cybernetic and interpretive traditions which perceive communication as a product of social interactions. According to the convergence perspective, effective communication wholly engages a social system in producing and exchanging information, as opposed to focusing on communication for change on an individual within the system. According to Campbell (2003), the convergence theory is based on the premise that culture-based communication and participation of a local community are the most important ingredients

of a successful communication intervention used to address social problems that face society such as economic problems and diseases like AIDS.

From the participatory convergence perspective, the rise in new HIV and AIDS infection, poor coping and management styles of the pandemic are due to lack of participation by the community at all stages in the intervention process, as many interventions do not take into consideration the needs of a community. Campbell (2003) affirms that the involvement of the community in an intervention is important for two reasons. First, the community serves as a key mediator between micro and macro levels of analysis of an individual's behaviour, and secondly, many scholars agree that the initial step in addressing the AIDS pandemic is to get people collectively to take ownership of the problem so as to use their local resources and unity to solve the problem. This is because a local community forms the context within which people negotiate their social and sexual lives. For this reason therefore, Campbell (2003) believes that interventions envisaging a participatory approach are important since the community embraces the problem as their own and unite, putting their differences aside. According to Campbell, any successful behaviour change process must include society because the society involves social norms, values and cultures set by community and the information must flow from society to government agency, which is important in supporting change in behaviour (Rogers & Kincaid 1981; Rice et al 2003; Campbell 2003; Morris, 2003).

The Convergence Model also relies on a cultural approach (Iliffe, 1998). According to this approach, the best way to change an individual's behaviour is to focus on the cultural perspectives of the community from where the individual lives. This

entails tackling the problem through a position of values, norms, traditions and other cultural institutions as platforms to discuss and communicate about change to eradicate the virus and disease.

According to Iliffe (1998) and Windahl (1985), people are more concerned with the traditional consequences of HIV and AIDS since these are associated with death, sex, blame, shame, rejection and stigma, which are all societal constructions of AIDS. For instance, AIDS prevalence is believed to be high in sub-Saharan Africa due to the cultural norms and taboos. This belief implies that the same norms and taboos can be invoked during HIV and AIDS behaviour change communication to make them effective in promoting the needed change in attitudes and behaviour.

Singhal and Rogers (2003) assert that where culture is involved people should think of its strengths rather than only limitations. For instance, cultural remedies envisage that people need to think and talk about subjects, which are normative and taboo as well as utilize the power of cultural artifacts, handicrafts, arts, mural and other cultural impressions to augment mainstream media communication, while targeting risky behaviours, and not people at risk (Singhal & Rogers, 2003; Windahl et al, 1985). Both the participatory and cultural approaches utilize convergence theory and interpersonal communication in social networks in very different yet complementary ways from reliance on linear communication model for AIDS interventions.

Freire (1972) observed that the convergence model is a departure from the linear communication approaches to a general theory of participatory development applicable in both societal development as well as developing health interventional strategies that utilize the bottom-up and horizontal communication for change. Using this model in

health communication, health problems among members of a community are perceived by these members as common threats to development and societal cohesion. This calls for collective efforts to address it using resources available at the community level.

From the convergence perspective, the recogniser of the threat can be an informed member from the community or an outsider who raises the consciousness of the community members and organises community members who then engage in the process of interpreting the threat through forms of interpersonal interactions, collective consciousness raising and discussions of problems to find mutual action for its aversion. The community members then recognise that unity is essential in setting specific and achievable targets. The community also realises their collective potential (social efficacy) to mobilise resources and empower themselves through collective capacity building to address the HIV and AIDS problems (Rogers and Kincaid 1981; Freire, 1972; Morris, 2003).

The present study relied on all the major dimensions of the convergence model to explain the strategies, structure and process of interpersonal communication that are effective in promoting attitudes and behaviours to enable the young women from low socio-economic statuses to control the high HIV and AIDS prevalence rate. These dimensions include the following:

- Getting people to take ownership of the HIV and AIDS problem through involvement and participation of all stakeholders as demonstrated by community drama in Zambia (Mulwo, 2008)
- Enabling the creation and sharing of information about AIDS by all the participants at the local level due to an open-ended of communication structure

- Building interpersonal networks of individuals that promote social interactions
- Placing premium on culture-sensitive engagements and modes of communication that ensure common social constructions of meanings, attitudes, norms and behaviour; and
- Building social efficacy of community members through motivation and positive reinforcement of acceptable attitudes, beliefs and behaviours which empowers them to act hence solving their problems.

Most of the communication interventions which are hailed as successful in addressing HIV and AIDS attitudes and behaviour change in the world have utilised the above dimensions of the Convergence Model in designing strategies and approaches whose structures and processes involve interaction and inclusion as described in the literature in chapter three of this study. Some of them include the Bridge Project in Malawi (Karim, 2005) and the Mothers' Club in Korea (Rogers and Kincaid, 1981) and the Summertown Project in South Africa (Campbell, 2003).

2.2.2 Understanding Women's Social Efficacy using the Social Cognitive Theory

The other theory which was utilised to augment the Convergence Model is the Social Cognitive Theory by Albert Bandura. In particular this theory explains the internal and external factors that influence attitude and behaviour change in individuals. The internal factor important in this study is the self-efficacy while the external factor useful is the role of social models in individual's learning, attitudes, beliefs and behaviour modification processes (role modeling or social learning).

The Social Cognitive Theory (Bandura, 1997) is an advancement of Social Learning Theory (SLT). Also called the Observational Learning Theory (OLT), the SCT is grounded on the belief that there is a reciprocal relationship among behaviour, personal factors and the social environment of a person. According to this theory our behaviour is affected by self efficacy or belief in our internal capacity (intrinsic motivation) to change as well as the social environment or people around us. Our behavioural intentions also affect our self efficacy and relationship with people around us (Bandura, 1997).

Bandura (1997) outlines six main constructs on which a person's attitude and behaviour change is based, which are relevant in deciphering the effective forms and processes of interpersonal communication for attitude and behaviour change in women from low socio-economic statuses. First, a person's change in behaviour is influenced by the belief that a behaviour exists in the context of personal factors, environment and behaviour intentions. This implies that attempting to change a behaviour must be preceded by the process of changing self efficacy and attitudes (Bandura, 1997). This happens when multiple ways of influencing both the attitudes and self efficacy are used.

The second construct states that a person's change in behaviour is influenced by one's behavioural capability. This implies that the person must have both the skills and knowledge to perform the behaviour. For instance, the person must know what to do and how to do it.

The third construct indicates that a person must anticipate positive expectations or outcomes from performing a behaviour. For instance, if the end product of engaging in a behaviour is motivating, the person will perform the behaviour unlike if practicing that

behaviour leads to punishment. This also implies that people engage in social exchange processes before a behaviour is changed.

The fourth construct explains that a person must have self efficacy or confidence in their ability to take action to avoid barriers. This is often achieved when a person sets incremental goals for self, sets a binding contract with rewards and non rewards and sets monitoring and reinforcement measures for self.

The fifth construct states that a person is also influenced by what he or she observes from important people around them. This means that people learn by watching the actions and outcomes of other people's actions. For instance, a person may learn from credible social models whose actions are rewarded and avoid those whose behaviours are not approved. This concept explains that people associate other's behaviour with either rewards or punishment and decide to practice the rewarded behaviours and avoid those that lead to punishment.

The last construct states that people also change their behaviour through reinforcement. This implies that people change behaviour when rewarded. People also rehearse and attempt to reproduce those actions by themselves which improve the likelihood of repeating our behaviour. Reinforcement increases the possibility of repeating a behaviour especially after a person get reinforced (McQuail, 2005; Bandura, 1997; Tan, 1985).

From the above descriptions, several dimensions of the Social Cognitive Theory are exposed. The dimensions of the Bandura's theory which are important in explaining

how women develop social efficacy and learn new behaviours in the present study include the following which are detailed in the next chapter on literature.

- Self-efficacy or belief and confidence in one's ability to change attitudes and behaviour to eradicate the barriers or problems.
- The belief that a person would change attitudes and behaviour when they have behavioural capability gained through relevant skills and knowledge.
- The belief in influence on an individual by perceived important people or role models which promotes observational learning, and
- The belief that positive expectations or positive reinforcement or giving motivations to a person will build and sustain the required attitudes and behaviour leading to avoidance of HIV and AIDS prevalence.

The above dimensions of the Social Cognitive Theory have been used in many studies to explain the communication process in both interpersonal influences as well as in studies on mass media effects. The most common application of the Social Cognitive Theory in health communication is the use of role models such as celebrities, authorities and figureheads in delivery of health campaign messages. For instance, they have been useful in the social marketing of condoms, delayed sexual debut and campaigns that control drug abuse in the broadcast media.

The role models are people who the target audience can identify with and who perform the behaviour being promoted so that target audience can observe, learn, and evaluate the results for themselves. Joram (2010) describes how some women groups in

rural parts of Tanzania fought HIV and AIDS using forms of interpersonal communication, involving modeling from para-professionals, village leaders, and other community members. Because of the social learning processes, the members of communities united to ensure HIV testing was effective while communities that did not have effective social models to learn from failed to achieve effectiveness in HIV testing.

The key concept in the Social Cognitive Theory, called self-efficacy, which is the confidence in one's ability to perform an action and achieve the desired results such as in mobilization of people for testing in Joram's (2010) study is important in demonstrating how the theory works. In Joram's study, some communities believed that they would succeed in mobilizing all their members to test just like successful societies even if there were many challenges that affected them like African culture and poverty (Joram, 2010).

From the pilot study conducted prior to this, the dimension of self efficacy attempted to explain why some women from low socio-economic status still managed to be impacted by communication to change attitudes and behaviour. The theory has also contributed to this study by explaining how the young women conceive the consequences of their actions and behaviours, and how motivation shapes their attitudes which help them to participate in or respond toward desired attitudes and behaviour associated with reduction of the HIV and AIDS prevalence.

In the mothers' club of Korea (Rogers and Kincaid, 1981) and the Care and compassion movement in Zambia (Mulwo, 2008), the value of self-efficacy was at the heart of effective HIV and AIDS behaviour change in women. More on precise

application of dimensions of the two theories are described in the case studies analyzed in the next chapter.

2.2.3 Theorizing the Avoidance Behaviour through Complementary Perspective

The study relied on both the Convergence Model and Social Cognitive Theory to explain the processes, structures, strategies and model of communication which was effective in promoting attitudes and behaviour change to reduce the HIV and AIDS prevalence among women from the low socio-economic statuses.

The synthesis of the two theories was significant for this study because none of the theories seemed sufficient enough from existing literature to fully explain the forms, structures and processes of communication which are effective in promoting behaviour change among lower status women to reduce risky behaviours. Therefore, integrating the two theories promoted adequate understanding of communication problems with previous communication interventions as well as the structure and processes of the forms of interpersonal communication which were more appropriate in promoting the avoidance of HIV and AIDS risks among the low socio-economic status women in the district.

From both the convergence and social cognitive theories, six main dimensions were isolated which seemed to adequately explain the process and structure of effective forms of communication that promote attitudes and behaviour change. These dimensions include involvement and participation of women, informational and economic empowerment, role modeling, local creativity through consciousness raising, cultural sensitivity and integrative approach which correspond with the forms of interpersonal communication which global and local literature review indicate were more effective

than the linear strategies of communication. The application of the six dimensions of Convergence Model and Social Cognitive Theory are exhaustively discussed in part 2.3 below.

2.3 An Overview of Transition from Linear to Interpersonal Approaches

As discussed in the background, the realisation of the serious danger of HIV and AIDS since the 1980s has triggered the development and application of various approaches and strategies of communication to create awareness and transform attitudes and behaviour. These approaches have mainly been linear, although aspects of behaviour change and social change approaches have also been applied. The approaches have used informational, educational, social marketing and advertising and mass media campaign strategies to communicate the dangers of HIV and AIDS with high-risk populations (Govender, 2010; Kiai, 2009).

The linear approach has been applied in many communication interventions as the dominant paradigm (Morris, 2003). However, many critics have argued that the linear approach has not considered the social and cultural contexts of HIV and AIDS in Africa. This is because individuals and their cultural values have been criticised rather than taking them as the vantage entry points for interventions (Govender, 2010). The linear model has also assumed that the communication process is the transmission of knowledge of experts to people of low literacy. The model has also considered mass media to have a powerful influence on individual attitudes and behaviour, which reflects the application of mass media influence largely considered a foreign belief in local communication contexts (Govender, 2010).

The behaviour change approach has also been applied in the interventions as a response to the belief that the linear approach was ineffective in many ways throughout the intervention (Govender, 2010). The introduction of behaviour change communication marked the beginning of the application of participatory approaches. This has shifted the focus from the mass media to local dialogue and local change where interpersonal communication strategies and interactive discussions are applied to promote participation, individual empowerment and consciousness raising (Morris, 2003).

Critics of the BCC approach have observed that it gives primacy to behaviour transformation neglecting other important factors such as situating the intervention within the cultural contexts of the target audiences. Just like the linear approach, BCC approaches have also been considered as replications from other different countries and contexts. They also lack active participation as the key element of communication, besides being unable to stand alone in interventions (Joram, 2010; Govender, 2010; Morris, 2003; Schiavo, 2007).

The limitations of the linear and behaviour change approaches necessitated a shift to socio-cultural strategies which saw the development of the Social Change Communication (SCC) approach. The SCC developed as an improvement of the BCC to include the key factors influencing attitudes and behaviour change such as participation, community involvement, localising the interventions through consultations and horizontal communication, mobilising the people and local resources, which promote culture-appropriate interventions for each audience group (UNAIDS, 2010; Govender,

2010; Morris, 2003). These processes have utilised various forms of interpersonal communication within local community contexts.

More recently, the social change approach has been reformed with frameworks embracing joint efforts and partnerships that seek to understand and explain the role of socio-cultural influence, gender relations, cultural norms, spirituality and environmental influences such as government policy. These frameworks are based on the understanding that beyond an individual exist social networks, structural and environmental determinants that affect people's attitudes and behaviour. This new approach indicates that responsible behaviour is achieved by empowering people through promoting situations where participants both create and share knowledge (Govender, 2010; Kiai, 2009; Morris, 2003).

The social change approach uses strategies and media such as community mobilisation. This includes a range of activities conducted at the community level such as drama, games, informal education sessions, motivational talks, and community meetings. These forms of communication are particularly useful in creating openness for discussing issues related to HIV and AIDS, and putting these issues in the context of the life circumstances of community members. They are attributes of interpersonal communication (Govender, 2010; Ndati, 2012; Mulwo, 2008; Kiai, 2009; Morris, 2003).

2.4 Interpersonal Communication and HIV and AIDS Behaviour Change in Women

It has been argued previously that most of the HIV and AIDS communication interventions have mainly relied on the linear and behaviour change models of communication. Evidence shows that the linear forms of communication have not been

very effective in promoting change in attitude and behaviour. Most of the literature suggests that interpersonal communication is more effective (Rogers & Kincaid, 1981; Singhal & Rogers, 1999; Freire, 1972; Campbell, 2003; Rice et al, 2003; Morris, 2003).

In the forms and strategies of interpersonal communication there is evidence of a greater emphasis on interpersonal activities and processes to be an integral component of HIV and AIDS intervention programme design and not a secondary consideration or an afterthought as is the case in forms of communication based on the linear model of communication (UNAIDS 1999; Kiai, 2009; Ndati, 2012; Freire, 1972).

The convergence communication theorists argue that a successful communication approach must involve the entire community in the process of producing and sharing information which makes all members of the community to be participants who act collectively to address their problems (Morris, 2003; Rogers and Kincaid, 1981). This communication approach uses local strategies and media where the target groups are the initiators and implementers of the intervention programmes that benefit them and the whole community (Campbell, 2003; Freire, 1972; Rogers & Kincaid, 1981).

Interpersonal communication is the ongoing, ever-changing process that occurs when people interact, creating meaning to messages, signs and symbols from the community, leading to relationship and consensus building and collective actions of people in social networks or dyads (Rogers and Kincaid, 1981). Literature on the role of interpersonal communication in promoting attitudes and behaviour change to reduce HIV and AIDS prevalence suggests that interpersonal communication promotes participation

and involvement, information and economic empowerment, social learning, consciousness raising, reliance on local creativity and culture-sensitive communication.

The literature below is a discussion of the application of the various aspects of interpersonal communication in HIV and AIDS behaviour change communication among women at the international, regional and local levels.

2.4.1 Interpersonal Communication, Involvement and Participation of Women

Scholars have underscored the value of participation and involvement in community development (Melkote, 2005; Okigbo, 2003; Freire 1972). Development scholars argue that increasing participation and involvement enables participants to support programmes as well as take responsibilities aimed at increasing the likelihood of success (Govender, 2010; Morris, 2003). In health communication, the current paradigmatic shift points to the fact that social and cultural approaches which promote participation are more effective than the linear communication approaches (Campbell 2003; Govender, 2010).

The assertion of the effectiveness of involvement and participation of women in HIV and AIDS communication at the community level is practically demonstrated in the study by Rogers and Kincaid (1981). This is one of the studies which have been hailed to provide the initial framework for the paradigmatic shift from the linear models to the participatory paradigm in the field of development communication (Govender, 2010). Rogers and Kincaid analysed the role of interpersonal network communication in the Mothers' Club Development and Family Planning projects in Oryu Li Village in Korea. The two scholars demonstrate that the Mothers' Club was formed by some Korean

mothers initially for their small economic empowerment and to encourage family planning, using their network of friends and building other informal social networks within the locality. Rogers and Kincaid's study considers the Mothers' Club Project to be a successful intervention through the mobilisation process, and attribute its success to the forms of interpersonal communication which encourage participation and involvement. Through the assistance of an enlightened member-cum-leader, Mrs. Chan, the Oryu Li mothers initiated two simultaneous projects: economic and family planning, using interpersonal networking, participatory development and social change processes. The mothers, assisted by the chief's wife, raised the consciousness of each other thereby forming small groups with networks to pass information about the club confidentially in the Korea's male dominated society. Despite the challenges they faced like the resistance of their husbands, apathy of some mothers, conservative cultural beliefs and club's management problems, the Mothers' Club surmounted all these to become the most enviable project that developed through interpersonal network-based communication (Rogers and Kincaid, 1981).

The study shows that interpersonal communication within networks of women can be instrumental in encouraging attitude and behaviour change to reduce the AIDS prevalence in similar set ups. For instance, the horizontal approach to communication was used to mobilise most of women in the community to initiate the programmes that solved their economic problems as well as gave efficient information to address the family planning issues effectively. This initiative can be replicated where the fight against HIV has to be initiated and sustained by people at risk themselves without the involvement of foreign state and non-state agencies.

The study by Basu and Dutta (2008) also exemplifies the value of involving women in HIV and AIDS affairs within their cultural contexts. In their study which analysed participatory culture-centered HIV and AIDS communication among commercial sex workers in India, Basu and Dutta came up with useful information for developing future interventions. They investigated how the commercial sex workers in India participated in creating and sustaining the HIV and AIDS communication practices and how sex workers interacted with their everyday living contexts to resist and reframe the linear strategies imposed on them by external health agencies. The two scholars investigated how participatory formations that emerged organically from within the community involved in commercial sex work challenge the commonly held notions of how participatory health communication models in marginalised spaces are and ought to be practiced. Their study observed that the marginalised communities are not devoid of agency and that the communication process within the actual target group leads to success as opposed to communication which comes from outside through government and other agencies. The study makes a strong case for culture-centered communication which involves collective dialogue, local group participation, interpersonal communication within cultural networks with shared social values, utilisation of local resources, mutual and common interpretation of the meaning of AIDS, and reliance on local media to distribute indigenous knowledge on AIDS (Basu & Dutta, 2008). From this study, there was application of participatory approaches, which is an aspect of interpersonal communication within the convergence model which puts effective communication intervention as an audience-side variable (McQuail, 1997). The forms of communication that worked for the women were oral exchanges in group networks as

opposed to those targeting specific individuals in an isolated place like in the linear approaches.

Another study that explores participatory engagement is by Chandler (2008) which focused on the influence of communication systems on the HIV and AIDs sexual decision making among older women in Florida, USA. From this study HIV and AIDS infection was concentrated among the black and Hispanic women. The study aimed to assist public health advocates to develop preventive communication interventions which are associated with self-efficacy among older women to influence sexual decision making that increased HIV and AIDS susceptibility. The study assumed that social communication systems had influence on women's sexual behaviour. The study recommended the communication within group networks to be improved to promote preventive attitudes and behaviour against HIV and AIDS infection reduction.

The continent of Africa has also had similar studies focusing on participatory communication. Mulwo (2008) details the case of the "Care and Compassion Movement in Zambia" which involved various faith-based and community leaders in promoting access and adherence to HIV and AIDS treatment, stigma reduction and community support for people living with HIV and AIDs. The programme demonstrates the actual application of community participation-based communication in meetings, seminars, HIV and AIDS workshops and informal dialogues to encourage adherence to safer sexual practices and de-stigmatisation of the AIDS pandemic among women and the youth.

According to Mulwo (2008), participation provided motivation to the PLWHAs to adhere to the ART treatment since it developed a sense of confidence that promoted

the adoption of the preventive attitude and behaviour. The creation of self-efficacy or confidence in the women is an idea within the social cognitive theory of Bandura which asserts the ability of women to take control of their destiny by adopting preventive attitudes and behaviour.

A similar participatory communication approach was also used in Ghana, through the *Stop AIDS Love Life Programme* which brought Christian and Muslim leaders together to raise the members' consciousness to fight HIV and AIDS through adoption of safer sexual practices (Mulwo, 2008). This programme attracted the Ghanaian mass media, which featured the religious leaders in a series of television spots with their followers as they modeled the behaviour of compassion and physical contact like hugging people with HIV and AIDS. The *Stop AIDS Love Life Programme* aimed at raising the awareness of HIV and AIDS as a common social enemy that required the involvement and participation of all members of the community (Mulwo, 2008). The major challenge of the programme was lack of well designed social structures within which the believers could enhance structured communication among themselves for independence in the intervention to be achieved. This is because the programme was initiated by the church leaders who conducted most aspects of the programme as opposed to full involvement of the concerned PLWHAs. The programme encouraged community drama, popular songs, peer education and community discussions to recruit and socialise members into various support groups where they were each assigned responsibilities in the prevention of HIV and AIDS (Mulwo, 2008).

Another study similar to Mulwo's analysis of the utilisation of community-level communication interventions in Ghana and Zambia is demonstrated by Coker (2005). Coker analysed the conversation of some HIV-positive Ghanaian women taking a television interview in Accra and found that in Ghana, just like in many African countries, the mention of HIV and AIDS signaled a high level of devastation for the infected population due to the inherent stigma associated with HIV status disclosure. The implication of the stigma was that the infected people who experience stigma do not share their concerns with other people for fear of seclusion and embarrassment. In this way they feel isolated and embark on casual and unprotected sex for social gratification and solace seeking.

Coker (2005) demonstrates that the high HIV and AIDS prevalence in Ghana was due to unprotected sexual practices of commercial sex workers from the eastern border with Ivory Coast. According to the study, the high rate of HIV and AIDS infection was due to the powerlessness of women to negotiate condom use in premarital and extramarital sexual relationships. The study sought to examine the motivations for the television interview of PLWHAs, given the risk of stigmatisation associated with such an attempt. The results showed that there was confidence in the HIV and AIDS victims to break away from stigmatisation since the victims indicated having contracted the disease through no fault of their own, which demonstrates a high self-efficacy gained through interpersonal discussions and several mass media exposure such as the radio and television within the community locality. Mobilisation would provide communication to the women in groups which foster their collective decision to change.

The study raised three major concerns: to raise the awareness about the rights of people living with HIV and AIDS; the need to encourage people living with HIV and AIDS to seek medical relief and counselling; and to bring relief to the families affected by the disease. Motivation, which is a key communication factor, was important in giving young women from low socio-economic class the confidence to speak up and solve problems of HIV and AIDS as a group (Coker 2005). The study, however, does not explain precisely the structure of the communication that was successful as well as the process of that communication that ended up in causing the motivation for status disclosure on television.

A study by Kohler, et al. (2005) also demonstrates the efficacy of interpersonal forms of communication in promoting preventive attitudes and behaviour change. The two scholars from the University of Pennsylvania analysed the importance of social interaction on the perception of the risk of AIDS and explored spousal communication about AIDS in rural Malawi. They operated with the study's assumptions that the severity of the HIV and AIDS epidemic in Africa is due to social and cultural barriers like absence of husbands for extended periods of time and the stigma associated with the sensitive topic of sexuality. The overall study results showed that social interactions have substantial effects on women's perceptions of HIV and AIDS risks. They concurred that social networking is essential in promoting attitude and behaviour change. They argue that the selection of social networks is also very important and it depends on marriage patterns, ethnic relationships, church groupings and business orientations. The study revealed that social networks are unifying factors especially when such social groups

were used to facilitate involvement in activities regarding HIV and AIDS as opposed to communicating at the women without their participation in the projects.

The study by Kohler, et al. (2005) relied on the social influence and social learning theories which focus on the social environment in addressing community problems. The two theories hold that a person's opinion, attitudes and behaviours are influenced by the prevailing social environment, which provides an explanation of how successful communication happens through role modeling. This study does not outline the structure of the social organisation with regard to communication as well as the roles played by members in the communication network. It does not also suggest the specific media to use in building such networks to ensure effective attitude and behaviour change to reduce the HIV and AIDS prevalence.

Other studies from Africa further demonstrate the usefulness of interpersonal communication. The study by Agadjanian and Menjivar (2008) employed the social capital perspective to examine the determinants and content of informal communication about AIDS among members of different denominations in Zimbabwe. The study detected that informal communication was more likely to occur in same gender networks, in more ideologically flexible and socially diverse congregations located in rural areas. The study also explored how informal communication is used to reconcile the other secular and church messages in HIV and AIDS communication, and found out that religion in Zimbabwe encouraged involvement in AIDS activities and discussions (Agadjanian & Manjivar, 2008).

The limitation of the study by Agadjanian and colleague is twofold. Firstly, the role models and religious leaders seem to dominate in the creation and relay of information at the expense of the women who need to be more involved in the process of communication to encourage change within their social groups. Secondly, the communication links among women in the community have not also been effectively defined in terms of specific structures like the case described by Rogers and Kincaid (1981).

The use of interpersonal communication to encourage participation is also demonstrated by Kalugendo and McLeod (2012). Their study analysed the role of community participation in development projects. The first of such cases is a community fire management project dubbed *Hifadhi Ardhi Shinyanga Initiative* (HASHI) in Miombo Woodlands in Tanzania. The project began as an environmental degradation remedy for man-made fires as agriculturalists cleared and burnt forests for cultivation while pastoralists burnt bushes for pasture re-generation. HASHI was a government initiative under the Ministry of Natural Resources which begun with a top-down communication approach through video demonstrations and community briefings to raise awareness or consciousness and mobilise local people to take action, but the initial approach failed to impact the villagers and mindsets were not changed (Kalugendo & McLeod, 2012).

After the failure, HASHI started to use indigenous knowledge called '*sukuma ngitili*' which means 'creating an enclosure' to engage people actively to manage fire in a way that they had done in the past to conserve forests. They enclosed and closed off an area near a village at the start of the season to preserve fodder and only opened it during the dry season to allow cattle to feed. This happened in the entire village and numerous

community meetings motivated the villagers and encouraged them to form environmental committees to formulate and enforce by-laws to protect the environment and establish land ownership, map and demarcate forests and protect them from fires. The HASHI project is a fine example of how bottom-up, 'listening-before-talking' approach, produced noticeable and sustained results.

The community's self-organising capacity was strengthened and social organisational structures within the community were established and reinforced thereby increasing people's confidence to continue reducing vulnerability to disasters through their own knowledge and efforts. The community members were able to own and replicate the techniques and sustain projects. The mobilisation used interpersonal discussions in a way that could encourage the entire village to address the AIDS scourge using their cultural knowledge and the power of collective action at the local community.

Kalugendo and McLeod (2012) also demonstrate how a community mobilised itself to build information resources through *Access to Information Initiative (ATI) Project* in rural Tanzania. The project had similarity with the HASHI project in the manner of community mobilisation and use of communication in social networks. The ATI project was initiated by the office of the Prime Minister in collaboration with UNDP and the Netherlands Development Organisation (NDO) to enable people access information on malaria, maternal health, water and sanitation and education in Uyui, Bunda, Morogoro and Bukoba rural areas. In Uyui, the activities included improving and renovating dilapidated information centers, collecting data on prevalence of malaria, how villagers received information on their basic rights and conducting awareness and

advocacy meetings. The team targeted health facilities and primary schools to strengthen their capacity as information sources in the community.

The aim of ATI project was to improve access of information to the whole community. In Bunda village, the emphasis was on establishing and equipping information centers and translating information so as to be understood by the entire community in their own language. The programme included promotion of community dialogue related to maternal health through village discussions, construction of labor wards, rehabilitation of dispensaries and purchasing of essential equipment. The goal of the Morogoro initiative was to promote gender equality and equity in education, monitoring of education funds and developing communication tools that ensured the villagers had information. It encouraged cooperation between the local community and journalists who generated powerful articles and media discussions on the thematic concerns of the community. They used community media where citizens voiced their concerns. In the rural parts of Bukoba District, the ATI project encouraged the formation of information networks. The local media helped to bridge the gap between community and government agents and enabled the community members to discuss and take collective action. This enabled them to build community information centers where media resources were kept. They also established village water funds to sustain their financial needs. The major lesson learnt from this project is that the best way to communicate with a community is through the community itself, which elicits utilisation of local media, local resources, collective action and ownership of ideas or projects.

In Kenya, Kohler, et al. (2002) conducted a study to investigate the influence of communication networks on individual risk perception of HIV and AIDS infection and

the favoured protective behaviour in South Nyanza District. Their study indicated that individualistic approaches such as informational, educational and behaviour change dominated the HIV and AIDS behaviour change in the country and that these models fail to fit completely into the cultures and societies of sub-Saharan Africa. The two scholars also recommended that aspects of community and social environment have to be considered in the HIV and AIDS interventions. For instance, the social networks are important since they provide a person with opportunities for health-related communication and interpersonal influence necessary for attitudes and behaviour change to control the prevalence. What is not clear; however, are the structural and process aspects of the networks communication. The findings also indicate that perceived risks and preferred methods of protection depended on the prevailing perception and favoured protection methods within interpersonal communication networks, and that women's perception of risks are shaped by strong relationships and cohesive network structures. This argument fits well within the convergence model of communication which places premium on the social environment of a person as instrument in attitude and behaviour change.

2.4.2 Interpersonal Communication and Women Empowerment

One of the critical factors for the success of interventions or community development is through both economic and informational empowerment of women. Rogers and Kincaid (1981) demonstrate that Korean women's projects that succeeded in achieving family planning and economic sustainability objectives were conceived on the value of empowerment. Rogers and Kincaid indicate that the Mothers' Club was formed by some village mothers initially for their small economic empowerment through

contributions from the network members and support from the NGOs and government in their locality.

According to Rogers and Kincaid, the Mothers' Club Projects were successful because of the assistance of an enlightened member-cum-leader, Mrs. Chan, who had information which empowered other women to initiated two simultaneous projects: economic and family planning, through social networking, participation and social change processes. The mothers, assisted by the chief's wife, raised the consciousness of each other thereby forming small groups with networks to pass information about the club secretly in the Korea's male dominated society. Despite the challenges faced like the resistance of their husbands, apathy of some mothers, conservative cultural beliefs and club's management problems, the Mothers' Club surmounted all these to become the most enviable project that developed through convergence and interpersonal network-based communication.

Another aspect of empowerment which has also proven significant to communication for behaviour change is the cultural empowerment. In this kind, one's culture is used as the basis for an intervention. Basu and Dutta (2008) indicate that the culture of a people when responsibly used as the dominant ideology upon which change-based communication is hinged can be extremely effective. This argument is also echoed by Campbell (2003). According to Basu and Dutta, commercial sex workers in India participated in creating and sustaining the HIV and AIDS communication practices within their culture, which empowered them to interact with their everyday living contexts to resist foreign strategies that their sub-culture cannot support in terms of ideological indistinctiveness. They indicated that interventions based on formations that

emerge organically from within members involved in commercial sex work are important in promoting change in a manner better than external influence. Their study demonstrates that marginalised communities are not devoid of agency and that the communication process within the actual target group leads to success as opposed to communication which comes from outside. The study makes a strong case for the use of local resource and reliance on local media to distribute indigenous knowledge on AIDS to boost knowledge of women, resulting in attitude and behaviour change (Basu & Dutta, 2008).

A study by Mulwo (2008) also indicates that people can regain their consciousness when empowered by mass media. In the case of the *Care and Compassion Movement* in Zambia many people learned how to deal with stigma upon seeing religious leaders supporting PLWHAs on television. The religious leaders also trained followers in meetings, seminars, HIV and AIDS workshops and informal dialogues which motivated the infected persons to adhere to ART treatment since it developed a sense of self efficacy in them. They also emphasised peer education programmes in addressing HIV and AIDS which empowered the women with knowledge to share with other community members (UNAIDS 2008; Mulwo, 2008). Most women also got enrolled into choirs, community dramas and support groups which empowered them to be independent.

The study by Agadjanian and Menjivar (2008) asserts that social formations or groups that occur due to sharing of common bonds such as business, ethnicity and socio-cultural ideologies motivate women to engage more in primitive discussions that promote learning and behaviour change. For instance, the study revealed that most of the discussions happening in such groups are on women's worries, seeking for more

knowledge and dissecting the causes of diseases and deaths in the community which are instrumental in promoting attitudes and preventive behaviour.

The fact that community empowerment can be effective in promoting attitudes and behaviour change with regard to HIV and AIDS reduction is also demonstrated by the *Bridge Project* in Malawi (Karim, 2005). The aim of the project was to persuade people to take preventive action against HIV and AIDS by raising people's consciousness. It also encouraged the local community to find the indigenous ways of dealing with AIDS through coining phrases which increased the community's perception of risk and empowered them to take control of their lives. Members of the community were persuaded using group dialogue and social exchange processes. After building consciousness in them, social networks began to form which developed collective capacity of the entire community. These groups then designed campaign messages to enhance the self-efficacy of all members by promoting small, manageable steps that people could take to remain free of HIV. The campaign slogan '*Nditha*' meaning, "I can!" in Chiwewa language helped to push the campaign agenda forward, making the fight against HIV and AIDS to be by the people and for the rural people of Malawi (Karim, 2005).

Another study which is important in explaining the power of empowerment of people at risk was done by Keene (2001). The study sought to investigate the strategies of stopping the spread of HIV and AIDS among sub-Saharan women using comparative cases from Uganda and Botswana. The study examined the strategies that worked and those that did not work in curbing the spread of HIV in the two countries in the Sub-Saharan Africa. The study was based on the assumption that the two countries had

obvious differences due to communication strategies employed, the position of women in the society, political history of the countries, traditional culture and the concept of HIV and AIDS in the two states (UNAIDS 1999).

Keene's study results advanced a case for empowering the women as the hope of decreasing the HIV and AIDS infection in Sub-Saharan Africa. It was noted that vibrant women groups in Uganda had seen the rate of HIV infection drop drastically, contrary to Botswana where the rate of infection among women remained high due to the repression of women in work places, in political organisations and at home. According to Keene (2001), the major factor leading to the vulnerability of women to HIV and AIDS was the socio-economic factor; and that empowering women meant improving their socio-economic statuses to reduce their vulnerability. From this study, it would be interesting to find out the precise forms of communication which empowered and raised the consciousness of women in Uganda to adopt preventive sexual practices.

Singhal and Rogers (1999) also contribute significantly to the debate on the effectiveness of empowerment in reducing the HIV and AIDS prevalence among women at high risk in Africa. In their study of the efficacy of the *Soul City Project* in South Africa, they demonstrate how multimedia approaches are important in beginning and sustaining discussions about AIDS among the population. According to the two scholars, the most significant role of the mainstream mass media (television, radio, newspapers) is to serve as a catalyst to bring attention or consciousness of people to the HIV and AIDS issues. Thereafter, the forms and strategies of interpersonal communication are used to continue the discussions on the HIV and AIDS issues, which ultimately leads to attitude and behaviour change.

According to Singhal and Rogers, the *Soul the City Project* is an example of a unique communication for social change which represents a series of integrated, ongoing mass media and interpersonal communication activities. The *Soul City* involves a 13-part television drama series promoting a health (HIV and AIDS) issue, followed by a 60 episode radio drama broadcasting in all South African vernacular languages on the same issue from the previous television episodes. This is then followed by the production of free-of-cost education booklets designed around the popularity of television characters, and then the serialisation of the stories by the newspapers. The value of this mixed media lies in its appeal to different segments of the audiences for change to occur in the entire social system (Singhal and Rogers, 1999).

From Singhal and Rogers' study, the *Soul City Project* recognised that overt behaviour change occurs when members of a community talk with each other after the mass media episodes have given them initial awareness. This implies that only close interpersonal relationships and discussions within social networks can advance attitude and behaviour change. From the study, each year after television and radio broadcast, several activities are implemented to keep people talking about the AIDS issue, and these activities include the Soul City Search for the Star (which recruits talents for subsequent radio and TV series), the Soul City Health Worker of the year (to recognise an outstanding outreach worker) and Soul Citizens (recognising the youth who actively engage in community development). The activities aim at developing role models that advance the fight against AIDS. Together with highlighting characters of the drama series, these provide avenues for audiences to learn from behaviours of the role model that are rewarded.

Another demonstration of communication for empowerment in action is the case of South Africa's *Summertown Project*. The project is a success story in stemming HIV and AIDS among the mineworkers and sex workers in Summertown Province in South Africa. According to Campbell (2003), the project was introduced in the province because in spite of the mining officials' efforts to reduce STIs and AIDS among workers through health education, the effect of the education was very minimal. This led to the introduction of a participatory approach to help build collaborative efforts of the local community, mine and sex workers, the concerned NGOs and civil society in the intervention process to reduce the HIV and AIDS prevalence rate.

The *Summertown Project* took close to a decade beginning with the mining industry starting to educate their workers on the effect of AIDS before and after the collapse of the apartheid regime (Campbell, 2003). This education was top-down and associated with individual change, not taking into account the social construction of sexuality among mine workers and sex workers, let alone their knowledge of HIV and AIDS and consequences of their action. The *Summertown Project* observed that effective education should be based on the social construction of sexual behaviour and values of the individual workers in social networks based on friendship, race, ethnicity, religion and sub-cultures (Campbell, 2003; Rogers & Kincaid 1981; Singhal & Rogers, 2003).

The *Summertown Project* then came up with different views of AIDS from workers, which mainly indicated that the educational approach was not effective, and that this was because the bottom-up approach to communication was lacking as the missing link (Campbell, 2003). This bottom-up approach to communication could encourage mine workers and sex workers to be involved in designing and implementing

programmes concerning HIV and AIDS. The project later included the alliance of management, trade unions, academicians and representatives of provincial and national health officials to the team (Campbell, 2003). The project aimed at the entire country, not only at miners and sex workers, but also at women, men and youth. The project aimed at getting people to perceive AIDS as a problem for the entire community and each individual had to participate in the efforts to reduce its prevalence. This led to the formation of peer educators who were provided with training to communicate relevant information about AIDS while a lot of community based organisations also became interested in the process of the intervention (Campbell, 2003).

Another important study which demonstrates the value of women empowerment in the fight against HIV and AIDS is by Joram (2010). The study on the effectiveness of interpersonal communication for HIV and AIDS positive persons in Tanzania was conducted in Iringa region and demonstrates how poor women used the power of interpersonal influence to encourage the HIV and AIDS testing among womenfolk, promote medical attention to service providers, promote attention of the infected persons to seek medical help, adhere to dietary support and to encourage counseling to develop positive life attitudes in the face of the HIV infection.

Joram's study reveal that there was success in adherence in the majority of cases, and this success was attributed to the forms of interpersonal communication which empowered the women. For instance, it was due to the caring interpersonal communication of para-professionals living in the community such as the village nurse who could overcome the fear of stigma by personal concern. There was also the use of consciousness raising support groups and interpersonal communication was within

organised networks of HIV and AIDS positive persons who linked regional, national and international health service providers with infected persons in remote villages, and the use of indigenous forms of folk media produced by HIV and AIDS community. In communities with low rates of adherence, it was found that political and religious leaders tended to discourage such interpersonal networks of HIV positive persons, which is one of the challenges of convergence communication among women in informal networks in the male dominated and culturally sensitive societies (Rogers & Kincaid, 1981).

Kalugendo and McLeod (2012) demonstrate the effectiveness of bottom-up communication in empowering the community members in Tanzania to have awareness or consciousness and mobilise local people to deal with fires that affect them, using indigenous knowledge. The government was willing to listen to villagers, identify and use local knowledge, understand the gaps that existed and then empower the villagers with new skills. The community's self-organising capacity was strengthened and social organisational structures within the community were established and reinforced thereby increasing people's confidence (social efficacy) to continue reducing vulnerability to disasters through their own lay knowledge and efforts. The community members were able to own and replicate the technique and sustain projects (Kalugendo, 2012).

There was also an element of community empowerment in the Access to Information Initiative (Kalugendo & McLeod, 2012). The aim of ATI project was to improve access of information to the whole community. In Bunda village, the emphasis was on establishing and equipping information centers and translating information so as to be understood by the entire community in their language. This was an excellent example of women empowerment in action.

The application of interpersonal communication in informal networks has also been demonstrated in Uganda. As mentioned earlier, the rate of HIV infection was higher in Uganda than Kenya about a decade ago (UNAIDS 2009), the situation which has now been reversed. In Uganda the FAO-Dimitra Project in 2005 has proven effective in transforming the attitudes of the rural women for both socio-economic improvement and increased HIV awareness and behavior change (FAO-Dimitra, 2005). The project implemented by the Gender and Population Division of the Food and Agricultural Organisation (FAO) was aimed at empowering the rural population by building their capacity and facilitating access to information, through local partnership where the women through their associations and grassroots organisations made their voices heard. The stakeholders integrated the modern and traditional means of communication, where women in networks shared their experiences and ideas through both informal dialogue and the multi-media campaigns. An important campaign that is hailed as successful is the '*strengthening rural women network with regards to information and communication, and combating HIV and AIDS in rural areas* through the integration of HIV and AIDS modules with all agricultural training activities. This was effective, especially through the integration of the rural radios with rural women networks (FAO-Dimitri, 2005).

2.4.3 Interpersonal Communication, Social Consciousness and Efficacy in Women

As previously demonstrated, the past approaches to communication for behaviour change were based on the assumption that people from low socio-economic statuses must be given effective communication, as opposed to their own forms of communication. However, with the development of the social paradigm, many scholars have proposed the self-initiated forms of communication as very central in the process of changing attitudes

and behaviours. Govender (2010) indicates that people only need their consciousness to be stimulated for them to act since they have local resources at their disposal. She indicates that when a community's social perception is activated, members realise their collective potential in solving their problems, and interpersonal communication is instrumental in this process.

The study of older American women by Tessler et al, (2006) is an important contribution to the assertion of the power of interpersonal communication in increasing consciousness which influences attitude and behaviour change. The scholars analysed older women's attitudes, behaviour and communication about sex and HIV in the United States of America where the rate of HIV infection was high through heterosexual intercourse. This was because the social organisations where older women were enrolled for support promoted the adoption of urban lifestyles and competition which encouraged discussions on sexuality. The study aimed at measuring sexual attitudes, beliefs, and behaviour and women's interpersonal conversations about AIDS in order to develop effective communication intervention to address the high prevalence. The study found that very little attention was paid to concerns of sexuality and communication about sexuality between the older women and their physicians or caretakers, leading to a failure in communicating with women.

The investigators realised that the potential for success was on the use of their interpersonal relationship as the basis for successful communication in their social contexts. The study suggested that older women's dialogue with their colleagues should be reinforced to extend to their physicians, their partners and other groups in order to stimulate their consciousness. The study suggested the use of the social construction of

the environmental circumstances of the women and of culture that would facilitate action to avoid extra-marital sex. The study indicates that the doctor-patient communication was ineffective, and that forms of interpersonal communication in groups were instrumental in promoting consciousness necessary for preventive behavioural action.

According to Mulwo (2008), the *Care and Compassion Movement* in Zambia which involved various faith-based and community leaders in promoting access and adherence to HIV and AIDS treatment, stigma reduction and community support for people living with HIV, was important in building required social efficacy for behaviour change. In the *Stop AIDS Love Life Programme* Christian and Muslim leaders came together despite religious differences to raise the social consciousness of the congregants to fight HIV and AIDS prevalence in religious cycles (Mulwo, 2008). The mass media were involved to dispatch information to a wide population. The Programme's aim was to raise the social efficacy of Ghanaians to re-define HIV and AIDS as a common social enemy through their socio-cultural processes (Mulwo, 2008). The study also demonstrates how community media stimulate discussions around the benefits of behaviour change. They also encourage activities that keep women and girls away from casual and unprotected sexual behaviour. Popular songs and music raise consciousness of the community members. For instance, popular musicians in the country would volunteer their talent as their contribution to the fight against HIV and AIDS like songs by *the Ghana All-Stars against AIDS* which promoted testing and enrolment in anti-retroviral therapies for those who were eligible.

Coker (2005) demonstrates how the conversation of some HIV positive Ghanaian women taking a television interview in Accra was influential in stimulating women to take HIV test. It indicates the enthusiasm with which Ghanaian women reduced stigma associated with the disclosure of HIV status. The study by Coker sought to examine the motivation for the television interview of PLWHAs, given the risk of stigmatisation associated with such an attempt. The results showed that there was confidence in the HIV and AIDS victims to break away from stigmatisation since the victims indicated having contracted the disease through no fault of their own. In conclusion, the study indicated that the HIV and AIDS patients in the last decade have the social efficacy necessary for status disclosure through interpersonal communication and several media such as the radio and television. Coker (2005) noted that the women who were courageous had engaged in several informal discussions in the villages, and such interpersonal conversations over time had culminated into confidence since interpersonal counseling had been conducted with the infected women on television interviews.

Similar demonstration of the role of the social consciousness raising process in promoting attitude and behaviour change can be seen in Karim's analysis of the Bridge Project (Karim, 2005). The aim of the project was to persuade people to take preventive action against HIV and AIDS through encouraging them to realise how AIDS was hindering their development. It also encouraged the local community to find its indigenous ways of dealing with AIDS through coining phrases which increased the community's perception of risk, which improved an individual's self-efficacy and empowered them to take control of their lives. It involved group dialogue and social exchange processes. After building consciousness in the members of the entire

community, social networks began to form which developed collective capacity (social efficacy) to widen interpersonal relations among members (Karim, 2005).

Another demonstration of the social consciousness raising process using interpersonal communication is the case of *Summertown Project* in South Africa. The project observed that effective communication should be based on the social construction of sexual behaviour and values of the individual workers in social networks. The *Summertown Project* rallied for the bottom-up approach to communication which encouraged mine workers and sex workers to be involved in designing and implementing programmes concerning HIV and AIDS. The project aimed at getting people to perceive AIDS as a problem for the entire community and each individual had to participate in the efforts to reduce its prevalence. This led to the formation of peer educators who were provided with training to communicate relevant information about AIDS while a lot of community based organisations also became interested in the process of the intervention (Campbell, 2003).

Another important study which demonstrates the value of social consciousness building using forms of interpersonal communication is by Joram (2010) on the effectiveness of interpersonal communication for HIV and AIDS positive persons in Tanzania. The study conducted in Iringa region in rural Tanzania, demonstrates how poor women utilised the power of interpersonal influence to encourage the HIV and AIDS testing among womenfolk, promote medical attention to service providers, promote attention of the infected persons to seek medical help, adhere to dietary support and to encourage counseling to develop positive life attitudes in the face of infections.

Joram's findings reveal that successful adherence was attributed to forms of interpersonal communication which created the stimulation for the preventive behaviours. For instance, it was due to the caring interpersonal communication of para-professionals living in the community such as a village nurse who could overcome the fear of stigma by personal concern. There was also the use of consciousness raising groups comprising of women within organised networks of HIV and AIDS positive persons.

The use of interpersonal communication to promote social consciousness for actions is also dominant in Kalugendo and McLeod (2012). The HASHI project is a perfect example of how local creativity can be made as the baseline for starting much complex projects. HASHI was a government initiative under the Ministry of Natural Resources which begun with top-down communication through video demonstration and community briefings to raise awareness or consciousness and mobilise local people to take action (Kalugendo & McLeod, 2012).

The aim of ATI project was to improve access of information to the whole community. In Bunda village, the emphasis was on establishing and equipping information centers and translating information so as to be understood by the entire community in their language. This implies the practical application of the social construction dimension of the convergence theory in the ATI intervention. The programme included promotion of community dialogue related to maternal health through village discussions, construction of labour wards, rehabilitation of dispensaries and purchasing of essential equipment. They used community media where citizens voiced their concerns.

Singhal and Rogers (1999) also contribute significantly to the debate on the effectiveness of the *Soul City Project* in beginning and sustaining discussions about HIV and AIDS behaviour change among the youth population in South Africa. According to the two scholars, the significant role of the mainstream mass media (television, radio, newspapers) is to serve as a catalyst to bring attention or consciousness of people to the HIV and AIDS issue. Thereafter, forms of interpersonal communication are used to continue the discussions on the AIDS issue, which ultimately leads to attitude and behaviour change.

From Singhal and Rogers' study, the *Soul City Project* recognised that overt behaviour change occurs when members of a community talk with each other after the mass media episodes have given them initial awareness. This implies that only close interpersonal relationships and discussions within social networks can advance attitude and behaviour change. From the study, each year after television and radio broadcast, several activities are implemented to keep people talking about the AIDS issue, and these activities include the Soul City Search for the Star (which recruits talents for subsequent radio and TV series), the Soul City Health Worker of the year (to recognise an outstanding outreach worker) and Soul Citizens (recognizing the youth who actively engage in community development). The activities aim at developing role models that advance the fight against AIDS.

The social construction of meaning and values study by Ndati (2012) is also important in explaining attitude and behaviour change among women. According to Ndati, group discussions in schools, the peer influence and informal dialogue between students and counselors, discussions of AIDS in school clubs, with relatives, friends and

partners were at the heart of influencing behaviour change among students. Ndati noted in his findings that behaviour change is not the decision of an individual student alone, but a collective decision of the entire group with whom a student is associated.

2.4.4 Interpersonal Communication and Social Learning among Women

Social role models have been touted as the most effective conveyors of messages for behaviour change the world over. The concept which is drawn from Albert Bandura's Social Cognitive theory shows that most of the behaviour people exhibit is learned from the environment. According to this perspective, people learn behaviour which are rewarded and shun practices which are punished (Bandura, 1986). In the present application, social role models are considered to be influential since most of them practice certain behaviour that some societies approve and many people are encouraged to emulate such practices. Health messages are often transmitted by the mass media and local personalities with a mass following in the society. Such personalities include artists, musicians, leaders and religious persons who are believed to be important in the decisional process of people. Many studies have shown the value of social models in attitudes and behaviour formations.

The first demonstration is in analysis of the role of social models in social change in Korean women by Rogers and Kincaid (1981). In the success of the Mothers' Club Development and Family Planning projects in Oryu Li Village in Korea, some women who were influential like Mrs. Chan mobilised other mothers to form small economic empowerment units and to incorporate family planning. This happened easily because Mrs. Chan was the Chief's wife hence very influential in social life of community

members. She also had higher education, apart from the fact that she had her respect from the entire community by virtue of the responsibility she held in the non-state sectors. It is worth mentioning that role modeling by the enlightened mothers in the village enabled the Oryu Li women to learn and to be empowered to move on with their projects amidst resistance from the men.

Pallikadavath, et al. (2006) also reveal that sources of information about HIV and AIDS have a greater influence in promoting change from risky sexual behaviours among women. This especially happens through message sources who people consider to be credible and influential in their social lives. This confirms the argument of persuasive communication scholars like McQuail (2005) and Tan (1985) of the power of interpersonal influence in attitudes and behaviour change processes.

Another study that asserts the value of role models in influencing attitudes and behaviour change was conducted in Jamaica by Muturi (2008) from the Kansas State University. Muturi examined the contribution of faith-based organisations (FBOs) in addressing the HIV and AIDS epidemic. The study used the social influence theory, which posits that opinion leaders such as priests and church elders have great influence on decisions of congregants to change their behaviours. Muturi (2008) demonstrated that religion plays a major role in Jamaican culture and that religious leaders have the potential to address HIV and AIDS in communities. The study established that religious leaders develop programmes which provide social, psychological and physical support in collaboration with health organisations to initiate educational services and programmes that impact understanding and motivate attitude and behavioural change among women.

The study by Muturi (2008) found that religious leaders used culturally appropriate communication strategies. For instance, leaders talked openly about AIDS; encouraged open forums to discuss AIDS matters; used the pulpit to talk about AIDS-related topics; they developed and distributed the Sunday bulletins; participated in forming networks of community of believers and outreach workers; segmented the audience by age and gender to discuss different topics on Christianity and HIV and AIDS; introduced interactive learning sessions where audiences taught themselves; offered interpersonal counseling on sexuality and AIDS; organised health fairs where members exchanged their milestones, challenges and lessons in collaboration with PLWHAs and experts; organised workshops and seminars which address various topics with para-professionals taking the lead and they also formed small groups to deal with stigma and improve effective learning with PLWHAs (Muturi, 2008). All these activities made them role models for many religious believers who were easily influenced.

Another major study which demonstrates the efficacy of social role modeling is by Kohler, et al. (2005) from the University of Pennsylvania. The two scholars analysed the importance of social interactions in the perception of the risk of AIDS and explored spousal communication about AIDS in rural Malawi. The overall study results showed that social interactions have substantial effects on women's perception of HIV and AIDS risks. The study also showed that people learn through informal discussions about the death of friends, relatives and neighbors and that during such conversations members of a social network contribute to the diagnosis of the cause of death through fragments of their local knowledge and mould their behaviours to that of a known model who is seen as responsible to evade the dangerous behaviours.

The study by Kohler et al. (2005) relied on the social influence and social learning theories which focus on the role modeling and self-efficacy of people at risk to adopt preventive behaviours. The social influence and social learning theories both hold that a person's opinion, attitudes and behaviours are influenced by the prevailing social environment through role modeling.

Karim (2005) investigated the effectiveness of interpersonal communication in the *Bridge Project* in Malawi and found out that role models such as community health workers were very instrumental in mediating mass media messages with the lay people who made it possible for attitude and behaviour change to be effectively implemented among the persons at risk of HIV and AIDS in Malawi.

Similar findings are also attributed to the *Summertown Project* which used the various representatives of workers and sections of sex workers to distribute the preventive messages. This was important in breaking the monotony of the top-down approach which was being used despite ineffectiveness (Campbell, 2003). The role models in this project comprised of the peer educators, representatives of the government, health practitioners, representatives of the workers' unions and the representatives of the sex workers in the province who provided information to the general population about AIDS while a lot of community based organisations also became interested in the process of the intervention (Campbell, 2003).

The study by Joram (2010) on the effectiveness of interpersonal communication for HIV and AIDS positive persons in Tanzania also chronicles the power of the social models to promote attitudes and behaviour change. Joram's findings reveal that the success achieved by the programme was attributed to the caring interpersonal

communication of para-professionals living in the community such as a village nurse who could overcome the fear of stigma to lead the development of consciousness raising groups in the community using indigenous forms of folk media to advance the fight against HIV and AIDS.

Singhal and Rogers (1999) also demonstrate the use of role models in the *Soul City project* in South Africa when they reveal that the mass media communication was augmented by the models that were being recruited as personalities behind message transfer. For instance, each year after television and radio broadcast, several activities are implemented to keep people talking about the AIDS issue, and these activities include the Soul City Search for the Star (which recruits talents for subsequent radio and TV series), the Soul City Health Worker of the year (to recognise an outstanding outreach worker) and Soul Citizens (recognising the youth who actively engage in community development). The activities aim at developing role models that advance the fight against AIDS. Together with highlighting characters of the drama series, these provide avenues for audiences to learn from behaviours of the role model that are rewarded.

2.4.5 Local Forms of Communication and HIV and AIDS Preventive Behaviour

An effective communication approach is one which relies on local creativity of the target group (Morris, 2003). Many studies reviewed show that most forms and strategies of communication for women were developed without relying on their lay knowledge and creativity, and as such they were developed by the external organisations (Govender, 2010). This was based on the assumption that these communication strategies had successfully worked in other environments. Studies have also shown that each

section of the community is not devoid of their own creative means out of the problems. This is why the new paradigm recommends appropriate communication which is localised to the target groups.

Pallikadavath, et al. (2006), reveal the limitations of mass media communication on the society such as loss of culture of people and loss of the creativity of society. It is also noted that over-reliance on the new media such as the internet, mobile phone and social media leads to negative technological influence which is associated with dependency. The findings also show that the electronic and print media were unaffordable among most women in rural India making them inappropriate means of communication with the rural women. The study recommended the use of community-level communication activities by villagers and NGOs to benefit the marginalised and under-served groups who might not make full use of the existing health service infrastructure let alone enjoy the full range of information. Also, there was need to design interventions that make use of the existing social resources since they have the promise of effectiveness in the dissemination of the HIV and AIDS awareness and change-based messages.

The finding of Pallikadavath (2006) that local forms of communication are effective is reinforced by the results from Basu and Dutta (2008) who realised that cultural forms of communication are very effective in reducing risky sexual practices. Govender (2010) indicates a paradigm shift in the use of communication from mass media to the interpersonal approaches. Basu and Dutta realised that participatory culture-centered HIV and AIDS communication among commercial sex workers in India was effective. The two scholars investigated how the commercial sex workers in India

participated in creating and sustaining the HIV and AIDS communication practices and how sex workers interact with their everyday living contexts to resist and reframe the linear strategies imposed on them by external health agencies.

Basu and Dutta (2008) investigated how participatory formations that emerge organically from within members involved in commercial sex work challenge the commonly held notions of how participatory health communication models in marginalized spaces are and ought to be practiced. Their study observed that marginalized communities are not devoid of agency and that the communication process within the actual target group leads to success as opposed to communication which comes from outside through government and other agencies. The study makes a strong case for culture-centered communication which involves collective dialogue, local group participation, interpersonal communication within cultural networks with shared social values, utilization of local resources, mutual and common interpretation of the meaning of AIDS, and reliance on local media to distribute indigenous knowledge on AIDS (Basu & Dutta, 2008).

The study of attitudes, behaviour and communication among older American women regarding sex and AIDS by Tessler et al. (2006) is an important contribution to the power of localised communication initiative in influencing attitude and behaviour change. The study showed that most of the communication with women relied on doctor-patient and mass media communication concerning their health. There are also situations of stigmatised informal conversations especially between counselors and their clients. The study showed that a successful communication strategy relies on interpersonal relationship within social contexts which are rampant in populations with low literacy

like the rural women. The study suggests that older women's dialogue with their colleagues should be reinforced to extend to their physicians, their partners and other groups in order to make such communication effective in promoting attitude and behaviour change.

The study by Mulwo (2008) also brings to the surface the importance of localised forms of communication in promoting attitudes and behaviour change. According to Mulwo, most interpersonal communication in meetings, seminars, HIV and AIDS workshops and informal dialogues happen in the community using local resources. They are instrumental in creating awareness and promoting attitudes and behaviour change to encourage adherence to safer sexual practices and de-stigmatisation of AIDS among women and the youth at high risk.

In Ghana, the *Stop AIDS Love Life Programme* by Christian and Muslim leaders was a local initiative away from the dominant mass media which mobilised local social consciousness of the congregants to fight the HIV and AIDS prevalence in their capacity as village or local citizens in the creation of solutions to the problem (Mulwo, 2008). After the interpersonal discussions, the Ghanaian mass media got interested and featured the religious leaders in a series of television spots with their followers as they modeled the behaviour of compassion and physical contact like hugging people with HIV and AIDS. It is worth mentioning that the mass media came after the local means had been exhausted. It has also been seen that even in the wake of mass media, interpersonal communication forms the avenue for discussion of the issues in details. Social efficacy is also built around cultural communication which is particular for the population.

Mulwo also demonstrates how community has also been used to stimulate discussions around the benefits of behaviour change, to expose myths and misconceptions about AIDS, and to encourage eligible persons to make use of services. In Zambia, community drama groups not only acted out comedy and compelling stories, but they also facilitated group discussions among community members following the drama. These community acts were organised among church groups or groups of elders. They subtly passed information regarding how to manage HIV and AIDS among the infected. The peer education programmes rely on the local personnel to deliver information to the local people. Popular songs and music are also used, which raise consciousness of the community members. Popular musicians in the country often volunteer their talent free of charge as their contribution in the fight against HIV and AIDS, such as happened in Ghana for the song *the Ghana All-Stars Against AIDS.* These songs and music have the advantage of reaching many people; often the most vulnerable segment of the society. Moreover, these songs often become 'hits' that local radio and television stations play free of charge because they attract wide attention from audiences.

The study by Agadjanian and Menjivar (2008) encourages the use of religious groups as cultural entities to initiate activities and discussions about AIDS in the church groups which eventually spread to the whole community. This is important in ensuring that preventive behaviour change information reaches a wider section of the community to reduce the HIV and AIDS prevalence among women.

The use of locally created communication in enhancing attitudes and behaviour change is also shown in Karim (2005). In the *Bridge Project*, people were informed of the dangers of HIV and AIDS to take preventive actions. The local forms of

communication also encouraged the local community to find its indigenous ways of dealing with AIDS through coining phrases which increased the community's perception of risk, which improved individuals' self-efficacy and empowered them to take control of their lives. The campaign slogan *Nditha* meaning, "I can!" in Chiwewa language helped to push the campaign agenda forward, making the fight against HIV and AIDS to be by the people and for the rural people of Malawi (Karim, 2005).

Joram (2010) also indicates the use of indigenous or folk media produced by HIV and AIDS positive groups as effective in promoting attitudes and behaviour change. In Kalugendo and McLeod (2012), the initiation of local projects such as HASHI and ATI in a rural Tanzanian province is important in providing local solutions to their problems. The local and indigenous knowledge called *sukuma ngitili* which means 'creating an enclosure' to engage people actively to manage fire in a way that they had done in the past to conserve the forests is an effective demonstration of the success of local initiatives. The community members were able to own and replicate the techniques and sustain projects that benefitted them. This was an application of convergence theory in action using interpersonal discussions in a way that encouraged the entire village to address the AIDS scourge using their cultural knowledge and the power of collective action at the local community.

2.4.6 Integrative Approach to Communication for Behaviour Change

One of the most effective communication approaches that have been applied in many HIV and AIDS interventions in the world is the multi-media approach which integrates the community, government and non-state agencies in developing

communication strategies that are important in promoting attitudes and behaviour change. Some of the studies reviewed indicate the centrality of using many different communication strategies that integrate mass media and interpersonal forms of communication with all stakeholders.

The study by Castaneda (2005) on HIV and AIDS risk behaviour among Mexican women working in Maquiladora has also proven important in demonstrating the effectiveness of an integrative method of communication for attitudes and behaviour change. The study shows that HIV and AIDS was high due to the fact that women were of young age, low income and low education levels and hence were exposed to both work related hazards and sexual harassment either directly or indirectly. The study found that HIV infections among the women were due to a more subtle and complex combination of their own behaviour and that of their male partners. The study recommended a comprehensive approach to education on the risk of unprotected sex and sensitivity to and on women working in Maquiladora towards understanding gender power differentials in heterosexual relationships. This was possible when dialogue was encouraged among women, between men and women and with the entire industrial establishment, rather than just providing them with education without their involvement in their matters. These discussions would be instrumental in encouraging behaviour change, women's understanding of their rights in sexual relationships, and men understanding the risks associated with unprotected sexual behaviour in workplaces.

Another study which demonstrates the efficacy of the integrative approach is by Kohler, et al. (2005). The two scholars analysed the importance of social interaction in the perception of the risk of AIDS and explored spousal communication about AIDS in

rural Malawi. They detected that the severity of the AIDS epidemic in Africa is due to social and cultural barriers like absence of husbands and the stigma associated with the sensitive topic of sexuality.

The overall study results showed that social interactions had substantial effects on women's perception of HIV and AIDS risks. They concurred that social networking was essential in communication for attitude and behaviour change. They found that effective attitudes and behaviour change occurred when all members of the community were engaged in the discussion. This was because the behaviour of the women alone was not the reason for the high infection rate but also the behaviour of men in the place of work and husbands. The study also showed that engaging the family, church, school and all social places using a mixture of mass media and interpersonal forms of communication was appropriate since each played its own role in the intervention process that kept HIV and AIDS prevalence rates low.

The findings also revealed that women always had informal conversations among themselves about HIV and AIDS, family planning and family size. The study also showed that people learnt through informal discussions about the death of friends, relatives and neighbors and that during such conversations, members of a social network contribute to the diagnosis of the cause of death through fragments of their local knowledge. Men and women also collectively navigate by evaluating the sources of risk which is an important avenue for integrating all the stakeholders in the HIV and AIDS intervention at the community level.

Egesah and Ondiege's (2002) study found that men as opposed to women were promoting prostitution in Kisumu, Siaya and Bondo districts in Nyanza Province. The study identified the male clients from bars, nightclubs and lodges and conducted informal interviews with them. The results indicated that majority of the male clients were between 25 and 36 years who had maintained long or steady relationships with the female sex workers with whom they had consistent sexual intercourse. It was also revealed that most sexual engagements happened without the use of condoms because these men believed they had one female client at a time. The study concluded that there was need for structured communication using the information, education and communication strategies to promote condom use in the client-women sexual relationships. The study had an important conclusion that both men and women need to be equally targeted since it takes the two people to spread the HIV virus through unprotected sex.

Another study which demonstrates the value of integration is the Campbell's *Summertown Project* study (Campbell, 2003). The project is hailed as a success story in stemming HIV and AIDS among the mineworkers and sex workers in Summertown Province in South Africa. According to Campbell (2003), the project was introduced in the province because health education provided by the government was ineffective. This led to the introduction of a participatory approach to help build collaborative efforts of the local community, mine and sex workers, the concerned NGOs and civil society in the intervention process to reduce AIDS prevalence.

The *Summertown Project* then came up with different views of AIDS from sex workers, plantation managers, men in the locality, the government and non-state agencies to develop the bottom-up consultative approaches to communication which ensured that

each stakeholder group was given appropriate communication concerning HIV and AIDS behaviour change (Campbell, 2003). This bottom-up approach to communication could encourage mine workers and sex workers to be involved in designing and implementing programmes concerning HIV and AIDS. The project later included the alliance of management, trade unions, academicians and representatives of provincial and national health officials to the team also including all important people from all parts of the country (Campbell, 2003). The project aimed at the entire country, not only at miners and sex workers, but also at women, men and youth. The project aimed at getting people to perceive AIDS as a problem for the entire community and each individual had to participate in the efforts to reduce its prevalence. This led to the formation of peer educators who were provided with training to communicate relevant information about AIDS while a lot of community-based organisations also became interested in the process of the intervention (Campbell, 2003).

Most of the successful communication projects have been introduced through the integration of various stakeholders. Kalugendo and McLeod (2012) demonstrate the effectiveness of bottom-up communication approaches in Tanzania especially in HASHI project which included agriculturalists, pastoralists, the community leaders, religious leaders, the representatives of provincial administration and environmental experts. It also demonstrates the use of participatory approach in enhancing success of the community projects.

The HASHI project was initially a government initiative under the Ministry of Natural Resources which later accommodated the views of the community leading to its success through local action. This happened in the entire village and numerous

community meetings motivated the villagers and encouraged them to form environmental committees to formulate and enforce by-laws to protect the environment and establish land ownership, map and demarcate forests and protect them from fires. The government was willing to listen to villagers, identify and use local knowledge, understand the gaps that existed and then empower the villagers with new skills. The community's self-organizing capacity was strengthened and social organisational structures within the community were established and reinforced thereby increasing people's confidence to continue reducing vulnerability to disasters through their own knowledge and efforts.

The community members were able to own and replicate the techniques and sustain projects. When HIV and AIDS is perceived as a community concern such as the fire management example given, the entire community can engage in collective interpersonal dialogue which shapes attitudes and beliefs, which ultimately lead to change in casual and unprotected sexual behaviour.

Kalugendo and McLeod (2012) also demonstrate another effective utilisation of integrative communication in the *Access to Information Initiative* (ATI) Project in rural Tanzania. The ATI project was initiated by the office of the Prime Minister in collaboration with UNDP and the Netherlands Development Organisation (NDO) to enable people access information on malaria, maternal health, water and sanitation and education in Uyui, Bunda, Morogoro and Bukoba rural areas in Tanzania. In Uyui, the activities included improving and renovating dilapidated information centers, collecting data on prevalence of malaria, how villagers received information on their basic rights and conducting awareness and advocacy meetings.

The aim of ATI project was to improve access of information to the whole community. In Bunda village, the emphasis was on establishing and equipping information centers and translating information so as to be understood by the entire community. The programme included the promotion of community dialogue related to maternal health through village discussions, construction of labor wards, rehabilitation of dispensaries and purchasing of essential equipment. The goal of the Morogoro initiative was to promote gender equality and equity in education, monitoring of education funds and the development of communication tools that ensured the villagers had all the needed information. It encouraged cooperation between the local community and journalists who generated powerful articles and media discussions on the thematic concerns of the community. They used community media where citizens voiced their concerns.

In rural parts of Bukoba District, the ATI project encouraged the formation of information networks. The local media helped to bridge the gap between community and government agents and enabled the community members to discuss and take collective action. This enabled them to build community information centers where media resources were kept. They also established village water funds to sustain their financial needs. The major lesson learnt from this project is that the best way to communicate with a community is through the community itself, which elicits the utilisation of local media, local resources, collective action and ownership of ideas or projects. This happens through face-to-face dialogue, meetings, community discussions and through community leaders and opinion makers (Kalugendo & McLeod, 2012), which are all attributes of the convergence theory.

Singhal and Rogers (1999) also demonstrate the value of integrative approach to communication interventions. In their study of the efficacy of the *Soul City Project* in South Africa, they demonstrate how multimedia approaches are important in beginning and sustaining discussions about AIDS among the population. According to the two scholars, the significant role of the mainstream mass media (television, radio, and newspapers) is to serve as a catalyst to bring attention or consciousness of people to the HIV and AIDS issue. Thereafter, forms of interpersonal communication are used to continue the discussions on the AIDS issue, which ultimately promotes attitude and behaviour change (Also see Singhal and Rogers, 2003).

According to Singhal and Rogers, the *Soul the City Project* is an example of a unique communication for social change which represents a series of integrated, on-going mass media and interpersonal communication activities. The *Soul City* involves a 13 part television drama series promoting a health (HIV and AIDS) issue, followed by a 60 episode radio drama broadcasting in all South African vernacular languages on the same issue from the previous television episodes. This is then followed by the production of free-of-cost education booklets designed around the popularity of the television characters, and then the serialization of the stories by the newspapers. The value of this mixed media lies in its appeal to different segments of the audiences for change to occur in the entire social system as envisaged in the integrative approach (Singhal and Rogers, 1999/2003).

From Singhal and Rogers' study, each year after television and radio broadcast the *Soul City* Programme, several integrated activities are implemented to keep people talking about AIDS, and these activities include the Soul City Search for the Star (which

recruits talents for subsequent radio and TV series), the Soul City Health Worker of the year (to recognise an outstanding outreach worker) and Soul Citizens (recognising the youth who actively engage in community development). The activities aim at developing role models that advance the fight against AIDS. Together with highlighting characters of the drama series, these provide avenues for audiences to learn from behaviours of the role model that are rewarded.

2.5 Summary of Literature and the Study Propositions

From the analysis of literature concerning the forms of communication which are used in promoting HIV and AIDS preventive attitudes and behaviour change, several studies have indicated interpersonal forms of communication as effective, especially within the dimensions of the Convergence Model and the Social Cognitive Theory. The following propositions have been formulated regarding the nature of the effective communication:

- Oral communication among women in the local community set up is more effective in promoting the adoption of attitudes and behaviour of the low status young women than the mass media messages targeting individuals in HIV and AIDS prevention.

- Free interpersonal exchange between high risk groups and the HIV and AIDS para-professionals are more effective in promoting positive attitudes and unprotected sexual behaviour than the routine physician-patient communication conducted in hospitals and health centers.

- The more the young women from low socio-economic class adopt the community norms regarding safe sexual practices given during community ceremonies and role modeling sessions the more they will develop attitudes and behaviour that reduce the HIV and AIDS prevalence.

- The more the young women from low socio-economic status develop high status aspirations as a result of role modeling and enculturation using role playing in community drama and lifestyles, the more they will inculcate attitudes associated with reduced unprotected sexual activity to control HIV and AIDS prevalence.

- The more the forms of communication used are associated with changing individual's values towards acceptable social norms the more there will be the formation of new attitudes among young women in the low socio-economic status to avoid unprotected sexual behaviour associated with HIV and AIDS risk.

- The folk media (drama, games, motivational talks, community meetings and popular music) are associated with distinct identification with new social roles which promote the adoption of preventive attitudes and behaviour against HIV and AIDS.

- Community drama and popular music generate HIV and AIDS consciousness among young women aimed at focusing their attention to issues, topics and challenges posed by the HIV and AIDS pandemic, which promotes attitude change associated with avoiding unprotected sex.

- Folk media encourage the participation of all community members in developing culturally-appropriate HIV and AIDS interventions which promote community norms and social efficacy associated with change in attitudes to avoid unprotected sexual behaviour to reduce HIV and AIDS prevalence.

- The more the caring, committed, empathetic and jovial the HIV and AIDS para-professionals are the more they are appropriate in guiding the high risk persons towards acceptable attitudes and behaviour to reduce HIV and AIDS prevalence among young women.

- Using peer educators from the community who have direct HIV and AIDS experience is more effective in promoting attitude change associated with avoiding unprotected sexual behaviour than relying on unfamiliar outreach workers.

- Using the local role models whose sexual behaviours are cherished by most women in the community is more appropriate in promoting attitude change associated with avoidance of unprotected sexual behaviour that reduces the HIV and AIDS prevalence.

- Culture-sensitive forms of communication which encourage the social construction of meaning of HIV and AIDS within the community context are more effective in promoting change of attitude, beliefs and norms to avoid risky sexual behaviours among young women in the low socio-economic status.

The above propositions demonstrate the specific conditions that make the forms of interpersonal communication to be effective from the literature review, and the present study sought to prove or disapprove them based on the practical research on the forms and strategies which are effective for attitude and behavior change among young women from the low socio-economic category in Rachuonyo North District in Western Kenya.

2.6 The Research Gaps

A review of the existing literature on HIV and AIDS behaviour change communication programmes so far launched the world over indicates that most of the interventions have been based on the linear model of communication (Govender, 2010; Kiai, 2009; Mulwo, 2008; NACC, 2008; Rogers & Kincaid, 1981; Morris, 2003). This has been based on the idea that communication process follows a linear causation only (Rogers and Kincaid, 1981). From literature review also, a lot of studies on HIV and AIDS communication have generally concentrated on the analysis of the effects of the linear models on behaviour. Most of these studies have focused on the youth (Ndati, 2012; Mulwo, 2008) and couples as the population at risk of contracting and spreading HIV virus (Nzioka, 1994). However, few studies exist at both the local and international circles targeting women and HIV and AIDS.

The rate of HIV and AIDS prevalence continues to be high among the young women despite the communication approaches used to promote preventive attitudes and behaviours. Analysis of many programmes has revealed over-reliance on the linear approaches in these interventions. The linear approaches have not been very effective because they have targeted individuals without paying attention to the social environment

(Govender, 2010). On the basis of the continued failure, the present study sought to examine the reasons for the lack of success of the previous interventions, with the ultimate aim of finding out the most effective forms and strategies of communication in promoting attitude and behaviour change among young women of low socio-economic status.

Secondly, there is a growing shift towards socio-cultural approaches utilised at the community level to involve all participants. Some of the efforts have not been more adequately successful due to the misapplication of the strategies employed. For instance, in cases where community level communication for behaviour change has been used, they have been haphazardly applied, leading to minimal effects (Govender, 2010). In some interventions also, a myriad of strategies have been combined and applied in different cultural contexts with very little impact on attitudes and behaviour (Singhal & Rogers, 2003). For instance, the local communication efforts have been spearheaded solely by foreign agencies (Govender, 2010). There is also evidence that the most effective communication strategies have been utilised to promote change in other fields of development such as agriculture, but not necessarily in the area of HIV and AIDS (Govender, 2010; Rogers & Kincaid, 1981; Kalugendo & McLeod, 2012). There is, therefore, an urgent need to find out the effectiveness of these strategies in the area of HIV and AIDS communication for their success to be determined.

The main reason behind finding out the new approaches with young women from low socio-economic statuses lies in the sense that in some of the relatively specific studies such as of Ndati (2012), the application of social communication for change has

been used in the context of the students in secondary school in Nairobi where the results have suggested a significant relationship between new approaches and behaviour change to reduce risky sexual behaviours. However, substantive studies still continue to attribute the wide knowledge-behaviour gap in HIV and AIDS communication to economic, cultural and socio-political factors, without focusing on the effect of the communication variables, which is the subject of the present study.

It has also been noted with concern from the literature review that most of communication for behaviour change studies occurs in urban areas with literate population where the findings are often used to develop communication policies for the entire population, including poor women in the rural areas. This has had a major problem especially because of the fact that the key principle of communication called appropriateness for specific audiences has not been applied. Also, most of the studies have analyzed HIV and AIDS management as opposed to preventive attitudes and behaviour. Nzioka (1994) investigated the social construction and management of HIV and AIDS among the low income patients in Nairobi. However, Nzioka's study did not focus on how women patients communicate to avert the HIV and AIDS prevalence and stigma.

Additionally, the study by Kiai (2009) analyzed the planning and implementation of HIV and AIDS communication interventions by NGOs in Kenya. Kiai's study did not extend to the investigation of the effective forms of communication specific to young women in the low socio-economic class, but on a general evaluation of the HIV and

AIDS communication interventions by AIDS NGOs at their planning and implementation levels.

In general, the above analysis implies that a vacuum still exists in determining the preferred and effective model of communication that promotes behaviour change in young women in the low socio-economic class to reduce HIV and AIDS prevalence. From the initial pilot study, the two groups of women seemed to be impacted differently by different communication programmes and the present study sought to delineate the communication efforts that led to behaviour change.

From most of the studies analyzed in the literature, interpersonal forms of communication in women networks have been shown be more effective in mobilising the community in advancing development. In the area of health and development communication specifically the HIV and AIDS pandemic also, studies such as Kiai (2009), Mulwo (2008), Karim (2005), Govender (2010) and Ndati (2012) have recommended further analyses of the role of interpersonal communication in promoting preventive attitude and behaviour change. None of these studies has, however, focused on the preferred forms of HIV and AIDS for young women in the low socio-economic status.

Another important gap to be filled by the present study is that in the instances where the forms of interpersonal communication have appeared to be effective, very little in terms of structure and process of such communication has been determined. For instance, there are cases where women fighting HIV and AIDS infection have been

shown to have developed the social efficacy for status disclosure, but the precise forms of communication associated with such confidence have not been identified.

In conclusion, most recommendations of previous studies present blanket statements regarding the need for effective interpersonal communication whose structure, process and elements have not been determined. The present study investigates the most effective forms or model for HIV and AIDS communication intervention for young women in the low socio-economic statuses in Rachuonyo North District in order to determine the effectiveness of the communication strategies in promoting preventive attitudes and behaviour that reduce HIV and AIDS prevalence rate.

Chapter Three: Research Methodology

3.0 Introduction and the Foundation of the Study Methodology

This chapter discusses the research methodology which was used to collect data based on the research questions for this study. It includes the description of the research design, study location, research population, the sample size and sampling procedures. It also discusses the research instruments and methods of testing their validity as well as the description of the data collection, analysis and presentation techniques adopted in this study.

The overall methodological framework used in this study is an adaptation from Fishbein and Joseph (2006) and Rogers and Kincaid (1981). Martin Fishbein and Joseph Cappella are behaviour change communication scholars at the Annenberg Policy Centre within the Annenberg School of Communication at the Pennsylvania University. The framework was applied in the study by Fishbein and Joseph dubbed, '*The Role of Theory in Developing Effective Health Communications,*' which appears as an article in the journal by the International Communication Association (2006).

According to Fishbein and Joseph (2006), instituting behaviour change studies involves identifying and defining the behaviour in question, understanding why some people practice it while others do not, isolating the discriminatory variables and then deciding which forms of communication are effective in addressing the discriminatory variables for desired change to be realised.

Everett Rogers and Lawrence Kincaid are the scholars behind the Network Analysis and Diffusion of Innovations theory. In their study of the role of interpersonal

communication in social networks of women with regard to the diffusion of family planning messages, a simple network analysis method was used to describe the process of interpersonal communication within women groups in Oryu Li village in Korea (Rogers & Kincaid, 1981). This method was useful in describing the process of communication which respondents reported promoted a change in their attitudes and sexual behaviours in the present study. The two methods are complementary in explaining the behaviour change process among high risk women in the low socio-economic class with regards to AIDS.

3.1 Research Design

The main research design employed in this study was a descriptive design employed qualitative variables in the comparative case study, where data on communication efforts from the two groups of women in Rachuonyo North District were interrogated. The two different groups of women which were studied comprised of those who remained in the organisations and had earlier reported to have changed their risky sexual behaviour due to some forms of communication; and those who had deserted the organisations having earlier reported not to have changed their risky sexual behaviour due to the forms of communication used.

A qualitative comparative case study is a method of collecting information by studying two or more individuals or groups with different key attributes about their opinions, attitudes, beliefs, behaviour and habits on a given issue in order to find out the causes or reasons for the discriminatory state of affairs (Kombo, 2006; Bailey, 1994).

The study also used key respondent interviews to collect data from the stakeholders in women development and health communication in the district. These included various HIV and AIDS programme coordinators, representatives of HIV and AIDS organisations in the district, health communication experts, representatives of the provincial administration, opinion leaders and chairpersons of the various HIV and AIDS support groups within HIV and AIDS-based organisations in Rachuonyo North District.

This study aimed to collect information from the respondents on their opinions and experiences about the preferred and most effective form and strategies of HIV and AIDS communication for young women in the low socio-economic statuses in Rachuonyo North District. As such, a description of case responses from the young women and a purposive survey of the key stakeholders in youth and women development and HIV and AIDS in the district were interrogated using the mixed method approaches. The value of this mixed method approach was that the inadequacy of one method to yield accurate and reliable information was augmented by the rest of the data collection methods and sources of information.

3.2 Study Location

The study was conducted in Rachuonyo North District in Homa Bay County. The basis of selecting this district was that it is one of the districts in Homa Bay County where the rate of HIV and AIDS infection has consistently remained high among young women in the low socio-economic statuses despite a lot of communication efforts to change attitudes and behaviour to reduce the causative behavioural practices (KAIS, 2007/2009; KDHS, 2008; NACC, 2012). Many organisations have also been set up in the

district to empower young women who are at high risk of AIDS using various communication strategies for attitude and behaviour change (KANCO, 2011).

The study was conducted on the young women from low socio-economic status aged between 18-35 years who were being served by the HIV and AIDS organisations in the locality and the women who had earlier been recruited but deserted the organisations due to different reasons, for ease of identification and recruitment into the sample frame. It was assumed that these women had information about HIV and AIDS through either formal or informal education, interpersonal interactions and mass media. These organisations were also managed by people who were either experienced in AIDS issues or informed about HIV and AIDS.

3.3 Study Population

Rachuonyo North District has two divisions (GoK 2007; Public Communications 2010; The Kenya Gazette, 2008). Most of the women respondents for the study aged 18-35 years from the low socio-economic status were purposively selected from the HIV and AIDS organisations throughout the district's two divisions and classified into two strata. The first stratum comprised of the young women within the support organisations who reported to have changed their risky sexual practices. They were in support groups distributed in the whole district. The second stratum comprised of those who reported not having changed their risky sexual behaviour and had deserted the organisations and living in the nearby shopping centers and beaches. The umbrella organizations included EGPAF, CHAK, WVPI, APHIA Plus and CRS all located within the district, from where women respondents were purposively selected from Got Oyaro Peer, Rawi Women,

Stepping Stone, Nyaoga-Koredo, Kawathgone-Brave, Bala-Mercy, Wagwe North, Kanyadhiang-Wedewo, Kagwa-Seka, and Kogweno Women Support groups.

A purposive strategy was important in selecting only the young women who could provide relevant information on HIV and AIDS communication. In the entire district, stakeholders in youth and women development and HIV and AIDS were involved in the study as key informants to give their opinions on the preferred and effective forms of communication appropriate in promoting attitudes and behaviour change to reduce the high HIV and AIDS prevalence among young women in low socio-economic statuses.

3.4 The Sample Size

The total number of respondents that was interrogated for this study was 120 people. This represented the two divisions with approximate total population of two hundred thousand people (KNBS, 2010). This was a small sample, but its purposive selection and the representativeness of the young women from the low socio-economic statuses, all stakeholders in youth development and HIV and AIDS control, and the use of mixed method approach to data collection yielded accurate and dependable results. The sample comprised of 100 young women respondents, a total of four opinion leaders nominated by the provincial administration, two health communication experts, four representatives of various organisations dealing with youth developments and disease control, four coordinators of the specific organisations where the low status women get HIV supports and six chairpersons of the specific HIV and AIDS support groups attached to the various organisations.

3.5 Sampling Procedures

Purposive sampling design was used to identify and select all subjects for the study. According to Kombo (2006), a purposive sampling design is a strategy where a researcher identifies only respondents of concern to the study and who have relevant information and directly selects these individuals or groups in order to be studied. In each of the two divisions, the purposive sampling technique was used to identify the organisations, from a list provided by the Kenya AIDS NGOs Consortium (KANCO), whose core focus is on the young women empowerment and HIV and AIDS control.

There were a total of ten (10) focus group discussions covering the entire district, each comprising of ten (10) young women respondents for both the two different strata. The first stratum had eight (8) focus groups constituted with the as support of the centre coordinators and the chairpersons of the various HIV and AIDS support groups to ensure that the young women who had reported to have changed their risky sexual behaviour due to communication were properly identified and placed in their stratum. The second stratum had only two focus groups each having ten (10) women respondents comprising those who deserted the organisations having reported no change in their attitudes and behaviour.

From the stratum of young women who had changed and were within the organisations, forty (40) respondents were individually interviewed using personal life story interview protocols in order to study the communication efforts that contributed to their change in attitudes and behaviour. Ten (10) women from the stratum that deserted the organisations were also individually interviewed using the personal life story protocols in order to provide control information on the forms and strategies of

communication that were responsible for lack of attitude and behaviour change to control HIV and AIDS prevalence.

Four center coordinators from all the selected organisations were interviewed as key informants using unstructured in-depth interview guide to solicit their views on the forms and strategies of HIV and AIDS communication which were effective and those that were ineffective in promoting attitudes and behaviour change to control HIV.

Health communication professionals or experts were represented by two respondents purposively selected from the district based on their knowledge of HIV and AIDS communication. Representatives of other youth development organisations and HIV and AIDS were represented by four respondents purposively selected based on their relevance to HIV and AIDS and who were interviewed using in-depth interview guides.

Members of the public were represented by four opinion leaders who were purposively selected by the local administrators such as chief and clan elders, based on their participation in public meetings and workshops on HIV and AIDS. They were interviewed using in-depth interview guides for this study. Lastly, six chairpersons of the specific HIV and AIDS support groups in the district were purposively selected for in-depth interviews using the key respondent guides.

The sample frame was made up of a total sample size of 120 respondents. The use of the mixed method approach comprising of key informant interviews, FGDs and personal life story interviews yielded reliable data from the respondents, because the sample was a representation of all the stakeholders in HIV and AIDS communication for the youth and women from the entire district.

3.6 Research Instruments

Focus Group Discussions (FGDs), Key Informant Interviews and Personal Life Story Interview methods were used to collect data for this study.

According to Kombo (2006) Focus Group Discussion (FGD) is a group composed of 8-10 individuals who share certain characteristics relevant for a study. It involves allowing participants to freely express their views and beliefs on issues without tension. It was necessary in this study to allow the young women at risk to give their collective opinions and beliefs on forms and strategies of communication which promoted attitudes and behaviour change to control HIV and AIDS. It enabled the study to get at the culture or the social norms of the young women in the low socio-economic statuses concerning HIV and AIDS and communication for change process. The low status women who had changed their behaviour belonged to different FGDs from those who had not changed their attitudes and behaviour.

Key Informant Interviews refer to oral, unstructured questions on the themes of the study conducted on a respondent considered to have information, where responses are recorded on the spot (Kombo, 2006). Key informant interviews were conducted among the coordinators of HIV and AIDS organisations, public opinion leaders, and the HIV and AIDS communication experts/professionals, chairpersons of the various support groups and representatives of the provincial administration to get their opinion on the forms and strategies of communication which were effective with low status women.

The Personal Life Story interviews were conducted among the selected respondents from the low socio-economic statuses from both the changed and unchanged

stratum of young women to understand and document their life circumstances specific to HIV and AIDS attitude and behaviour change. It enabled the researcher to get at the individual values, behaviours and attitudinal dimensions associated with HIV and AIDS communication for change.

The use of mixed methods approach made the findings more valid and reliable than when only one method was used since the weaknesses of one method were

3.7 Testing Validity and Reliability of Research Instruments

According to Kumar (1996) validity refers to the ability of a research instrument to measure exactly what it has been designed to measure. To measure the validity of FGD items and interview guides prepared, the objectives were reviewed by three independent communication experts, one from Jaramogi Oginga Odinga University of Science and Technology, the other from USAIDS offices in Homa Bay and the last one from University of Nairobi, to confirm whether they were addressed by the questions in the instruments or not. Suggested changes were made to the instrument after the review.

The research instruments were also disseminated to pilot groups from Rachuonyo North District, adjacent to the district where the study was to take place in order to find out their reactions or answers to the questions. With their responses appropriate review of the instruments to improve their accuracy was made. The question items were categorized into five thematic areas such as HIV knowledge, previous forms and strategies of HIV and AIDS behaviour change communication, impact and challenges of the previous strategies, the preferred communication strategies, the process and structure

of the ideal model and the effectiveness of the proposed communication model, on which the responses were sought from all the respondents.

Reliability of research instruments, on the other hand, is the degree of consistency and stability of an instrument to be able to give similar results when used repeatedly in similar environments (Kumar, 1996). When interview questions are answered in the expected way by different respondents in similar conditions, reliability is proved. In this study, a pilot test was carried out to the instruments to ensure their consistency before dissemination to the actual respondents. The result proved their accuracy for use.

3.8 Data Collection Procedures and Challenges Encountered

Before the actual data collection, a research permit was sought from the National Council for Science and Technology (NCST) in the Ministry of Higher Education Science and Technology. After this, the research assistants were recruited and trained. A pre-visit to the study site was made in order to gain familiarity with the location, introduce the research team and meet the respondents. Additional authority was sought from the HIV and AIDS organisations and the local provincial administrators. Appointments with key informants were made and venues for discussions arranged.

During the actual data collection days, punctuality was observed; interviews were conducted systematically; the focus group discussions were guided competently while recording information on video compact discs. The research assistants (RA) were picked from the experienced persons to assist in coordinating all aspects the process.

During the entire research process all ethical considerations were made. For instance, using the data for academic reason alone, observing confidentiality by not

naming the respondents and the support groups, relying on data given voluntarily and not manipulating the results for ulterior motives.

In general, it is important to state that the study utilised key respondent interviews, life story interviews and focus discussions which yielded the needed qualitative information for the study. This implies that quantitative tests were not conducted; hence the information on which the conclusions were based was the subjective responses of women from Rachuonyo North District. Secondly, due the fact that only qualitative responses were generated, a lot of challenges were encountered such as language problems which necessitated the researcher to rely on the community interpreters. Most of the interpretations were done by the few referees who accepted to be included in the study and this took a lot of time and consultations with people who better understood the local language. Reporting of results was also difficult due to translation challenges.

This study was conducted during the rainy season in Nyanza with heavy torrents and floods which made it extremely difficult to reach the people. This made the research period longer than expected. Lastly, most of the respondents were either too shy to give information or wanted financial gifts to give information which posed a greater challenge for the researchers. However, the needed information was gathered and used for the study

3.9 Data Organisation, Analysis and Presentation Techniques

Data from the respondents were sorted and corrected for errors, coding was done and thereafter the data stored in both hard copy and electronic forms. According to

Kombo (2006) the entire process involves changing raw data to information, information to fact, fact into knowledge and expressing knowledge in terms of narrative inferences.

The form of data for this study was mainly qualitative, which were analyzed using quick impressionist summary analysis where the key findings were recorded verbatim from participants about their views on HIV and AIDs and forms of communication. This was the method used to analyze responses from key informant interviews, personal life story interviews and FGDs. Thematic analysis where data was classified in terms of topics or major issues from discussions was used for FGDs and interview items analysis (Kombo, 2006) and presented in narrative format using both reported and direct speeches from all respondents.

Chapter Four: Data Presentation, Analysis and Interpretation

4.0 Introduction

This chapter presents the findings of the study on the forms and strategies of communication which promote reduction of risky behavioural practices associated with the HIV and AIDS prevalence among young women in the low socio-economic statuses in Rachuonyo North District within Homa Bay County in Kenya.

The chapter begins with a brief review of the research objectives and assumptions; the classification of respondents and the kinds data generated from them; the contents of the instruments used and the methods of presenting the data before embarking on statement of the actual findings from the study, which comprises of findings on the knowledge of predisposing behavioural practices, the previous and current communication efforts, the impact and challenges of the previous communication efforts, the preferred and effective forms and strategies of communication suggested by the young woman and key respondents to be the most effective, process and structure of the effective communication approach and the effectiveness of the proposed model and communication strategies. The chapter ends with a summary of the study findings.

4.1 Preliminary Overview

4.1.1 Research Objectives and Assumptions

The overall objective of this study was to find out the effective forms and strategies of communication in promoting attitudes leading to the reduction of risky behaviours to control the high HIV and AIDS prevalence among young woman aged 18-

35 years from low socio-economic statuses in Rachuonyo North District in Kenya. Four research objectives were identified to guide the study and these included the determination of the HIV and AIDS knowledge level of the target women respondents, finding out the forms and strategies of communication which were used in the previous and current HIV and AIDS behaviour change communication, finding out the preferred and effective forms and strategies of communication in promoting behaviour and attitude change, and lastly to determine the most effective communication model for the HIV and AIDSs intervention for women in the low socio-economic statuses in the district.

This study was based on four study assumptions, namely: that there was high HIV and AIDS awareness among the low status women in Rachuonyo District, that previous HIV and AIDS interventions relied on mass media messages and public communication campaigns which were not very effective in attitude and behaviour change, that forms of interpersonal communication were effective in promoting attitude and behaviour change to control HIV and AIDS prevalence among women; and lastly, that forms of communication within the convergence model constituted the effective structure and process of communication associated with attitude and behaviour change to control HIV and AIDS prevalence in women from low socio-economic class.

4.1.2 The Response Rate and Respondents Categorization

A total of 120 respondents for this study were purposively drawn from West Karachuonyo and East Karachuonyo divisions of Rachuonyo North District and classified in the table below for ease of analysis of findings in terms of respondent category, data collection method and instruments; and the kind of data collected.

Table 4.1 Response Rate and Respondents Categorization

Category	Respondents	Kinds of Data	Collection methods	Research instruments
A	80 women still attached to HIV/AIDS Organisations (Changed Women).	Group data for socio-cultural responses	8 FGDs each with 10 women (A1-A8 groups)	Discussion Guides
B	20 women who deserted the organisations or relapsed (Not changed)	Group data for socio-cultural responses, for control role	2 focus groups of 10 members (B1-B2).	Discussion Guides
C	40 women from category A (Changed Women)	Individual data from personal life story	Life story interviews	Life story guide
D	10 women from category B (Not Changed)	Individual data for control purpose	Life story interview for control purpose.	Life story Guide
E	4 HIV/AIDS programmes coordinators in organisations where women are attached	Individual opinions on the contents of instruments	Key Respondents interviews	Interview Guide
F	4 Representatives of AIDS NGOs in Rachuonyo North District	Individual opinions on contents of instruments	Key Respondents interview	Interview Guide
G	2 Health Communication Experts/ Academics	Individual Interviews	Key Respondents Interview	Interview Guides
H	4 Representatives of the Provincial Administration	Individual Interviews	Key Respondent Interview	Interview Guide
I	6 Heads/ chairpersons of specific support groups for HIV/AIDs preventions	Individual Interviews	Key Respondents interviews	Interview guides

Source: Researcher 2013

4.1.3 Contents of Instruments

A total of three kinds of research instruments were used to gather data for this study. These included life story interview guides used to capture the life experiences and efforts towards change from each selected young woman. The instruments also included Focus Group Discussion guides for all the women respondents meant to elicit group responses so as to find out the role of culture in communication for change in attitudes and behaviour. Lastly, the key respondent interview guides were used to gather in-depth information from coordinators of HIV and AIDS programmes in support organisations, experts in health communication, the local administration, representations of NGOs dealing with AIDS behaviour change and chairpersons of specific support groups.

The instruments contained relatively similar questions or discussion items since they were meant to supplement each other. Overall, the thematic areas that controlled the responses of the interviewees were areas like knowledge of HIV and AIDs predisposing factors, previous/current HIV and AIDs communication efforts, impacts and challenges of the previous/current efforts, the preferred or effective forms and strategies of communication that promote attitudes and behaviour change, the process and structure of communication that was more effective and the effectiveness of proposed model, forms and strategies of communication in promoting attitudes and behaviour change to control HIV and AIDS prevalence. All these broad areas entirely covered the research objectives of the thesis.

4.1.4 Methods of Presentation of Findings

This study relied on mixed narrative presentation methods which included analytical descriptions and case studies. The findings are stated in direct speech and sometimes reported by the researcher. For each thematic area in the instruments, responses from life story interviews, FGDs and key respondents have been stated. This is followed by a brief descriptive analysis of the findings. This was important since the responses are corroborated and contextual analyses are used to boost comprehension and flow of the facts.

4.2 Findings on Women's Knowledge of HIV Predisposing Behavioural Practices

Many studies reviewed in this study indicated high HIV and AIDs knowledge and awareness among most sections of world's population (Govender, 2010; Ndati, 2012). In the present study most of the women respondents interviewed demonstrated adequate knowledge of the various predisposing behaviours associated with HIV and AIDS infection among them as indicated in table 5.2 below

Table 4.2 Women's Knowledge of the Causes of HIV and AIDS

Causes of HIV and AIDS	No of women who know it
Unprotected sex with infected persons	93
Prostitution	88
Casual sexual intercourse	83
Trans-generational sexual behaviour	56
Extramarital sexual encounters	83
Wife inheritance	76
Sexual experimentation	50
Drug abuse and alcoholism	68
Polygamy	50
Infected children during home deliveries	55

Source: Research Data, 2013.

The women respondents also indicated a number of factors that exposed the young women to contracting HIV and AIDS in the district. These factors include poverty, spousal separation and infidelity. The table below shows these factors in terms of their rating by the women on the perceived risk of HIV and AIDS exposure.

Table 4.3: Factors that Expose women to HIV and AIDS

Behavioural Practices	**Rating of Level of Risk**
Unprotected sexual practices	Very high
Prostitution	Very high
Wife inheritance	Very high
Casual sex	Very high
Mother to child infection	Not high
Use of unsafe needles	Not high
Sharing of body clothes	Not high

Source: Research Data, 2013.

When asked to single out the specific factors responsible for the high HIV and AIDS prevalence among them, most of the women respondents indicated that it spread due to factors like traditional cultural practices, poverty, low education and negative attitudes, beliefs and behaviour. The women respondents stated that all these factors were responsible at different levels indicated by the number of responses. Table 5.4 shows how the women responded. From the responses, it can be noted that negative attitudes, beliefs and behaviour is leading followed by cultural factors, while poverty and illiteracy took third and forth slots, respectively.

Table 4.4: Factors Responsible for high HIV Prevalence according to the Women

Factors for HIV and AIDS Prevalence	No of responses by women
Cultural factors	26
Poverty	23
Illiteracy	11
Negative Attitudes, Beliefs and Behaviour	40

Source: Research Data 2013

From the life story interviews, several women described the behaviours and practices that exposed those who were currently infected and those who were at high risk of contracting the disease. They enumerated the various practices and classified them within the various groups that existed within the locality.

Q: What behaviours or practices are you saying exposed you to HIV and AIDS risks?

C1: Let me tell you. Many people still deny they practiced promiscuity despite their husbands being around for sexual satisfaction. Many of us also considered pregnancies to be worse than HIV and AIDs hence relied on birth control pills so their husbands cannot know.

C2: If my husband had not gone to work at Migori Town leaving me behind I wouldn't have fallen prey to these village men who sell doughnuts....{laughter}.

C3: I didn't know that I was going to be sexually exploited when I accepted to work as a house help to those men in Miriu Dam. Haki (surely) they appeared responsible but do not be cheated. They are wolves in charge of sheep!

The responses above indicate that some women believe the practices associated with HIV and AIDS are having sexual affairs with other men while in marriage ('mpango wa kando'), long distance relationships and poverty which make women susceptible to sexual abuses. These responses were confirmed by women in the focus group discussions who listed many factors responsible for HIV and AIDs risks such as prostitution, promiscuity, wife inheritance, early marriages, sexual experimentation, peer pressure,

abuse of contraceptives, family break ups, revenge for husband's infidelity, drug abuse, night discos, polygamy and idleness of women.

A1: Who doesn't know that when a good thing happens in the family, men are the ones responsible but when a bad thing occurs the woman is the devil. The men we live with at home are dangerous .....And because we are lesser due to our culture, we are often exploited sexually and must not contradict or embarrass them (men).

A4: But if you dare argue you will be beaten and your luggage packed for you to return to your maternal home. We live in fear in our families!
A2: Even when one's husband dies, she must be inherited ('itere') by a village inheritor. This makes women's lives to be in danger.

A1: In our 'chamas' (merry-go-rounds), women are socialized to use birth control pills, but our husbands must not know this. Meaning that we can have other men we sleep with but should not be known by husbands, which is actually rampant in some support groups.

The above sentiments by the women respondents concerning their exploitation by men or husbands since they are weaker and culturally meant to be submissive is also underscored by some women who relapsed in their preventive behaviours and returned to the beach lifestyle from the supporting organisations. In their focus groups, they indicated that while in the organisations, they were taught how to behave well to control HIV and AIDs prevalence but when they returned home, men over-powered them. From key informant interviews, this was because the Luo culture gave men more power to determine the occurrence of sexual intercourse in the family, which led to exploitation and misuse of women. The women demonstrated that the predisposing practices to a lot of extent results from the abusive acts of men in the community.

B1: We are back to the beaches since those organisations brought us near our molesters (men) and taught us to be disciplined, which we became. The local men took advantage of this and sexually harassed us even more, because we were no longer hard on them.

B2: Since these organisations were not fulfilling all our needs and insisted on good behaviour, we could not survive hence had to come back and do what we know pays best (prostitution).

B1: I know 'joboya' ni wabaya (I know fishermen are bad) but we also need money. Life has to move on! What will happen to my daughter if I don't give her food and pay her nursery fees?

B2: The big challenge we have is that they (organisations) do not need us back when ready to deliver our babies hence we do so through 'nyamrerwa' (traditional birth attendants) which promotes infections to our babies when we deliver them. God bless us!

B1: By the way most of these babies have come out HIV negative despite our conditions. God has always protected them for us.

The fact that HIV and AIDs knowledge is high was not an understatement. From the above discussions with women who had not changed their behaviour, it is apparent that enough knowledge of the behaviours associated with HIV and AIDs prevalence exist and the women who resumed prostitution had the awareness and knowledge even of the prevention of mother-to-child infections (PMTCT). The women also indicated that HIV did not only spread through unprotected sexual intercourse alone, but also through transmission to the baby during birth. This shows that women's knowledge of HIV transmission was very advanced considering the literacy level being very low in the district among women, which is an indication that the linear approaches partly succeeded.

B2: May I say this, you do not only get infected through consented sex, and we are also being raped by some boys from those chang'aa (illicit brew) dens. Some of us, especially me got the disease through an earlier marriage I had which I left sometime back. My former husband used to beat me up when I realised he had "mpango wa kandos" with so many women from the liquor dens.

From a personal life story interview with some women who had not changed their attitudes and behaviour and had undergone relapse due to some reasons, it was noted that those women at individual level understood the consequences of their behaviour but still

practiced the behaviour for some reasons. This serves to assert that the HIV and AIDS knowledge especially of the predisposing factors is very high among women in the district although preventive attitudes and behaviour have not changed.

The women respondents were also asked what they knew about HIV and AIDS and they indicated a number of issues about HIV and AIDS as part of their knowledge. The table below shows what the women indicated they properly understood about HIV and AIDS in their community.

Table 4.5: Specific Information Women Had About HIV and AIDS

What Women Knew about HIV/AIDS	No of women
The Origin of HIV and AIDS	14
The Causative behaviours and practices	93
Prevention of HIV and AIDS	76
Management of HIV and AIDS	70
Adherence to best preventive practices	51
Teaching people about HIV and AIDS	50
Symptoms of HIV and AIDS	30

Source: Research Data 2013.

Q: You said you know what you are doing is bad. Why then do you continue to do it?

D1: I don't like if people know that I sleep around with men for cash. But I have to do it since my children must be in school besides eat good food. Since my husband died I have been called names. I accept to live with those names but life has to continue. I cannot allow them to choose inheritors for me but the man has many wives and does not give me money. He is just busy with my body. I have learned the hard way. I just want to die when my kids have finished primary school. The organisations like EGPAF promised to pay fees for my kids. Let us wait and see, but many things lead us to do all these we are doing and we know we are endangering our lives and those of our partners. The messages they give us fail to be practical since words alone do not help us.

D2: I know it is bad to do this but I want to get more capital to start my small business and soon nobody will see me here. I am also tired since women ridicule me and I can't even belong to their "chamas" because they claim that I am dirty and they don't need *dirty* money!

D3: None of the HIV and AIDs causative behaviours have missed to occur to me. I have had multiple sexual partners, engaged in unprotected sex with "mpango wa kandos", I've been married four times, I have been a serious alcoholic and now I do this (prostitution) since nobody can provide for my needs effectively. All these messages which urge people to change need to be given when one has acquired some business or money. That is why I cling to my "orya" (Arabian man) to boost me with business!

All the responses above were confirmed by the opinion leaders, health communication experts, representatives of AIDs NGOs, centre coordinators and the provincial administration who listed factors such as retrogressive culture, poverty, casual sex, prostitution, polygamy, peer influence, fish business and idleness as the HIV and AIDs predisposing factors. In their interview each key respondent explained how each of these factors was exposing young women to HIV and AIDs risks in the district and many parts of the country.

Q: Share with me the practices or behaviours which expose women around here to HIV and AIDs prevalence.

H1: First, I see a lot of "chamas" (merry-go-rounds) here. People say they are good but reports I have indicate that women in those groups have multiple sexual partners they sleep around with.

H2: My concern is that due to poverty, some women have embarked on fish selling business and selling of local brews. These are avenues for such behavioural practices. I hear the prevalence reports indicate this to be true. In my location, I have also dealt with cases of forced inheritance of widows so they are not new here.

F1: Most of our clients are widows who are being misused by the retrogressive cultures. We also have cases of rape, PMTCTs, prostitution and drug abuse to deal with. We are trying to communicate to these people to avoid re-infection, infecting others and passing AIDs to the babies. We have done a lot and we are happy. The problem is poverty since we may not provide all the needs of all women. This is why others relapse back to unprotected sex and unfaithfulness.

G1: The most common of the behavioural practices associated with HIV prevalence is unprotected sex among unmarried women and promiscuity among the married couples. There are a lot of factors causing these, but most outstanding ones are cultural practices and poverty levels around here. All these disadvantage women as opposed to their male counterparts.

G2: What is happening which makes HIV and AIDs prevalence to be higher among women than men is attitude-behaviour problem. This is because the knowledge and awareness of causative factors is high but the behaviours do not correspond with knowledge. For instance, despite knowing that the unprotected sexual intercourses are responsible, men still sleep with women without protection same to women who do not negotiate for the protective measures. Culture and poverty do not matter much where there is effective communication, only changing attitudes hence behaviour can be changed.

From the experts' views, the women have high knowledge of HIV and AIDs and the risk factors or practices. Most women who have changed their attitudes and behaviours have acknowledged they had bad behaviour which necessitated their attitude change to adopt a new behaviour which is not risky. In many cases these have been due to unprotected sex and vices like promiscuity. Those who have changed have adopted safer sexual practices which they recognise to be able to control the prevalence of HIV and AIDs. Those women who have had behavioural relapses still recognised that they were practicing unsafe sexual practices but indicated there were certain factors for continuity which would be changed in future to keep the HIV rates low.

4.3 Findings on Previous HIV and AIDS Communication Efforts among women

The most consistent argument in the literature concerning HIV and AIDs preventive behaviour is that most communication interventions have not been very effective in impacting the youth and women to change attitude and behaviour (Govender, 2010; Ndati, 2012; Kiai, 2009). Most of these studies reveal that most of the interventions associated with the failure have relied on the linear model of communication which makes use of the mass media and public communication campaigns (Govender, 2010).

Most scholars attribute the failure of these models to the single causality rather than multi-causal nature of human communication (Freire, 1972; Morris, 2003). It has been argued that the linear strategies of communication do not take into account cultural differences and the role of environment in individual's change process (Govender, 2010). This was why one of the major assumptions of this study was that most interventions have failed due to their linearity and one-way causation which the present study sought to confirm.

When asked to state the communication efforts so far used to inform or educate the women respondents about the need to change the predisposing high risk behaviours, most of the respondents in the focus groups named radios, televisions, films, videos, mural pictures, bill boards, posters, pamphlets, fliers, magazines, mobile marketing, school curricula, messages from local provincial administrators in meetings, in funerals and churches, women groups, seminars, road shows, health practitioners in hospitals or health centers, village elders, AIDs NGOs, community health workers, speeches of HIV and AIDs volunteers, hand-outs, peer counselors, flip charts, books on HIV and AIDs, sign boards, local songs from radios or sung in public forums and guidance during PMTCT training.

The women were also asked how they got to know about HIV and AIDS. They listed a number of forms and strategies of communication responsible for such knowledge level in the district. The women mentioned a range of media which informed them as shown in the table below.

Table 4.6: Media for HIV and AIDS Knowledge among Low Status Women

Media of HIV and AIDS information	No. of women who received through it
Vernacular radio	73
English/Swahili radio	11
Television	02
Cinemas, videos and films	04
Chiefs' meetings	09
School curriculum	13
Moving vehicles	03
Village elders	26
Women groups	86
Community health workers	50
Billboards/posters, etc	10
PMTCT clinics	12
Volunteer and peer counseling	55
Community Folk media	36
Village birth attendants	33

Source: Research Data 2013.

B1: A lot of communication has come from radio such as "mpango wa kando'. Others have been done in hospitals when they were teaching us at Got Oyaro dispensary on how to take care of babies.

A8: We have seen posters with people talking about dangers of HIV and AIDs. 'Nyamrerwa' (birth attendants) have also distributed some pamphlets to us. They have tried to use radio Lake Victoria in programmes dramatizing HIV and AIDs in the community.

A1: It is all over in radio, churches, markets, chief barazas and we have been made aware of the dangers of HIV and AIDS.

A4: May I say that nowadays somebody cannot say they lack information because many women "mwonyo" (take ARVs) and they educate fellow women in churches as well as talk in chief barazas.

B2: Even my daughter in class three told me they are taught in schools about symptoms of HIV and AIDS and they are urged not to discriminate against someone due to the symptoms. They are quite aware and we can't hide the truth from them since the message is all over the place.

Similar impressions were also received from individual young women who were interviewed in the life story interviews. The women who had changed and those who

relapsed were able to list all the forms and strategies of communication through which they received the HIV and AIDs behaviour change messages. Those who changed on the basis of these indicated they changed due to scary videos of HIV and AIDS ravaged bodies, advice from the village community health workers and the programmes they listened to from the local vernacular radios. Others stated that a lot of communication for awareness was on bill boards, murals, leaflets, sign boards and televisions. These, they indicated, had enhanced their awareness levels. Some of them indicated they read books which detailed the lives of characters in the fight against HIV and AIDs; and from HIV and AIDs support groups or discussion clubs in educational institutions in the locality.

Most of the women who reported that they had changed their behaviours indicated the specific media which made them do so. These included vernacular radios, chief's meetings, school curriculum, village elders, community health workers, doctors' advice and discussions in informal groups. The table below summarizes the responses of the women regarding which media promoted their attitudes and behaviour change.

Table 4.7 Media that Prompted Attitude Change to join the Support Groups

Media that Prompted Change in Women	No. of Women who changed
Vernacular radio programmes	73
Message form chiefs' meeting	09
Conversations with doctors at health units	12
Discussions in the women groups	80
Messages of peers counselors & volunteers	55
Schools curriculum	13
Television programs on AIDS	01
English/ Kiswahili radio programmes	02
Community songs ,dance and talks	36
Door to door campaigns.	48

Source: Research Data 2013

Q: Through what means of communication did you come to know of HIV and AIDs?

C3: Many ways. I first knew HIV and AIDs through radio programmes on KBC. Then the talk was all over.....on television, discussion in chief barazas, in churches, in hospitals and dispensaries and nowadays even my child in pre-unit class must be having information. I mean ..... they nowadays know even better than us due to teaching in schools. Fellow women in my church groups also discuss the issue. It is only in specific homes where such discussions are limited to only discussions about death of people.

C2: I have received the HIV and AIDS messages through a number of means of communication: peer counselors in this community who are HIV and AIDs volunteers who assist AIDs organisations and Ministry of Health to pass messages. Even in the local community, many people discuss it informally! For instance, when someone is sick or dead such discussions start in low tones when people have narrative predictions of the causes of death. Everywhere we go you see posters, billboards, murals, we listen to radio programmes on HIV and AIDs and counseling sessions we have in the pediatric clinics and VCTs.

Most of the women respondents who had relapses in their behaviour also indicated that HIV and AIDS behaviour change messages were common place and targeted risky behaviour like alternative sexual partnering (*mpango wa kando*). They narrated that such messages were heard from radios, videos, cinemas, community health workers, peer educators and para-professionals giving support in the HIV and AIDS organisations that they fled away from. They indicated that the messages for preventive behaviour were very common in all places. Even in public places such as lodgings, public places (bars) and restaurants, messages were all over especially in toilets and condom dispensers hanging everywhere. In all the disco clubs they attended, there was hardly a time when music teaching on HIV and AIDs precautionary measures were not played.

The media that women who relapsed indicated were not very effective in reaching them with HIV and AIDS behaviour change messages in their rural areas include television, English and Swahili radio programmes, billboards, school curriculum, doctor-

patient communication, cinemas and films, chiefs meetings, messages from moving vehicles, pamphlets and leaflets as shown in the table below.

Table 4.8: Media that Women indicated as not Appropriate for Behaviour Change

Media not appropriate	Those saying they were not appropriate
Television	98
English/ Kiswahili radio	98
Billboards/ posters/ magazines	90
School curriculum	87
Doctor-Patient communication	88
Cinema/ film/ videos	96
Chiefs meetings	91
Mobile Marketing	97
Pamphlets, brochures and books	87
Mobile phone text messages	95
Internet	98

Source: Research Data 2013

B2: The message intensity is very high from radio, leaflets, billboards, hotel rooms, lodgings, on condom dispensers.....and name it. I must say that it is not that we lack messages; it is some other factors about life!

D5: Sometimes I become embarrassed when these messages continue to repeat even when I have a new client especially from televisions in the hotel rooms.....you simply switch off the television lest it changes the mind of your client.

B1: Part of the reasons why these people need to give us a break is that some of these people giving these messages are just like us. They speak water and drink wine..... (Laughter)

D3: One day I will shun this behaviour because I have disappointed my peers who talk to me about change daily. God should help me!

From the statements above, it is evident that the awareness level of the young women concerning behaviour change is not lacking, but the willingness to change behaviour through the development of enabling attitudes, beliefs and norms. For instance, some women have stated that the messages were numerous, repetitive and boring. This

means that the attitude of these women to change from promiscuity and unprotected sexual practices need to change. The implication of this is that the forms and strategies of communication being used have not been effective in changing attitudes. What is evident among women who have not changed their attitudes and behaviour is that messages seem to come from people or sources they have negative opinions and attitude about. This is even reinforced by the argument of the participant below.

B1: I wish the people who were giving these messages were different in behaviour from us and our behaviour (of prostitution). They would have been a little believable.

One of the contradictions evident in this message is that some women thought that the messages were being given by foreigners who do not share in the life experiences of the young women at risk from the district. This was hinted as one of the failures of the informational approaches to behaviour change relying on the mass media to disseminate messages for behaviour change.

B2: The information from televisions is conveyed by people who don't lead the lifestyle of suffering around here; hence do not make much sense to us. Sisi ni akina mama wa kawaida (we are regular woman from this locality).We are very different from them!

D3: Some of the officers from these organisations abuse people saying we are badly behaved and that is why we are HIV and AIDs infected. They don't watch their language and if they did, some of them can make people change since they are considered role models to some of us here in the community.

The above concerns do not seem different from the experts' opinions because the latter also indicated that a lot of communication efforts for behaviour change were being made by strangers in the life of the young rural women. For instance, it was indicated that there was a society-wide communication initiatives to stem the prevalence of HIV virus among women. Most of the key respondents named mass media, folk media, community

organisations and doctor-patient communications as the most common forms or strategies of communication for behaviour change in the district. Some key respondents indicated that there was evidence of a shift from the mass media and public campaign strategies to the more interpersonal strategies that promote attitude and behaviour change. This sentiment has been shared with a number of available literature on communication strategies for attitude and behaviour change shifting from individual change to more socio-cultural approaches at the community level (Govender, 2010; Nzioka, 1994; Ndati, 2012; Kiai, 2009; Rogers & Kincaid, 1981).

E1: Most preventive strategies we have been using were based on the informational approach, but due to enlightenment and high awareness level we have seen, approaches need to change from mass media, public campaigns, and individual guidance to the social approach that takes into account local creative means and cultural sensitivities. At the moment the linear approaches still dominate our interventions.

E2: I find it encouraging that the mass media, visual aids, public campaigns and community based techniques we have used have created very high awareness levels in women, youth and even men. What we need to do is find ways by which this knowledge/awareness can be translated into preventive behaviour by changing strategies to involve those able to promote change in attitude, hence behavioural or social change.

When these experts were asked why there was need for strategic change, they reported that the linear strategies had been responsible for the high awareness level and persistent use of the linear approach only yielded minimal effect in behaviour change. According to the academics in the area of health and development communication in the region, the linear models were meant to pass messages for information's sake and this they did effectively. However, continuing their use erodes the gains they had made in providing information for awareness creation because people get resistant to them. This implies that the informational strategies were conceived with the sole intention of

creating awareness, although in some studies (Singal and Rogers, 2003; Mulwo, 2008) findings have shown that they are also very useful in promoting behaviour change among students in universities and colleges. In the present study, some key respondents explained the nexus between the linear and interpersonal approaches:

G2: The continued use of mass media and public campaign strategies serves two related functions: one, they may still work to further promote or increase the awareness levels especially in the changing forms of the HIV and AIDS epidemic. Two, it should also be known that for some people, especially rural dwellers, the linear approaches can promote attitude change.....see what they have done for the youth in primary or secondary schools in Kenya! They have promoted discussions around condom use and sexual abstinence among most of the youth.

A lot of responses from women indicated that most of the forms and strategies of communication through which they got to know about HIV and AIDs were based on the linear model making use of mass media such as radios, films, televisions, community paraprofessionals and the local provincial administrators. All these strategies had been instrumental in increasing the HIV and AIDs awareness level in the rural district. What was more important was the observation by the communication and health experts that there was an urgent need for a paradigm shift from the linear to cultural or social approaches. There was also evidence of new forms and strategies of communication within interpersonal paradigm which seemed most effective because the experts as well as the women respondents alluded to it. Worth noting is that the high HIV and AIDs awareness level among women has been as a result of several communication strategies of different kinds applied in different contexts for current success to be achieved.

4.4 Findings on the Impact and Challenges of the Previous Communication Efforts

There have been a lot of heated debates regarding the effectiveness of the forms and strategies of communication being used to promote attitude and behaviour change to reduce the HIV and AIDs prevalence. Three opposing sides have emerged. Those who feel the linear approaches have been effective have pointed at the high awareness level created by the mass media. Such scholars and strategists attribute the high awareness level to the linear approaches and consider them effective (Govender, 2010; Singal and Rogers, 2003). In the present study, many communication experts have observed that in villages in the rural areas, the mass media and the public communication campaigns as well as the doctor-patient communication have promoted both high awareness and minimal attitude and behaviour change.

Conversely, the scholars who feel that the linear approaches have not been effective have indicated various reasons for the lack of success. These include their assumption that all human beings are rational, independent and responsible when given information. These scholars also argue that such assumptions are dangerous since human behaviours depend on the various contexts and for such behaviour change to be achieved, there is need to focus on broad cultural and social patterns available in the environment of individuals. Such beliefs discredit the gains made by linear approaches (Govender, 2010).

The third perspective is a middle ground between the linear and socio-cultural approaches that make use of both the strategic thoughts. For instance, both linear and cultural approaches are important for different but complementary functions in an individual's change process.

When the respondents were asked whether the approaches or strategies so far used were effective, the majority of them indicated that they were only effective to some extent. This was followed by those who felt they were not effective at all. Those who felt they were effective came a distance third with mixed reasons that they were responsible for behaviour change. In general, most of the women respondents and key respondents felt that these approaches were not very effective in attitudes and behaviour transformation. The table below is a summary of the responses on the effectiveness of previous communication strategies.

Table 4.9: Effectiveness of the Previous Communication Approaches

Whether Previous Efforts were Effective	Number of women Who Agreed
Previous Approaches were effective	27
Previous Approaches were ineffective	63
Approaches both effective and ineffective	10
TOTAL	100

Source: Research Data 2013.

From the study most of the women respondents indicated that the previous forms of communication were ineffective. When asked to explain why they thought they were ineffective, various reasons emerged. The table below summarizes the responses of the respondents concerning the reasons for ineffectiveness of the previous forms and strategies of HIV and AIDS communication for HIV and AIDS preventive behaviours.

Table 4.10: Reasons for Ineffectiveness of some Communication Strategies

Reasons for Ineffectiveness	No of women Who Agreed
Messages were difficult to understand	50
Messages were too general and diffused	48
Messages were in foreign languages	60
Messages conducted by irrelevant people	45
Messages were inaccessible due to cost	70
Messages were boring to the women	33
Messages were culturally inappropriate	40
Messages gave no room for details	70
Messages gave no room for feedback	68
Communication context was too formal	50
Communication lacked motivation	60
Communication had scary messages	33

Source: Research Data 2013

Q: Have the previous and current communication efforts been effective in promoting attitude and behaviour change in you to control HIV prevalence?

A1: Not fully. They have enabled us to get informed that AIDs is incurable, not a curse, anybody can catch the disease since AIDS lives with us here, the need to know my HIV and AIDs status and how to take care of myself.

A2: To some extent, it has enabled us to understand the cycle of HIV and AIDs from acquisition, to development, transmission and death. But with all these, people still practice unprotected sex with partners whose status is unknown.

A3: Partially. Only awareness on how HIV and AIDs attack people, but this is remotely done in the radio or television. The knowledge it gives is theoretical and does not demonstrate what is here and now!

When the same question was asked during the life story interview with women who were going on with support programmes, the responses were in both affirmative and negative. Most of those who had changed attitudes and behaviour pointed towards role models and interpersonal means of communication as responsible for promoting positive change in behaviour. Most of the women indicated the mass media was only capable of increasing awareness but could not model a positive behavioural practice in the women.

The reasons given were diverse with majority indicating their inaccessibility while others indicating that the messengers were people who were both socially and physically removed from the local environment and that they belonged to different socio-economic statuses from them. This implies that most of the media personalities belonged to high socio-economic status group and did not share common lifestyles with them.

C5: My efforts to change began much latter than the programmes from the radio or from films that they show us in churches and health centers. I was motivated by the caring talk and professionalism of the volunteer community worker deployed by EGPAF. Surely some people are humble and knowledgeable in their job!

C1: They have been good but not very effective. They appear to address some different people not us since the persons who are behind such programmes are not familiar people. I wish you had listened to the heart-rending testimony of the volunteer woman who talked to us in the church last week!

In the focus group discussions with young women who had relapsed in their behaviour, a lot of reasons were given for the ineffectiveness of the previous and current HIV and AIDS communication efforts. They indicated that most of the forms of communication did not give room for questions and answers (or lack of feedback). Some of these forms were seen to promote vices in the community. For instance, the "*mpango wa kando*," adverts on Kenyan televisions; most of them were written to be read in English or Kiswahili yet illiteracy level was high for billboards and posters; most of the women said they did not have time to listen to and finance to buy the radios or televisions and messages always passed them unaware; most of them also argued that due to availability of ARVs, contracting HIV and AIDS was not the end of life; some of the women also believed that HIV and AIDS was imaginary, but "chira" (curse) was real.

Some women also felt that they needed all HIV and AIDS information to be written or spoken to them in their vernacular language since they could not pick up a thing from radios, TVs, films, books and road shows. This sentiment came up in the focus group discussions where the women demonstrated how it was difficult to interpret a pictorial message from a mural due to language barrier and cultural differences in the two contexts where massages were used.

Conversely, some few women indicated that the previous and current communication efforts were effective. From their focus group, there was a general consensus that such forms of communication had promoted HIV testing among the woman. They also indicated that some of them accepted their HIV positive statuses due to the communication used. Some of them reported that some of the vital choices they made about health previously and currently were due to the communication strategies. Those who tested positive indicated they had planned their lives based on the information they received from the communication efforts so far.

C6: If it had not been for the communication efforts put by the government and AIDS NGOs we wouldn't have known our HIV positive status and probably we would be dead by now. Only God knows where I would have been!

C4: I have planned my life diligently because of the communication I have received about AIDs. Even though many women still live in fear of stigma and misinformation, issues as "*chira*" (curses) are no longer major challenges in the fight against AIDs.

D2: We must thank these organisations and the government for their efforts to give information and education programmes a chance to reduce infections in our community.

The young women who had relapsed on the efforts to change behaviour reported in their life story interviews that some attitude change had been noticed which had made them a little keener about practices perceived as risky. They indicated they changed a

number of attitudes and beliefs even though actual behaviour like abstinence, protected sexual practices and fidelity had not been reduced. These were all attributed to the forms and strategies so far used to provide information.

D3: Those forms of communication helped to change our beliefs that discussing HIV and AIDs was embarrassing, that HIV and AIDs was a disease of other people, that failure to reach orgasm during sexual intercourse does not reduce HIV and AIDs spread as well as that HIV and AIDs was not only a disease of the rich people, but of anybody.

D2: Yes, many people had a lot of myths and untruths which these forms of communication have helped to crash. Nowadays few people believe the myths and cultural superstitions regarding HIV and AIDs.

The key respondents who included the health communication experts, opinion leaders, local provincial administration officials and representatives of AIDs NGOs reached a consensus that the communication efforts so far used had been effective in increasing awareness about AIDs as well as promoting attitudes and behaviour change in some sections of the women. They also indicated that the current gains made in the fight against HIV and AIDs was very partially attributed to these linear forms of communication (about 40 percent); and that there was need for other approaches to take the intervention to the next level by promoting attitude and behaviour change in more complicated audiences such as the low status women and adults within African cultural contexts.

G1: While many scholars and strategists agitate for a shift in paradigm, it is important to note that such new approaches can only work in an environment prepared by the linear approaches.....as in....one must first have high awareness then proceed to the next level of attitude change. Thus for me limiting the use of one model endangers the performance of another one in this business of strategic mitigation.

H1: You see Oriaso, most church leaders had a negative reaction to "*mpango wa kando*" adverts recently due to allegation that it promotes promiscuity. They should lead from the front to provide an alternative message. Let us see if their proposed message won't be a modification of the one being criticized now.

From the responses above, it is clear that the previous and current communication strategies have served a purpose. What is clear from the arguments above is that both the new and older approaches have distinctive, but complementary roles to play in the intervention process. It is also clear from the discussion that the linear approaches have performed their roles within the stage of their application and have been responsible for the current status of the intervention so that any shift in approaches will serve to further the development of communication intervention due to changes in the cycles of HIV and AIDs. The two approaches can also co-exist to serve the same function. For instance; the older approach can be more effective in the future context as can the newer approach for the older contexts. The general impression, however, is that the older approach (linear approach) has been overtaken by events and the ever changing contexts of our societies. All the respondents agreed that when new approaches are used, the impacts will be greater than when the older approaches are continued hence lose taste with the changing faces of the AIDS pandemic.

4.5 Findings on the Preferred and Effective Communication forms and Strategies

The major reason given by many scholars and strategists in health and development communication for the perceived failure of the linear approaches to communication is that such communication assumes that targeted individuals and groups are devoid of alternative means of communication (Govender, 2010). The linear approaches have also been criticized as only targeting individuals as isolated elements in

communication environments. The linear approaches are also blamed for placing premium on individual behaviour change disregarding the value of social environment surrounding individuals. Such approaches are also referred to as replications from western countries that fail to fit in the cultural and social contexts of sub-Saharan Africa (Kunda and Tomaseli, 2009; Govender, 2010).

Most of the literature reviewed indicates that most of the strategic interventions have been informed by the linear, one-way communication models. Many scholars claim that these approaches were forced on people to change attitude whereas these interventions did not have the clout to promote change in attitudes and behaviour. They claim that such processes of change ought to involve macro alignment and change in the entire social norms and community members. For this reason, therefore, the failure of the linear strategies have developed the need for strategies that stem from within the community by the target groups who are believed to have the capacity to identify and classify the problems facing them as well as device the local means for solution to these problems. The linear approaches are generally considered as exogenous top-down communication strategies without the input of the people whose attitudes and behaviours need to change (Govender, 2010).

In health and development communication of the present time, any successful or effective intervention strategy is considered to be that which has been conceived by the target population since it will benefit them. In HIV and AIDs behaviour change, a lot of linear strategies have been used, with minimal impact on attitude change (Govender, 2010). This now calls for a change in strategic thinking meant to develop only strategies that the target groups initiate or propose as effective and appropriate in order to promote

attitude and behaviour change. These forms and strategies of communication, when adequately formulated, implemented and evaluated by the same people who are their targets, are believed to be potentially effective and relevant for them.

It is believed that young women in the low socio-economic statuses in rural villages are not devoid of the communication strategies that work for them, making them to change attitudes and behaviour to control the high HIV and AIDs prevalence. This might provide room for new approaches that would be more effective than the approaches that have been developed for the women that they fail to identify with and consequently fail to impact on the women.

From the present study, women respondents in focus groups comprising those who had changed their behaviour and attitudes to control HIV and AIDs prevalence mentioned several forms and strategies of communication that they believed promoted their efforts to change behaviours. These strategies included interpersonal discussions, using support groups where women discussed behavioural issues, involving volunteers who were PLWHAS or para-professionals, relying on testimonies of the experienced members of the community, integrating mass media with interpersonal approaches, community dramas, songs and dances and message passed through accessible dialects and signs such as vernacular radios; participation by all community members in the planning, implementation and evaluation of communication programmes; involvement of the entire community and agencies or concerned bodies, empowerment of major stakeholders such as women in self-sustaining projects that reduce poverty and idleness, role modeling for good behaviour practices and consciousness raising through striking of local culture as a source of local innovations for local solutions to local problems.

The table below summarizes the responses of the women concerning the number of women who agreed to the fact that the listed forms and strategies of communication were appropriate and most effective in promoting attitude and behaviour change to reduce HIV and AIDS prevalence in Rachuonyo North District.

Table 4.11: The Preferred and Effective HIV and AIDS Communication Strategies

Effective Forms and Strategies	No of Women Who Agreed
Interpersonal discussion in the locality	95
Support groups	96
PLWHAs volunteers / counselors	73
HIV/AIDS paraprofessionals	70
Community media /cultural media	75
Vernacular radio	70
Participating in HIV/AIDS talks	83
Community involvement	88
Economic and informational empowerment	98
Social role modeling	88
Door-to-door communication	86

Source: Research Data 2013.

In order to understand how the proposed or preferred communication strategies are effective in promoting attitudes and behavioural change to promote preventive attitudes and behaviour, all the proposed forms and strategies of communication have been classified into five categories namely: participation and involvement, community empowerment, social role modeling, local creativity, cultural sensitivity and integrative aspects. The women explained how each strategy was effective in transforming their behaviours and attitudes both from life story interviews and focus group discussions. Specifically, the women who had indicated a change in their attitudes and behaviours were examined concerning how such forms and strategies of communications were effective in the change process.

4.5.1 Promotion of Community Participation and Involvement

The discussion in the focus groups indicated that women were not fully engaged as participants in the communication that concerned them under the previous communication interventions. They reported that it was only through treating the women as participants and not as mere message recipients that the communication interventions could be effective for them. They observed that the communication they received especially from the government was created by the 'concerned bodies' with the belief that the women were too illiterate to help themselves. They observed that in such communication the morale of the women was lost since they perceived the interventions with suspicion and meant to denigrate them rather than for their own good. This has been the main reason for the failure of the linear communication strategies from review of literature (Govender, 2010).

In ideal situations, therefore, the women suggested the various levels and forms of participation that they thought would lead to success, which were lacking in the previous engagement. They mentioned that proper participation could make them capable of recruiting new members into the groups, where they were engaged in teaching the new members, where they were given new responsibilities to perform, where they were consulted in arriving at decisions of the community members and where they were fully recognised as having the ability to manage their affairs. These they said were very important in developing and implementing interventions that succeed in promoting change in attitudes and behaviour.

B1: We have not been effectively consulted by these people. What they do is come and mobilise us to attend the meetings where they teach us, have us give testimonies and give

us 50 bob each. We write our names, contacts, occupation and sign but nobody follows up with us!

B2: It is true that what they are doing for us is done in their offices and we are only thought about when they want to show us to their benefactors. This is truly corruption!

From the information above it is factual that active participation of women in their affairs has not been properly incorporated. The women observed that they were included only to 'rubber stamp' the shoddy or corrupt operations of the government and some self-centered NGOs. Many of the women also felt that some people misuse the women for their selfish gains. In cases where women indicated there was enough involvement, the women were actively engaged in initiating projects, recruiting members into support groups and they also sat in meetings to make decisions on all the activities of the groups and took part in implementing all the activities and operations of the groups or organisations.

A1: In our support group all members are equal. We sit and contribute in our meetings and make decisions. Each one of us has a responsibility and takes initiatives for the good of the organisation. In all meetings, each member gives reports on her activities and outlines the way forward, successes and failures.

A2: Yes, since we started the group, we have been together in setting, implementing and evaluating our programmes. We are given freedom and responsibilities. We have drama groups and choirs where all of us take different roles and we surely are determined to achieve these goals.

The above statements suggest that for effective participation in the intervention for HIV and AIDs, members formed groups and recruited new members into these support groups. These groups are managed by all members who are effectively involved with each person having a responsibility. This gives no room for one to backtrack or

relapse in the process. Moreover, the groups were situated within the community where HIV and AIDS prevalence was meant to be reduced.

From some of the life story interviews conducted women indicated that the support received in their initial stages of HIV and AIDs attack rejuvenated their lives and gave them hope that they too were with the community and could still live despite their HIV positive statuses.

C4: When I tested positive four years back, all my family members and relatives deserted me. They left me alone to die since my husband had died earlier. The only people who came around me were women from our support group who brought me food, gave me strength by motivating and persuading me to take the drugs. After I became stronger, they inducted me into all the activities of the club and gave me responsibilities to hold. I grew stronger in the group and right now I am the vice chairperson of our group. We have vibrant community choir and drama groups which are hired by politicians, institutions and the DC during various events.

Most of the women who deserted the supporting organisations to relapse on their risky sexual behaviour did not belong to any of these groups and their stories were different. They lacked the support and encouragement of support groups in enforcing adherences to recommended behaviours like taking drugs and sustaining required nutritional lifestyles.

D1: I don't have the support of the group because sometimes we don't have money and the children suffer. I try to take my drugs but sometimes I feel aloof, tired and lack motivation to continue living. The only time I have company is while in the beaches with beach women and men or in the bars. Surely life is not rosy!

The coordinators of the HIV and AIDS organisations reported the significant success they had achieved following the establishment of the support groups and

allowing them to operate independently in the villages. They reported that the support groups had made the women more active and responsible for various interventions at the community level. They also indicated that the bulk of the work nowadays happened through the groups themselves without much influence from the organizers.

F3: Listen to me Mister. There is nothing as good as when the hunted becomes the hunter! These women are active, aggressive and do a lot of activities for themselves. Ours is only to motivate them and source for finances outside here. We sometimes do supervision, you know!

The above sentiments were shared by the health communication experts who observed that the most effective methods of HIV and AIDS intervention were those that encouraged participation of the target groups, where they were free to participate in all activities that benefitted them at the community level. Such creativity made the women to own the programmes meant to assist them. They indicated that these participatory programmes had proven successful in countries like Uganda, South Africa, Rwanda and Eritrea where the HIV and AIDs prevalence rate was much higher than Kenya less than a decade ago. It was also noted that when it came to involvement, all the targeted persons needed to be engaged as equal partners not as subordinates who only needed assistance.

The involvement of women in HIV and AIDS activities and communication could start at the community level and build partnerships that were vital for producing a host of social workers to cover the entire community to promote the intervention. The involvement of women would reduce idleness and encourage the application of positive energy in activities that benefitted the entire community. The women as well as the key

informants indicated various reasons why they thought the participatory approach to communication was effective. Some of the reasons given include:

- Through participation, women took part in creating sessions for discussing HIV and AIDS issues which enabled them to access information necessary for behaviour change.
- The fact that it promoted allocation of responsibilities to all women was important since it made the young women too busy to engage in risky sexual practices and instead utilize their potentials in worthy causes.
- Made women to feel part of HIV and AIDS communication intervention hence promote their goodwill for success to be achieved.
- Taught women the life skills which were very important in evading HIV and AIDS since it empowers women with tactics for avoiding risky sexual practices.
- Opened up forums where women openly discussed their problems and provided avenues for creating local solutions to problems affecting women such as HIV and AIDS.
- Made women take charge of their destiny and to be responsible people in fighting to promote breakthroughs in their challenges.
- It was the only avenue for airing or venting their concerns for assistance from other able people.
- Raised the consciousness of women about issues that affect them and build both self and social efficacy which are instrumental in fighting the HIV and AIDS scourge and stigma.

Another important aspect of participation that the women respondents hailed as very effective was the use of HIV and AIDs support groups. A support group is a group of women who come together due to risks associated with the HIV and AIDS virus. It involves the act of helping one another among the womenfolk themselves. Within support groups are local solutions to local problems with very little intervention of the out-groups. Respondents indicated that support groups were very important for the following reasons:

- Support groups were small groups or mini-organisations for women at high risk where localized solutions and guidance on HIV and AIDS preventive behaviour were encouraged.
- The fact that it had voluntary membership enrolment was important since it reduced stigmatization among the members.
- Brought solace to members and cured loneliness associated with HIV and AIDs during positive diagnosis.
- A lot of sharing and teaching of women about HIV and AIDS happened in the support groups since most members have experience with HIV and AIDS.
- Support groups were vehicles of economic empowerment meant to rid women of poverty since the concerned women formed merry-go-rounds that financially sustain them to keep poverty away.
- Easy accessibility of information concerning HIV and AIDS trends due to continued interactions of the members using interpersonal dialogue.
- Promoted the sharing of preventive attitudes and beliefs about HIV and AIDS, hence promoting the culture of sexual responsibility.

- In the support groups women were free to discuss their issues and the effect of stigma was very limited.
- It was a cheap method of communication intervention for HIV and AIDS since the women were locally available from the community to initiate, implement and evaluate the programmes.

In conclusion, the study showed that participation and involvement of women enabled the adoption of a horizontal interpersonal communication strategy. This form of communication was important in attitude and behaviour change in two main ways: through encouraging collective dialogue and the formation of communication networks known as support groups. Collective dialogue and communication networks involve interactional process environments where the women are fully engaged in group activities with support group members especially the infected to rejuvenate their life through emotional guidance, the sharing of coping and preventive tactics and strategies, presence of collective lifestyle change through normative reformation, responsibility assignment which ensures that each group member engages in useful activities and making the women to build useful partnerships that encourage financial, social and emotional support which are necessary in attitude and behaviour change process.

4.5.2 Promotion of Women Empowerment

From the focus group discussions, the women recounted how lack of the right information or knowledge endangered them in activities that posed high risks. The women also narrated how poverty led most of them to engage in risky sexual behaviour with partners of unknown HIV statuses. The empowerment that women indicated as vital

were those that uplifted their socio-economic status and those that enlightened them with accurate knowledge or information for their informed sexual or behavioural choices.

A1: Many women have fallen prey to the HIV and AIDs virus due to both the lack of information and poverty. A well informed woman always makes the right sexual decisions and chooses partners wisely.

A8: If women can be encouraged by their husbands to get into some income generating activities in order to be economically stable, such risky practices like transactional sex can be reduced.

A3: We only need sensitization which can raise our consciousness to use our resources to make us financially stable. We become HIV ravaged because of poverty and inaccurate information.

When asked how they could be financially empowered, the women indicated that the supporting organisations can give loan to each support group with little or no interest charged so that they can start "chamas" (merry-go round) to mobilise funds for projects, given grants by organisations, given projects by banks as corporate social responsibility, be allocated some money from the Constituency Development Fund kitty to do horticultural and livestock farming which would boost their financial capacity. They also indicated that they could start revolving funds. These sources would give them economic stability to avoid being distracted by poverty and to make them self-sustainable. They also indicated that such support groups would provide the needed HIV and AIDs information and encouragement to avoid behaviour that posed risk. Some focus groups had women who had benefitted from their savings to start projects that were self-sustaining.

A1: We began our support group as a simple "*Chama*" because all of us were selling fish in our market. When fish was limited due to water weeds, "*joboya*" (fishermen) wanted to have sexual relationship for exchange with fish. We had formed our "Chama" two years back. We just came back and strengthened it. Now we don't get "*omena*" (herrings)

from the lake but from the market in large scale. We recruited young men who sell them for us in far markets like "koyugi" (Oyugis) Mbita and Nairobi.

From the life story interviews, the women indicated how the social networks they had formed for economic gains assisted them to both have financial comfort and readily available HIV and AIDs information. Most of them had small businesses and projects which were thriving due to the support they got from the support groups. They intimated that such small businesses reduced their free time, hence limiting the opportunity for sexual abuse by men.

C2: Why would I be worried? I can now have my own money for my needs and those of my family. I ceased seeking financial support from politicians and some people who wanted to sexually misuse me for business. It started in a small way but surely it has saved me!

The young women who had relapsed in their behaviour and resumed commercial sex work also confirmed the need for both information and financial empowerment. They agreed that economic stability was important, although they indicated that they had HIV and AIDs information. What was lacking was financial empowerment to enable them start businesses for self-sustenance. Some of them reported that as soon as they got enough money they were going to stop their risky sexual behaviour and seek the necessary skills to start and run their businesses and projects to rid themselves of poverty.

D4: You see we too do not like what we are doing. Just for the sake of money. Once I get enough, I will seek training and start my business or project at home. I can't continue doing this till my death. God will provide money!

The key respondents confirmed the need for both informational and economic empowerment of women as necessary for successful communication interventions. They

too observed that poverty had taken a toll on women making them to seek alternative avenues for financial stability. This had led the women into commercial sex work. They also confirmed that the inaccessibility of the mass media messages which were often used was to blame for the lack of change in attitudes and behaviour. They indicated that empowering women involved raising their consciousness with information to change their attitudes, social norms and behaviour. They also observed that raising consciousness to engage in small business was more effective so that they mobilise finance in their small caucuses or support groups.

I1: Giving loans or grants may be effective but not so much. We have observed that such loans or grants are often misused. What is effective is encouraging them to form groups from their own community where they do savings such as in their "chamas" (merry-go round) to raise capital for themselves. We should only provide them with training on business mapping so that they learn their potentials from alternative projects they can start and manage effectively.

G1: While it would be a good idea to empower them for financial stability, it is much more important to encourage them to stick together in the social networks of the like-minded support groups. These provide avenues for them to use interpersonal means of communication to exchange ideas about the main danger which is the reduction of the spread of HIV and AIDs. These finances should not be the end-points; we need them in groups for social support.

One of the representatives of the HIV and AIDs NGOs that operated in the area observed that giving grants would be effective only with women who had experience with the initial projects which were successful. He observed that the big challenge for the communication efforts was the poverty and cultural practices in the communities and such empowerment should also include men in the area so that the cultural and poverty problems were addressed among all members in the community.

F2: While it is true that HIV and AIDs prevalence is higher in women, interventions to change behaviour associated with its spread should not be isolated to the women alone.

Men who molest them also need to be part of the intervention. Both men and women should therefore be empowered with information to avoid the cultural norms which endanger people like forced inheritance. The financial empowerment should also include men for both genders to be effectively sensitized. What would happen if you see your wife busy with projects and not include you in them? This is total war (laughter).

From the discussions, it is evident that women and men needed both financial and information empowerment. This was important because an informed society makes right choices and decisions in the wake of HIV and AIDs risks. It makes women to be aware of preventive measures as well as how to live with the virus to avoid instances of lack of adherence to medication as well as stop re-infection or putting other people in danger. Such people include their sexual partners and children. The financial empowerment boosts the living standards of the population to eradicate poverty. This makes women self-sustaining and prevents idleness. The financial empowerment should include grants and personal or group savings. The idea of spiritual empowerment can also help.

The respondents indicated that both economic and informational empowerment was important in the communication intervention in order to promote HIV and AIDS attitude and behaviour change in the following ways:

- According to the Luo culture women had traditionally less economic and informational empowerment and raising their socio-economic status could reduce susceptibility occasioned by overdependence on men who take advantage of them and sexually misuse the women.
- Empowerment gave them information and economic resources to fight HIV and AIDS. For instance affording decent meals and the needed drugs.

- Made them self-sustained so as to reduce risky behaviours such as commercial sex work and casual sexual practices.
- Empowering women with information and economic stability promoted a change in their attitude as well a reduction of risky sexual behaviour.
- Raised the consciousness of women to address HIV and AIDS issues in the community effectively.
- Reduced their low self concept in the society hence boosted their confidence to take charge of their lives.
- Encouraged useful engagement of women hence reducing their time to engage in risky behaviours that expose them to the AIDS pandemic.
- Empowerment involved some educational sessions where women learnt the cultural norms and behavioural practices associated with sexual responsibility.

In summary, the study revealed that women empowerment was a vital communication component that sought to remove the burden from the benefactors to the women themselves. As noted, when women are not empowered to fight the HIV and AIDS prevalence, all the efforts belong to the government and the non-state actors. Women who indicated having changed their sexual behaviours mentioned three levels of empowerment: socio-economic, informational and emotional or spiritual empowerment. The women indicated that socio-economic empowerment made them engage in self-sustaining income generating activities such as merry-go-rounds, social projects and proper use of loans and grants which both limited their over-dependence on the men who sexually molest them and reduced idleness. The support groups they formed led to the

sharing of ideas, stress and coping strategies, which ultimately leads to emotional purgation and avoidance behaviours.

4.5.3 Interpersonal Communication Promoted Social Role Modeling

From the focus group discussions, most women indicated that some women members of the community, community health workers, support group leaders, religious leaders and provincial administration officials motivated them to join the support groups and encouraged them to practice responsible sexual behaviour. Some women also indicated that their joining of support groups was influenced by the good role modeling provided by their leaders. The role models comprised the local and foreign models that influenced the women to change their behaviour to reduce HIV and AIDS prevalence.

A3: If it was not the eloquence, patience and assertiveness of our community health worker; her soft-spoken self I wouldn't be in this group. I did not join this group earlier because of the arrogance of the former public health worker who was transferred to Homa Bay Hospital.

A1: Good leaders are credible, transparent and accountable! These are the virtues that define the members of our group. Most people and other groups around here envy us. All our members are able to motivate people to join our group. I am a proud leader of this group since all people I have worked with gave it their all and members of the community trust us.

From the sentiments above, role models have been reported to be able to influence attitude and behaviour change. According to the respondents above, it was the caring role models who motivated them to join the support groups since the behaviour of members were guided by community virtues which were encouraged. From the discussion with the young women who deserted some organisations, the sentiments were that the leaders of those groups were corrupt, arrogant and exhibited behaviour that could not be tolerated.

They taught women to abstain or have protected sexual intercourses and avoid commercial sex work, but were themselves found in compromising situations with men around lodging, brothels, pubs and dingy alleys at night. This constituted negative role modeling which failed to influence women to behave in a manner that would reduce risky sexual behaviour.

According to most of the women from life story interviews, some women stated that the coordinators of some support organisations linked the women with some men, which promotes sexual exploitation, and to avoid such sexual pressure, they decided to leave these organisations back to the former casual sex lifestyle. This implies that the leaders they trusted turned against them to expose them for more abusive relationships. The women indicated that positive role modeling was important to enable the young women in the low socio-economic statuses to develop high socio-economic status aspirations which would necessitate preventive lifestyles that reduced HIV and AIDS prevalence.

D2: Let me tell you, the main reason why I fled was that these groups were turned into sexual relationship avenues. Our leaders gave us pressure to hook up with some men. Some of them were very promiscuous. They slept around with other men but pretended to us. They were also very rude and arrogant to us. Someone cannot belittle me like that!

D5: I was fed up with people who wanted to sexually misuse me. That is why I have come here. Better to be used for gains than for nothing! I said these people are wolves in sheep's clothing! They cannot motivate someone and I cannot recommend a friend to join those things (groups).

The above sentiments suggest that the women who relapsed back to the beaches were not motivated to stay in the groups since there was poor role modeling going on. The major role of the role models is that they motivate attitude and behaviour change.

From the life story interviews with two women who had changed their behaviour and were members of the support groups, it was evident that good social role models were effective in promoting the change of attitudes and behaviour to control the spread of HIV virus in the community. Most women indicated that those people who they considered well behaved were instrumental in promoting change to seek medication, avoid re-infection as well as adopting preventive behaviours. This was because these models provided inspiration and practical experiences needed in the process of change.

C2: Having me accept my HIV and AIDs status was not an easy thing. I had believed I would not live to see the elections of 2007. Many villagers giggled at me as if I was good for dead. I was called names. Only one person always stood by me and came to my house. This was our "nyamrerwa" (village mid wife). She would bring me food and convince me that I still had a lot of years to live. She taught me how to pray and always trained me on how to walk again and above all guided and counseled me to accept my status and not to fear. She was ever prayerful. She would bring to my home different women who told me that they were HIV positive so I didn't have to worry. When I began going to public places, I would see her invited to sing in public gatherings. She would talk to people about preventive measures for HIV and AIDs as well as distribute food to the infected women in my village. The village mid wife was loved by everybody for her soft spoken and assertive personality. She trained me on cultivating the beans which I nowadays sell in large scale. She gave me fertilizers and would always see my food menu. From her I learnt a lot that life has to continue with precaution and following guidelines and recommendations. I can assure you I have lived for over 10 years with the virus and only some other cause of death will take me. Not "Ayaki" (AIDs). NO. She is the greatest friend I have now because she has saved my life!

C1: My life wouldn't have been here had I not heeded the advice of Mr. George Akong'o, the chairperson of our support group. He took me through his story of how he got infected, how villagers belittled him, how he was assisted by EGPAF community and advised me to settle down for change in behaviour to take medication to prolong my life. He is hard working and is able to source for the seeds to plant. These have made me get rid of poverty. I also have small business and "sukuma wiki" (kales) plantation that supplements my nutritional needs. He taught me many things concerning how to live with HIV virus. I believe without him I would be dead by now. God will bless him for his work!

The assertions above describe the role that social models play in motivating individuals to change attitude and behaviour. The respondents indicated that local models like community health workers and HIV and AIDs volunteers had good rapport with people of all kinds in the village. They also indicated that these models have experience in the area of HIV and AIDs and give people accurate and appropriate information that promote attitude and behaviour change. They also have wider connections and bring forth different people with various expertise who in turn motivate the women to take preventive and promote measures against HIV and AIDs prevalence.

A1: These people have assisted us with information we needed to change our habits and behaviours. They have introduced us to many knowledgeable and supportive people who have changed our lives. For instance, the village mid-wife introduced us to the USAID coordinator who has been very supportive to us financially.

The social models come from both within the community and outside it and the respondents indicated that even though those from the community were more appropriate, some of them had no financial capacity to help directly although they had skills for living and raising consciousness of the high risk people to start business and shun risky sexual behaviours. The role models sent by NGOs were trained communicators and were confidential about sensitive matters. Because of this they had supported the high risk women both financially and with useful information for behaviour and social change. Most of the women indicated that both the local and foreign role models were complementary and very useful in encouraging attitude and behaviour change to reduce HIV and AIDS prevalence.

C2: One of the people who have prompted change in my attitude and behaviour regarding HIV and AIDs and my babies is Mrs. Elizabeth. She was soft-spoken, responsible for her

kids and open to all people. She is ever concerned about other people. How I wish I had a heart like hers, people wouldn't die in my watch!

The fact that role models influence people's attitudes and behaviours can also be underscored by the sentiments raised by women who fled the organisations to continue with prostitution along the Lake Victoria beaches. When asked whether they would change their lifestyle to live like others who had changed, a lady hinted that she yearned for a day when she would live like the village para-professional-cum-head of HIV and AIDS-based organisation a Mrs. Karoney. This foreign role model was indicated as having changed the lives of many young women in the village.

D5: Some of these people are motivating. They talk with concern. It is only that poverty has rippled us. I would want to be like Mrs. Karoney whose sole job is care for fellow women to live decent lifestyle free from HIV and AIDs. I haven't met others as responsible. She convinced my friend Phanice to get settled in her marriage recently through humility and good communication.

All the key respondents confirmed the value of influential people in attitude and behaviour change process. All the HIV and AIDS centre coordinators observed that they always tried to model acceptable behaviour in the way they dealt with women who needed support. They hinted at some of the behaviour that could motivate others to change. The academics in health and development communication field also indicated that it was the effectiveness of the role models that made even television advertisements to be hosted by people with outstanding behaviour and personalities to be emulated. They reported that positive role modeling was very important in promoting behaviour change; and that each community had role models in various issues that could be utilised in a multi-dimensional HIV and AIDs intervention.

E1: We all must strive to be ambassadors of hope and change in the society since through our stories, talks and behaviours we touch the lives of others. We also encourage those who head various groups to have good behaviour to be able to motivate people for adherences.

G1: People always change attitudes and behaviour through social learning. This means other people identify with admired behaviour of models since these people are heroes or heroines. Because their behaviours are rewarded most women want to be like them and because of this women learn to behave like models so that they too can be rewarded in the society.

When asked the specific ways by which the women thought social role modeling was instrumental in promoting HIV and AIDS attitudes and behaviour change to reduce the HIV and AIDS prevalence, the following answers were noted:

- Role models were people from both the community and outside whose behaviour was admired and women could emulate such behaviour since they were the community behavioural expectations.
- Social models reinforced observational learning and promoted the adoption of good character
- Provided practical teaching making women informed about HIV and AIDS since they have a wide experience in the area of HIV and AIDS.
- They engaged village women in discussions especially in the media that appeal to and prevail upon women to shun irresponsible sexual practices.
- They engaged in personal promotion of good character which provokes the need to change irresponsible sexual behaviours.
- Some of the role models provided resources which women use to fight stigma and infection of HIV and AIDS at the community level.

- Most of the community models were very influential people and connected the women with many helpful people and organisations to assist them directly or indirectly in the fight against HIV and AIDS.
- Most of the social models were very friendly and approachable people who spent most of their time providing counseling services to the women at risk which promoted a change in their mindsets.

Another very critical finding from the study was that a successful communication intervention was that spearheaded by people living with HIV and AIDS (PLWHAs) in the district. This was because these people lived within similar social context with the persons at risk of contracting the HIV and AIDS pandemic and they volunteer information and counseling services to the masses. When respondents were asked the specific reasons for indicating these people as the most effective in conducting HIV and AIDS awareness and behaviour change campaigns, the following responses came up:

- They had practical experience with HIV and AIDS hence give people accurate information concerning the required attitudes and behavioural practices.
- They were highly trained in order to train other people in the life skills and preventive behaviours especially through the trainer-of-trainees workshops that they continuously attend.
- They were locally available and kept secrets of people which give the high risk women the confidence to intimate to them for practical assistances.
- They were considered role models in the community due to their changed lifestyles which gives them an edge over their peers in guiding women on issues of morality and behaviours that reduce irresponsible sexual practices.

- Most of them were very dedicated to support people at risk since they had also been supported and felt the pain others were going through due to stigma and other psychological depression.
- They were humble and warm to fellow women, which made them to develop and retain friends in the community. This is significant in building useful communication networks to educate women on issues related to HIV and AIDS.
- Using PLWHAs was not an expensive approach to communication since they developed informal networks easily which are platforms for open discussion and understanding of the issues about HIV and AIDS.
- The PLWHAs from the community used vernacular language in their interactions with the high risk women which makes their messages accessible and intelligible to many women. This avoids misinterpretation associated with the use of formal English and Kiswahili which most women do not understand.
- They had HIV and AIDS resources that support HIV and AIDS managements in the community. Most of these resources were shared with the high risk women more easily compared to those in the health centers in the district.

The women respondents also indicated that the HIV and AIDS para-professionals living in the community were very important spearheads of HIV and AIDS communication in the society. The HIV and AIDS para-professionals are either locally or foreign trained personnel in the areas of HIV and AIDS. They come in various forms such as community nurses, community social workers, and paramedical personnel, community birth attendants and mid wives, health volunteers. They can be deployed by the health sector, inter-governmental agencies and the community organisations. Most of

the women respondents reported that they were very instrumental in motivating them to change behaviour. Specifically, they indicated the ways by which these people promoted attitude and behaviour change:

- They were more adequately trained and knowledgeable of HIV and AIDS and many women in the district trusted them to give accurate information.
- They were easily approachable and accommodative to all sections of the community which makes women have confidence in them to be able to keep secret and manage stigma and psychological disorders.
- They were dedicated to help women change lifestyles and welfare due to the fact that their profession is based on public interest meant to promote the welfare of the humanity.
- They acted as role models for good behaviour which makes the women want to emulate and identify with them.
- Most of them were readily available for detailed sessions with the women concerning both life circumstances and challenges posed by the HIV and AIDS pandemic in the district.
- Most of them used vernacular language which was more accessible to the women in the villages.
- They had more HIV and AIDS resources to give for free to the deserving women in the community.
- They connected the women at risk to various supportive NGOs, state organs and inter-state agencies which promote access to HIV and AIDS services.

- They provided counseling and testing services as well as advising women on effective management of HIV and AIDS in the community.

In conclusion, the study realised that role modeling was an important interpersonal communication strategy that influenced attitude and behaviour change among women. The role models specified as instrumental in the change process included the local and international models who worked for HIV and AIDS organisations or who were behind the HIV and AIDS behaviour change strategy implementation in the district. Other notable influential models were provided by the people living with HIV and AIDs (PLHWAS) themselves who undertook to educate, inform and guide other members of the community on the coping and preventive behaviour and practices voluntarily. The para-professionals working as either HIV and AIDS counselors or community health workers were also very useful in motivating the women to adopt healthy lifestyles in the community. They provided the needed information to women and the youth especially in the area of reproductive health and healthy social and sexual behaviours. They also provided financial and emotional assistance to their clients through humility and effective interpersonal communication skills.

4.5.4 Promotion of Local Creativity and Cultural Consciousness

Most of the linear strategies have been criticized for their insensitivity to the various cultural contexts where some interventions made for women in the western countries have been applied in the sub-Saharan African context where there are obvious cultural clashes. This makes those strategies fail to fit in the African contexts. The linear

approaches have also been blamed for being developed for women not by the women themselves (Govender, 2010).

Most of the relatively successful communication initiatives in the world have had the local inputs of the targeted people. This is because the local women are not devoid of local creative means of providing solutions to the local problems. HIV and AIDs is also viewed at village level as a local problem since it is spread through local people. Hence, it needs local solutions that emanate from the local ideas of the high risk women or people who have interest with them. The idea of local creativity places interventions in their appropriate cultural contexts so that women adopt these ideas fully since they (interventions) have their input. The feeling of ownership of the ideas, problems and solutions are important for the needed attitude and behaviour change to be realised.

From the focus group discussions with women who had changed their attitudes and behaviour related to HIV and AIDs it was noted that the fight against the pandemic required the creative ideas from the women themselves. The women identified various local means out of the HIV and AIDs problems. According to the women who had indicated having changed, local drama, community songs and dances, local women networks, vernacular languages and dialects, community media, public testimonies, informal dialogues, oral traditions like storytelling, cultural and religious marriages, community-produced visual arts, informal adult education, traditional ceremonies and role playing were the most effective and culturally appropriate forms and strategies of communication for rural women in their local community.

The women observed that all these local forms and strategies of communication occurred in the community where cultural norms and taboos existed and such norms required appropriate forms of communication which all women could resonate with because they were products of what practically happened in the community.

The women who indicated having changed their sexual behaviour also added that some forms of HIV and AIDs communication should be infused in curriculum used in schools to prepare future mothers who were still within the formal education system. Adult education also needed to be strengthened to include HIV and AIDs; cultural practices which should be upheld and those that needed to be discarded like child mothers; child soldiers; child labor and socio-economic activities and virtues should be dealt with appropriately.

A2: Our grandmothers taught us to respect the institution of marriage and sex. Look at the idea of sex before marriage and the value of virginity which were premium in the traditional time, and how the new behaviour change strategy of ABC has glorified it. The idea of woman inheritance was not also a bad idea since it made widows sexually responsible to one known person after the death of the husband. This is similar to 'being faithful' in the ABC strategy. All in all most of these discounted cultures of the Luo were not meant for badness... (Laughter)

Some of the women also indicated the need to support community initiatives that promoted good livelihood. These also included church-based HIV and AIDs care and groups that infiltrated into the community where the sermons are laced with HIV and AIDs behaviour change information. The women also suggested that community games and sports which would allow participants to mix and share cultural messages including responsible sexual practices that reduce HIV and AIDs prevalence in the community also needed to be incorporated in the intervention.

Q. Why do you think these cultural initiatives will be important in reducing HIV and AIDs prevalence in this location?

A3: Simple. They are cheap means of passing messages. They are sex and age appropriate. They are also able to reach so many people. They do not lead to suspicion like communication in hospitals. I believe the women in the local community have idle or primitive energy that need to be exploited.

A1: We also need to empower ourselves and our colleagues to stand up and take charge of their lives. Most foreign ideas do not fit well with our socio-cultural situation. I feel embarrassed when those messages are passed to everybody including my children without respect for our culture. It says sexual matters do not need to be discussed openly.

The arguments above demonstrate that most women believe that the local solutions are cheaper and make use of the women in their own community to be able to provide solutions to their problems. The women also observed that the local initiatives were specific to each group hence conformed to the ideals of the cultural norms. All messages ought to be specific to age groups and gender, which promotes their effectiveness. As one key respondent puts it, using local language or dialect promotes intelligibility since it gives no room for different interpretations.

E4: I was once a counselor in charge of a VCT and relied on English a lot with my clients until one day when I released the result to a client telling her of the status as being HIV positive. The term was misinterpreted to mean good or absence of the disease. I later learnt that the client felt happy and ridiculed those who were infected of their sexual indiscipline which still exposed them to the disease. I was very sorry and embarrassed. From then I was cautious of the language to use. Women such as those need strictly vernacular language or dialects to reduce chances of miscommunication.

One of the health communication experts also observed that most of the previous strategies have ridiculed people's culture rather than take advantage of it. He indicated that people have remotely or rudely been informed to shun cultural practices to adopt new lifestyles. These he observed could only work within contexts where such cultures were

not the dominant ideologies. The best preventive and coping practices were those that integrated the new practices with the old cultural practices, since individuals did not live in isolation of their culture. To him, an effective form or strategy of communication was one that strikes the cords of the cultural contexts where application is done to make it effective. This, he said, would work well because the environment of a person determined whether the individual would change or not.

B4: I was chased away by my in-laws after my husband died because they didn't understand the kind of lifestyles I had developed. They claimed I had new suitors because some white men from USAIDs used to visit my home to find out my condition. These people rarely visited other homes, neither were they familiar. I had met them in the health centre and got introduced to them as a patient undergoing counseling. I later understood my in-laws because what I was doing was totally new and our culture had not approved of such relationship with strangers.

F3: We too as service providers have had a lot of blames from the community. Some people do not understand our roles. That is why we have appointed link persons who educate members of the community to accept us. This has now become easier with the setting up of many support groups which are managed in the community using their resources and energy. The community has now realised our roles since we strive to conform to the culture of these guys so that they own the programmes.

The stories by the two respondents demonstrate that foreign strategies are in many cases met with resistance from the community members since they often clash with the social norms and expectations. That is why all strategies being implemented in a community ought to get the goodwill of the members and it must have a little extension of the prevailing culture and local ideas which are produced within the community. This occurs when there is effective integration of the foreign ideals with local strategies such that none of them is perceived as sub-standard. Most linear strategies did not consider the integration with the community culture. As a result, they did not have the support and goodwill of the community. Most of them could not be implemented since it was

expensive and demanding to push them forth. Relying on local creativity reduces cost since the solution emanates from the community using local resources by the members of the same community.

The health communication experts confirmed the value of relying on the local cultural initiatives insisting that this was the new paradigm of approaches which when properly understood would be the most effective in developing and implementing successful interventions. This is because such interventions have the support and needed goodwill of the community hence making it a more cost-effective mitigation to mount with assured success in behaviour and attitudes change. The scholars, however, noted that its limitations lay in its specificity with community. This implies that it requires all communities to mount their own interventions since it is not as pervasive as mass media and public health campaigns.

The women respondents identified interpersonal discussions, community folk media, vernacular radio and door-to-door campaigns (nyolworo) as the most effective creative means of attitudes and behaviour change in the rural community. They also indicated various reasons supporting their assertions as described below.

Interpersonal discussions help because:-

- They often use vernacular language which is most accessible to all women.
- They are led by people who are quite informed and can be trusted by women.
- The feedback is readily available to the women on which to base their sexual decisions.
- They happen at all times hence availability of change-based information.

- They embody the cultural nuances of the community hence place HIV and AIDS discussion in the immediate socio-cultural contexts.
- They build interpersonal ties or friendships which lead to openness and expansive networks for efficient information flow to the entire community.

The community media which were also felt to be effective comprised of cultural songs, dances, teachings, proverbs, tongue twisters, sayings, storytelling, celebrations, and initiation ceremonies, musical instruments and public speaking events. The women indicated the various reasons why they were important in the change process as follows.

- They are locally created or innovated for societal benefits
- The songs are an embodiment of societal issues, problems, challenges, and good practices which mould behaviour of people towards the social norms.
- Community dances involve women in activities hence keep them busy and away from bad behaviour associated with irresponsible sexual practice.
- The community dramas involve the women to be busy and keep them away from bad deeds.
- The community drama facilitates high social status aspiration which changes the behaviour of women from unprotected sex and promiscuity to the decent ones.
- The community education days involve teaching of culture and morality.
- Music from the community is in vernacular language which is accessible by women.

The women respondents also indicated vernacular radios as important for a number of reasons given below.

- They broadcast in vernacular language and improve message accessibility since they are an extension of the community or public sphere through convergence.
- The presenters are members of the community, which promotes identity with them.
- They are available in most places in the village since most have local area coverage.
- They are free to air and only batteries are needed to play making them more affordable to the women.
- They have programmes that teach the women good behavioural practice to evade HIV and AIDS scourge.
- Most of the radios are portable and women carry them to all work places or to markets which promote the access to change-based information.
- These radios host opinion leaders who discuss HIV and AIDS issues promoting need to change from irresponsible sexual behaviours.
- The presenters or characters on such radios are role models to be emulated by most of the young women at risk.

Lastly, women respondents also proposed the door-to-door HIV and AIDS campaigns so as to reach as many households as possible with behaviour change information. They indicated that door-to-door campaigns are important due to the following merits.

- They help bring HIV and AIDS services to the family where there is freedom.
- It helps to reduce the stigma that women fear since it reduces status exposure to the family alone.
- Bring resources to the family to manage problems associated with HIV and AIDS.
- Bring solace to the deserted families or members of the community.
- Use local vernacular languages hence accessible to most of the women
- Reduce cost since it uses volunteers from the community and outreach workers.
- Provide moral or religious support to the family.
- Provide guidance and counseling services which reduce irresponsibility.
- Provide special services and management skills to reduce adverse effects.
- Have a wider reach as they target all individuals in the comfort of their families.

In summary, the study realised that the local creative means of consciousness raising was a very effective strategy for promoting attitude and behaviour change among rural poor women. These strategies included the interpersonal discussions, folk media, vernacular language and media and door-to-door campaigns. These were important processes because they improved message accessibility, audience reach, adherence to local culture, enlisted the support of most members of the community, cost-reduction, and continuity of the intervention and participation of the targeted members of the community. The study revealed that most of the poor rural women lacked the new technology of communication, consequently relied more on the traditional modes that were compatible with the dominant culture and philosophy of the Luo community where the interventions took place.

4.6 The Process of Effective HIV and AIDS Communication for Women

The study also aimed to describe the process of communication that promoted behaviour modification among the women who had indicated they had changed their sexual behaviour. This was important because such a process would be part of what effective communication model entails, as well as encourage the women who had not changed to transform their sexual practices in order to eradicate the HIV and AIDS prevalence. The responses of women regarding the process of effective communication have been classified under the interpersonal communication strategies below.

4.6.1 The Process of Communication for Involvement and Participation

Women from the focus groups described the process through which they came together to initiate their support groups, beginning from one person to many people each forming the current support groups. Members of the discussion groups described how they were recruited into these groups and how the process of taking up responsibilities and participation began. There were two ways that the women got involved with the HIV and AIDS communication activities. The first method was through a woman who sought the HIV and AIDS treatment from Homa Hills Health Centre, and the second method was through the community social worker who gave people information through public meetings throughout the district.

The discussion heard that the sick woman had gone to the health center to seek medication. Unaware of the kind of disease she was suffering from, the woman got tested for HIV and the result came out as HIV positive. In the process of treatment she was asked to bring forth the husband. Together they received counseling and information

regarding HIV and AIDS. Back home, they advised all the other couples who had a similar condition. This led to the development of a large group of HIV and AIDS community in the area around Rawi and Mainuga beaches. The story was spread through interpersonal discussions in the entire division where more people became recruited into the positive living support groups. These groups became strong social networks where the infected got HIV and AIDS services, while the high risk persons began to be educated and informed about the HIV and AIDS preventive behaviours. The uninfected also formed their own groups to inform, educate and help in the management of HIV and AIDS in the area. Most of the infected and uninfected members of the groups have become volunteers working for the people and linking them to health facilities and supportive NGOs.

A3: The founder of our group is long dead but we now work with some members who helped in forming this group. Our story is long. We are told that it was started by a family in Kanam who first learnt that they were infected by the HIV.

A5: There are many of such early HIV and AIDS families in Wagwe, Koredo, Kanam, Kauma, Kasaye, Kochoo and Kokoth who were infected and formed these groups through interpersonal networks

A1: We are still related to date. We know each other because in each sub-location, there are representatives who help people at risk with information and engage them in activities that lead to prevention of further infections. We work together with community leaders to recruit many people into the various groups and because of this even those who are not positive have been encouraged to form preventive clubs called zero support groups.

From the explanation above, it is evident that interpersonal communication networks which formed in each clan and at the sub-location level in the entire district were responsible for the formation of numerous other support groups. The women respondents indicated that they used to meet in many forums where they exchanged ideas. They also continuously recruited more members into these groups in order to

widen the interpersonal networks for HIV and AIDS related information to flow to all members of the community.

The second way by which the women formed the participatory groups was through the community health workers deployed by the government in the villages. They were responsible for providing HIV and AIDS support services in the two divisions of Rachuonyo District. Because of this, they worked closely with the local provincial administrators and community leaders. The community health workers nominated reference persons in each class and sub-location, who in turn recruited the beneficiaries of the support services. All these functioned as support groups, whose main objectives were to provide information to the high risk persons as well as educating the masses on safe sexual practices alongside liaising with the government and NGOs to provide drugs, nutrition and informational materials that benefitted the entire community.

A3: We have several other support groups formed by the community health workers. They too have social networks in the clans and the community. They link the community with the government for sustainable drugs, nutrition and other support services.

A5: During public or community functions, we join together as one community to achieve our common goals. No one can separate us when it comes to that, even though we operate a bit differently.

From one of the life story interviews, a woman recounted how she was recruited into their support group. She indicated that she was informed by another woman who was a friend to the former assistant chief's wife. She observed that it was the network of the assistant chief's wife with several other women that introduced her together with other women into the support group.

C3: I was recruited by my friend. I have also recruited two other women into the support group. The new recruits have also been successful in leading others into the fold. It is simple. It requires one to develop and keep friends in a large network of business, church members, and house wives in our homes as well as our discussions from markets.

The discussions with the women revealed that involvement and participation of women in the various HIV and AIDS preventive initiatives occurs through the formation of local networks of the like-minded women. It initially begins with two people where massive recruitment exercise then takes place leading to more people and elaborate communication network forming where discussion and assumption of various roles occur. In these groups HIV and AIDS prevention initiatives are developed and implemented to reduce risky sexual or predisposing behaviours.

4.6.2 The Process of Communication for Women Empowerment

The women were also asked the process through which they got empowered to adopt the HIV and AIDS preventive behaviours. Most of them observed that they always suffered due to delays in the support services given by both the government and the NGOs. They indicated that the suffering they experienced as a result of this motivated many of them to start small businesses as well as revolving funds (chamas). With the *chamas,* the women visited each member's home every Sunday evening to give their collections. The fact that these members were economically stable made other women in the area to be recruited to expand the *chamas* into women clubs. Even the men joined these rotational savings at times. Within the *chamas,* the women got both the financial and social support they needed to live independent lives. As the *chamas* grew bigger, the women during each social gathering began discussing social and family issues affecting

them such as family planning, nutritional planning, health and sanitation and disease (HIV and AIDS) prevention and management.

A6: We have made it because of the little savings we made during the days we did business. We used to save in our group of six women, who are all successful today. We had a *chama* in which each member could be visited once a week to be given her collection.

A4: In our chamas women were free to interact and discuss the social issues such as birth controls, sanitation matters, health and nutrition. We still do it to date! We have excelled so much in sharing information about HIV and AIDS.

From the life story interview with women who had changed their risky sexual behaviour, the story was not different. They indicated that it was their network of friends that enabled them to come up with the support groups where social issues including HIV and AIDS behaviour change have been discussed and implemented. The women confided that their financial and social stability resulted from the efforts from their own friends and their networks. A part from these, the women indicated that they also benefitted from education, information, socialization and guidance from their friends.

C5: The friends we developed in the community are the ones who helped us to get rid of the HIV and AIDS infection. We contributed money to eliminate poverty and we also shared about our social lives in this era of HIV and AIDS infection. You see Oriaso we have basically killed two birds with one stone! (Laughter).

The demonstrations above indicate that the communication that led to women empowerment emanated from the community networks and the social ties within the networks formed in the community. The preventive messages have been distributed to the entire community using these networks as communication links or channels. All the

women who have been empowered both socially and financially attribute them to the strong social bonds that occur among their friends and common womenfolk.

4.6.3 The Process of Modeling Responsible Sexual Behaviour among the women

The study also noted that role modeling was an effective means by which women were motivated to learn new responsible sexual behaviours in the district. The women respondents from focus groups were asked how they learnt from both the local and international models regarding preventive HIV and AIDS behaviours. Most of the women indicated that the process of learning new skills and behaviour involved observation, imitation and reinforcement of the rewarding social and cultural behaviour. The women indicated that they only imitated behaviour of the models that were both socially and culturally acceptable in the community. They indicated that they learnt how the models talked with people, how they worked diligently to serve others, how they related with the men in the area that exhibited responsibility and how the women showed humility to people who need help. The women also observed that negative models whose behaviours went against socio-cultural expectations were not emulated by anyone who still lives in the support groups.

A3: We have been helped to change our risky sexual behaviours through learning the responsible practices of the para-professionals, community health workers, volunteer members and some of our friends. They have demonstrated the socio-culturally acceptable behaviours that have been emulated by everyone in this village.

A2: Mrs Karoney and Karen have stood out as the best role models whose behaviour has influenced my habits and sexual practices. Most of my friends have been challenged to behave like them. Only the members who adopted acceptable behaviours still live in this part of the district. Many hard-headed women have gone! (Meaning: they have died).

C1: I have always avoided the harshness of some people especially the provincial administrators. These people quarrel with everybody and they expect even our children to behave like them. When they speak in public forums they talk as if they have a good image to be emulated by the youth and their peers!

From the descriptions above, social learning process that has led to the change in attitudes, norms and behaviours has included observation of the role models whose behaviours and personalities have been both socially and culturally approved by the community members. The women who have changed have copied these behaviours in order to get both cultural and social approval from the community as well. Such new behaviours include responsible sexual behaviours like protected sexual practices, avoidance of promiscuity, commercial sex, trans-generational sex and pre-marital sexual escapades.

4.6.4 The Process of Communication that Inspires Local Creativity in HIV Control

The women respondents were asked the process of communication that promoted and raised their consciousness to change their attitudes and behaviours against HIV and AIDS. Women from the focus groups indicated that they began to work independently because the financial support they were receiving from the government was not enough to cater for all their needs. They indicated that this problem led to a lot of deaths. The women were energised to find localised solutions to their challenges.

The women indicated that the support groups that they had formed due to the government initiatives had individuals with different skills and knowledge that could financially sustain them in the groups if well utilised. From the support groups there emerged the fact that most women had business prowess, others had handicraft skills,

while others understood clay work. Some women could weave baskets, mats and fishing traps to be sold in the community or to the tourists who visited the district. These skills made the women to get financial support in times of crises.

The established groups in the vicinity also enabled the women to discover their gifts such as acting in community drama, singing in folk choirs, engaging in village dances, and public speaking during public gatherings as well as teaching fellow women and those at risk of contracting the AIDS virus. The fact that the women formed the support groups and the government provided funds and medical support provided an opportunity for the women to establish more and stay in the social groups, where women with various gifts, skills and knowledge converged together to provide the local sustainable financial and social support for themselves and other persons at risk of the HIV and AIDS pandemic.

A1: Our support groups are made up of people with various gifts and skills which we have collectively tapped to help us out of the HIV and AIDS challenges. Women in our group know how to weave baskets and mats for barter trade; some know how to smear houses while others are gifted in business activities. Others act in educative and entertainment drama clubs as others sing in either church or secular choirs. All these have been helpful in modifying the lifestyles of our members since people no longer find time to loiter in urban centers and in the beaches!

C9: Let the sleeping dogs lie. We are now able to take care of ourselves. God has empowered us with various gifts. I can sing, dance and act and still get my clean money! Some of us no longer sit waiting for hand-outs from the donors and NGOs.

C10: There mama (grannie) has said the truth! I hear some people still say the governors will help us so we should wait.....hahaha....They too have families to feed. Some of these supports people are waiting for will come through the groups such as happened through CDF to Dwong'a. The leaders will also not get people out of their houses to be helped. God helps those who help themselves!

From the above statements, women got awakened to take charge of their destiny through interpersonal networks that originated from the local community. The tribulations associated with over-dependence on the support from the government motivated the women to look for local solutions that supplemented the assistance from the government and the NGOs. In the support groups, women with various skills converge together and employ the various gifts in providing solutions to their problems. The identification of individual gifts involves observation and interpersonal discussions and relationships of people within groups with shared norms and interests.

4.6.5 The Process of Culture-Sensitive Communication in Behaviour Change

It has been observed earlier that being sensitive to the culture of a community promotes the use of appropriate content and strategies in communicating with members of that community. This is because such a community has cultural communication codes, social and structural facts, norms, beliefs and codes of behaviour that the communication must seek to modify. Women respondents for the study noted that culture was an important parameter in influencing attitudes and behavioural change. They also indicated that the process of learning or acquiring the culture was through informal education given by people who were both socially and culturally competent in the local setting.

From the study, it was revealed that the dominant Luo traditional and religious culture had immense influence on people's beliefs and behaviour. Informal communication forums were central in promoting the learning of these cultures. The women indicated that learning of the Luo culture went together with learning of HIV and AIDS preventive attitudes and behaviours. For instance, the women indicated that in each support group there was at least one elderly woman who was believed to be the custodian

of the Luo culture. These elderly women were responsible for teaching the younger women the social and cultural expectations on their behaviours. These include teaching on gender roles, cultural taboos, the dos and don'ts of the community, sexual responsibility, management of health issues, relationships of the couples and food and nutritional expectations in the family.

From the study, women from both the focus groups and life story interviews concurred that after the cultural competence was gained by the women in the support groups, the latter had the responsibility of teaching the new recruits on the expected standards of behaviour. In this case, there was a continuous transfer of cultural knowledge to many generations in the community through informal dialogue and observation from the womenfolk. The women observed that most of the cultural knowledge taught was directly related to the new strategies advanced by the HIV and AIDS behaviour change interventions.

A1: In each support group an elderly woman teaches the younger women socially and culturally acceptable behaviours like avoidance of pre-marital sex, trans-generational relationships, alternative sexual partnering, commercial sex, lesbianism and bestiality. They also inform the women of the cultural dangers of non-compliance which are related to the effects of irresponsible sexual behaviour in the era of HIV and AIDS- death!

A3: Most of the cultural norms that these women teach are transmitted during informal learning sessions at home or in the centers. Each member of our support group knows and abides by them.

C3: In fact most of those who disregard these norms do not survive for long because they die from *chira* (or curses). Most of these curses are HIV and AIDS infections.

From the statements above, it is evident that cultural knowledge forms a greater part of the HIV and AIDS interventions in rural community due to the influence of the dominant culture. Most of the cultural dos and don'ts are directly related to the required

behaviour which leads to avoidance of HIV and AIDS. Most of the cultural expectations regarding women's behaviours are transmitted during the informal discussions at the community level by people who are regarded as culturally literate such as the elderly persons. Such means of communication has been hailed as effective because they are localized in the community as well as their anticipation of punishment for non-compliance, which is reinforcing.

H1: I think interpersonal discussion is effective in promoting attitudes and behaviour change because it is conducted by people who are respected in the village as custodians of culture. They observe the use of sensitive language as well as use metaphors that keep the learners wondering what they mean, hence provoke deeper understanding!

4.7 The Structure of the Preferred and Effective Communication Model

There were emerging two models used in the previous communication efforts. These included the model used by the government and the model used by the NGOs, CBOs and FBOs. These models operated differently due to sources of funding and the communication approaches used in each of them.

The respondents identified the main structures of HIV and AIDS communication in the district. When asked which structure was the most effective in communication, the respondents indicated their preferences giving various reasons for their answers. The table below shows the preference of communication structures.

Table 4.12: Low Status Women's Preferred Communication Structure

Styles and Structure of communication	No. of women who prefer the structure
Government structure alone	10
Community based structure alone	42
Integration of government and community	48
TOTAL	100

Source: Research Data 2013.

4.7.1 Position of Women on Government's Model of HIV and AIDS Management

From the focus group discussions, respondents described the government model as made up of elements such as National AIDS Control Council (NACC) at the national level, the Provincial AIDS Control Committee (PACC) at the provincial level, the District AIDS Control Committee (DACC) at the district level and the Constituency AIDS Advisory Committee (CAAC) at the constituency level. These operated under the ministerial bureaucracy and the communication is often top-down although reports of the grass-root participants have to reach the national level from where funds are disbursed.

In the model used by the government, the women respondents demonstrated that planning for HIV and AIDs communication was initiated at the national level led by the National Aids Control Council (NACC). They explained that the NACC tasked the agencies below it to develop strategic plans for their levels so that implementation occurred under controlled surveillance of the Ministry of Health and the agency (NACC). The respondents indicated that under such arrangements, they had little role to play save for the recipients', although some of them were appointed to the local facilitative committees but with little contributions to make.

The women, who indicated they liked the government structure of HIV and AIDS communication, gave the following reasons for their preference.

- Government is a great financier of HIV and AIDS and is predictable.
- The government supervises programmes effectively due to the elaborate human resource structure that exists.
- The government licenses all other operators including the non-state involvements at the community level.
- The provincial administration which government works with is all over the place which promotes quick service.
- The government has allocated budget for these projects throughout the country hence can afford comparative learning.

The respondents explained that most of their roles there were to 'rubber-stamp' the account statements for false representation justifying corrupt dealings occasioned by this arrangement. Although some of the women in the discussion groups felt that such system was meant for good, but vices such as corruption and nepotism had infiltrated it. The respondents also observed that most of the people who sat on these committees were not AIDS victims or people with HIV and AIDS experience. This limited the operations and effectiveness of the model used by the government to fully achieve its mission.

A6: The arrangement as it is now has led to corruption and ineffective decisions. Most members in those committees are corrupt and their appointments are based on nepotism to permit stamping of corrupt dealings.

A3: Not all levels are ineffective, I must say. The problem to me is that what is meant to be our affairs is presided over by some irrelevant people who want us to simply rubber stamp their deals.

A2: Let me tell you. They are in office all the time. They don't know what is happening at the grassroots. I would propose that this thing be given to some of us who are directly related with it.

When asked whether some of them were practically represented in these committees the women respondents indicated that they were represented but those appointed were relatives or stooges of the political elites to help perpetrate corruption since they rarely advanced the causes of the members. Some of the women respondents indicated that such arrangements had their advantages and disadvantages. The greatest advantage mentioned was that of lobbying the benefactors to supply drugs and the dissemination of such drugs to the beneficiaries. However, some of them also indicated that those processes were equally marred by corruption. Some of the respondents also said that such bureaucracies were acceptable since all government initiatives were operated bureaucratically, which ultimately benefitted the actual population.

B1: I wouldn't have a slight problem as long as my health rights are observed. Even if it was given to one of us, such vices like corruption and nepotism would still have been there.

B2: It is normal for government projects to run this bureaucratically since it passes through many heads. These people have tried their best. Many people would have died by now here in Nyanza. When you look at the skin of most people, they are healthy (*more laughter).*

The statements by the two respondents above were confirmed by the key informants who lauded the initiatives of the government especially in managing communication and supplying of life prolonging drugs. They attributed the current better

standards of life of many people in the district to the government initiatives especially its integration with NGOs and other concerned bodies in the fight against HIV and AIDS prevalence among women and youth in the district. This has been captured in the statements below.

H3: The government of Kenya has tried hard to improve the life of her people. There are many health centers, hospitals and CBOs that operate freely to disseminate HIV and AIDs information and life prolonging drugs. We also have the support of many NGOs, CBOs, FBOs, civil society and individuals.

H1: There may be many challenges, but with time such will be surmounted. The government has collaborated with various non-state bodies to offer HIV and AIDs prevention services. The problem there is that representatives of high risk people in committees have not been proactive before. But now I see they are alert.

The respondents were also asked whether they approved of the way the government and its agencies were dealing with HIV and AIDs communication. They indicated that the forms and strategies of communication were appropriate with some members of population such as the youth and men. For instance, they indicated that information, education and behaviour change strategies were appropriate for the youth in schools, colleges and universities as many studies also revealed. They were also effective with men, women and youth in urban areas where there was a bit of enlightenment due to available mass media and literacy level being higher than in the rural villages. The respondents indicated that men, unlike, women were more exposed since they would move easily to town unlike most women who remained at home most of the time.

Most of the respondents, however, indicated that the government's top-down approach was ineffective with rural women since most of them were illiterate, poor, lived in inaccessible locations cut apart from mass media reach. In general, the model used by

the government was not appropriate for all sections of the population in the country. They said such an approach also gave more room for corruption and cultural inappropriateness of strategies and messages. This lent support for the community-based model used by NGOs.

4.7.2 Position of Women on the NGOs/CBOs Model

The general position of the women on the appropriate model supported the model that was used by the NGOs, CBOs and FBOs in the community. The statements below capture this position which came from more than half of the women respondents.

D5: When messages are passed through radio or television, I do not get them because I am busy around here, but if it was passed through my friends, I can get it. The main issue is that the government has resources and nobody else has so we must make do with such messages even if they are disgusting to us like "mpango wa kando" adverts.

D1: These things would better be done by people they concern, not everybody. I like the new model being developed by NGOs like EGPAF since they rely on the community initiatives so that only those programmes are supported. They encourage participation and less corruption. They empower women to take their active roles in the society.

These sentiments got a lot of support from the key respondents who indicated that there was need for community initiatives to be supported as this made them effective in addressing HIV and AIDs communication. They observed that there was need to strengthen ties between NGOs and the government so that government would work closely with NGOs, CBOs, FBOs, civil society and all community members so that such communication initiatives, their planning and implementation could be done at the community level. The government and these non-state bodies should only be responsible for funding, monitoring and evaluating programmes at the community level while

community members to be empowered to do the other functions such as needs assessment, identification of appropriate solution and implementation of the programmes alongside their leaders.

G1: There is need to build partnership between state and non-state bodies for funding and monitoring and evaluating programmes while the initiation, planning and implementation to be done by the community members and their leaders. This will promote participation and appropriateness of the intervention.

G2: Many non-state bodies have realised the need to work directly with community other than involving middlemen with unnecessary bureaucracies. These have proved effective in the fight against HIV and AIDs spread. The most effective model will be one in which community forms the base of all activities with the government and NGOs just doing funding and supervisory roles.

The arguments above imply that, generally the high risk community, health communication experts, health practitioners, international partners and the local public administrations endorse a model that is conceived, planned, implemented and supervised at that community level. This means that funding and supervisory roles should be done by both the government and non-state bodies, inherent in the community HIV model.

The women respondents who indicated that they supported the community based model indicated the following reasons for their preference over the government's model.

- Lack of corruption in projects by the community agents due to participation
- Have no bureaucratic process hence quick service delivery to the members
- The approach is bottom-up and begins with the community where the problem is located for appropriate solution to be taken.
- The process is public interest-based as opposed to politics

- The community members participate fully in implementation of projects.
- All arrangements begin at the village level for the village folks
- Non-state actors are humble in dealing with the HIV and AIDS community

However, some funding mechanisms such as fundraising can be done at the community level. This would be effective since it would lead to the full participation of members of community with bureaucratic strings being dismantled to improve service provision to control HIV and AIDs prevalence. This model involves building and sustaining partnership among the stakeholders in the society. These stakeholders, according to the women respondents, include the government, non-state actors, the media, the community, the health fraternity, local leaders and opinion leaders.

4.7.3 Towards a New Model of HIV/AIDS Communication for Low Status Women

According to most of the women respondents there was need for a new model which could be composed of various groups of people from the community as the initiators of the HIV and AIDs communication programmes, and should include the following individuals or groups of people at the initial level of the communication intervention.

- PLWHAs with living testimonies and experiences
- Trained counselors or paraprofessionals to conduct more training programmes.
- Social workers with links inside and outside the community and who are capable of linking the system to the donors (Government and NGOs)
- Community health workers who have appropriate training and life skills
- The religious community such as Christian and Islamic FBOs and leaders.

- The representatives of provincial administration in the community like chiefs and assistant chiefs
- Teachers from all levels of education who are trained to serve as trainers of trainees.
- The non-governmental organisations and community based organisations

According to the women respondents the implementers of the HIV and AIDS communication programmes in the proposed model would include the following individuals or groups of people from the intervention contexts.

- The People Living With HIV and AIDS (PLWHAs)
- Community Members
- The Mass media
- The local Role models
- Community Social workers
- Community health workers
- Community Opinion leaders
- Representatives of the provincial administration
- Teachers who have the training as TOTs with willingness to serve the community
- Counselors drawn from local health establishments
- Communication experts especially in health and development specializations.

The respondents also indicated the following as the key financiers of the HIV and AIDS communication programmes in the proposed model, with various sources of funds indicated for the community's local initiatives.

- Government for loans, grants, donations, remunerations, medical supply.
- Community-fundraising, lobbying, savings, running businesses for capital.
- Non-state bodies-loans, grants, donations, remuneration, medical supply, running costs.

The supervisors, monitors and evaluators of the communication programmes would include the following groups of people according to the new model of HIV and AIDs communication mounted by all HIV and AIDS stakeholders which includes the community and the high risk persons from the community to socialize them to take responsibility for their actions.

- The Government of Kenya, i.e MoH and Health Agencies such as NACC.
- Representatives of the Provincial administration
- The NGOs, FBOs, CBOs and the civil society
- The community leaders.
- Community members represented by PLWHAs and para-professionals

The components of communication using the new communication model include the following activities and strategies undertaken by the suggested initiators and implementers.

- Giving people information to create awareness
- Involving people in identifying problems e.g. HIV and AIDs

- Encouraging participation through consciousness raising
- Providing motivation for collective goal achievement
- Community empowerment with information and economic resources
- Social role modeling of good behaviours, through both local and foreign models
- Promoting HIV and AIDs preventive lifestyles through allocating responsibility
- Creating forums for exchanging of information concerning HIV and AIDS, and
- Tailoring all activities to appreciate culture of the target community.

From the discussion with all respondents the communication process which was effective occurred at the community or at the local level using lay processes and the communication structure envisaged the integration of the key stakeholders drawn from the community, state and non-state agencies. This model uses the society-wide approaches comprising the participants as initiators, implementers, targets, financiers, supervisors and interpersonal communication methodologies and strategies.

The women who indicated the integrated approach as the most effective approach gave the following reasons for their choice as the structure that would work well in promoting attitudes and behaviour change among low status women in rural areas.

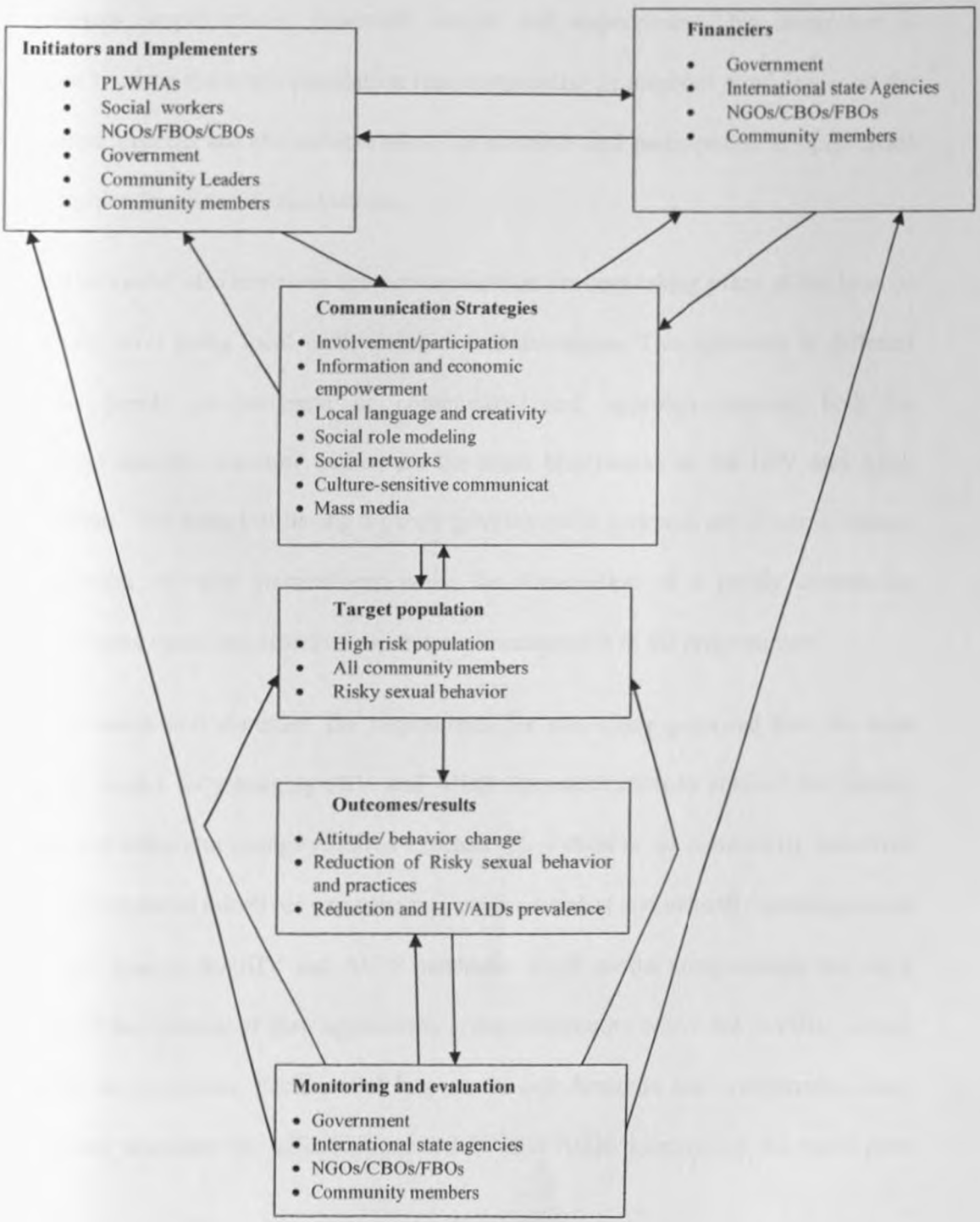
- The fight against HIV and AIDS has involved collaboration between the state and non-state actors and this would not be an exception
- A lot of non-state actors are brought in to fund projects.
- Good integration makes each party have specific responsibility which sustains the project.

- Initiation, implementation and evaluation take all stakeholders' efforts to be successful.
- The community is the common ground for all stakeholders' interventional processes.
- A mixture of communication strategies and approaches are used due to the fact of audience differences (use of mixed communication approaches).
- The principle of complementarities where the community is as important as the state and the non-state actors in the fight against HIV and AIDS.

According to the proposed model the people who initiate the communication programmes would implement the same to the target group who are members of the entire community. The government and non-state agencies as well as the community would be the financiers of the interventions. The same government and non-state actors as well as the community would do the supervisory roles in consultation with the community leaders. The proposed communication approach is consultative, multi-directional and exchange-based which makes it flexible for all members to agree on common direction to take in the intervention. According to this model there are constant interactions of participants and the fact that the whole communication process takes place in the local environment makes the resources to be used cheaper and culture-friendly. The diagram below shows the structure of the Proposed Integrated Community HIV and AIDs Communication Model.

Figure 4.2: The Proposed Integrated Community HIV/AIDs Communication Model.

Source: Researcher, 2013



The Proposed Integrated Community HIV and AIDS Communication Model assumes that the government and community-based organisations have the potential for integration with the community members in each of the stakeholder categories such as the initiators, implementers, financiers, targets and supervisors. This integration is important because the target population (the community) is involved at all stages of the intervention process and the collaboration, consultation and participation is open-ended which enables free flow of information.

The model also envisions the communication process taking place at the local or community level using local methodologies and strategies. This approach is different from the purely governmental or community-based approach because both the government and the non-state bodies are the main benefactors of the HIV and AIDS interventions. The danger of having a purely governmental approach are in one-sidedness and exclusion of other stakeholders while the domination of a purely community approach limits funds and effective supervisory mechanisms in the programmes.

In conclusion therefore, the respondents for this study proposed that the most successful model for managing HIV and AIDS communication to achieve the desired attitudes and behaviour change requires a mutual integration of the community initiatives with the government initiatives since the two are interrelated and mutually interdependent in the fight against the HIV and AIDS pandemic. Each model complements the other especially if the context of their application is the community where the problem occurs and needs interventions. Each model has merits and demerits and compensates each other, which promotes the effectiveness in HIV and AIDS intervention for rural poor women.

4.8 The Effectiveness of the Preferred Interpersonal Communication.

The respondents were also asked to demonstrate the effectiveness of the forms, strategies and model of the communication they proposed were appropriate in promoting attitude and behaviour change to control the HIV and AIDS prevalence. Women from the focus groups of the changed respondents indicated that the interpersonal communication approach was very effective. They reported the instances where communication such as this was used with either them or the cases they could recall as successful in the community or outside it.

From the study the most effective forms and strategies of communication were interpersonal in nature, which envisaged participation, empowerment, local creativity, role modeling, culture-sensitivity and integration, as opposed to the linear models, in promoting behaviour change in the society. The table below shows the overall responses concerning the effectiveness of communication strategies that the women proposed.

Table 4.13: Rating of the Effectiveness of the HIV Communication Strategies

Forms of communication	Respondents/women	Interpretations
English or Swahili radio	02	Not effective
Government initiatives	10	Not effective
Community initiatives	84	Very effective
Interpersonal Discussions	90	Very effective
Vernacular radios	83	Very effective
Community/folk media	88	Very effective
Participation in activities	93	Very effective
Empowerment of women	96	Very effective
Social role modeling	78	Very effective
Door-to-door campaigns	76	Very effective
Support groups	92	Very effective
PLWHA/ paraprofessionals	76	Very effective
Television programmes	02	Not effective
Chiefs meeting	16	Not effective
School curriculum	13	Not effective
Billboards/posters	10	Not effective
Doctor- patient dialogues	17	Not effective
Cinemas/films and videos	09	Not effective
Pamphlets and magazines	03	Not effective
Mobile phone/ internet	04	Not effective

Source: Research Data 2013.

Various testimonies came up proving the effectiveness of the proposed communication model and strategies in promoting attitude and behaviour change from the women who had changed their risky sexual behaviours and remained in the supporting organisations to continue with the benefits.

A1: I would say that our support group is still intact because of the selflessness of the members. We all know that apart from our individual savings, we have benefited from CDF funds. Every other day we also benefit from NGOs like EGPAF and community organisations such as Duong'a. Isn't this integration for success?

A2: But it is also true that government has been very supportive. They have subsidized the nutrition we consume for our day to day living besides making accessible and free the ARVs. We mostly attend government functions where we are adequately recognised.

Most of the women respondents observed that both the government and non-state agencies could work together if they avoided disagreements which were based on the differing interests. For instance, most government policies were championed by politicians while most non-state agency's policies were for public interests although some NGOs also had been reported as exploiting the victims or high risk people for their personal interests. For instance, one respondent in a life story interview had this to say:

C3: These people have made me tell my private testimonies in different forums but when I finish my story they even leave me trekking back home after being given ksh.50. What a misuse of people. They eat on our names! This is not a meaningful involvement.

The value of the integrated approach lies in the compensatory principle where inadequacies of one approach to intervention is compensated or solved by another approach. For instance, if the government is not readily available or accessible to boost an intervention, then the community approach comes in handy to sort the problem. This is why interventions at the community level have succeeded because of the additional responses of community members because the level of motivation and empowerment is higher than during the initial stages of interventions characterized by economic and social pressures. They observed that reliance on one of them exposes the intervention to stress.

Most of the women respondents in the focus groups also indicated that their change process was characterized by a lot of communication interventions from the community, government and non-state agencies through various programmes which originated from and were implemented by community members, which were more

effective than those from the external environment such as the government and other international state agencies. This was because of the cultural sensitivity and participation. The interventions that came from the collaboration of the key stakeholders were also effective and those that came strictly from outside the community were not recommended due to suspicion and lack of involvement of community and cultural insensitivity in the message strategy they used.

In a life story interview with a woman who had relapsed in her preventive behaviour, there was an indication that most of the linear forms of communication and strategies were ineffective because of the authoritative nature of the messages and messengers. The woman demonstrated how she was ridiculed by the local provincial administrators who were stationed to give them life prolonging drugs indicating that she was a prostitute in the public.

D4: You can't believe it, but he shouted at me calling me a bitch in the market place because I had not visited his office to pick ARVs. Gosh! I can't go back there again.

The women respondents from all focus groups also intimated that the interpersonal forms of communication were effective because women liked to use interpersonal relationships more than the more distant mass media. For instance, the large variety of methodologies in communication provided a lot of alternatives to use to pass messages which promoted attitude and behaviour change let alone giving information.

From the focus groups with women in the support groups, various reasons emanated for the choice of interpersonal forms and strategies of communication. These included but were not limited to the following: Firstly, most women in the village had

free time for informal discussions and it is in such contexts where issues which were serious to the women were discussed such as family planning, women battering, alternative sexual relationships ("mpango wa kando"), sexually transmitted diseases (STDs), cultural norms and HIV and AIDs infection.

Secondly, most women in rural areas had a lot of questions about HIV and AIDs which needed in-depth discussions necessitating the use of face to face approaches as opposed to the mass media. Thirdly, due to financial limitation, women in the rural areas could not afford other conventional means (media) of communication like televisions, radio and film hence they relied on cheaper means of communication like interpersonal conversations. Fourth, most women in rural areas identified with social models whose behaviours and lifestyles were considered modern so they copied so as to be like them. This makes role modeling an effective technique to use for promoting behaviour change.

Fifth, most women generally liked entertainment so that any avenue where entertainment could be found was most likely to be attended. For instance, women would join choirs, dramas, dances, local games, beauty competitions and cultural ceremonies. Sixth, most women in rural areas were illiterate and could neither read nor understand English or Kiswahili. This is why local dialects or languages with local signs, symbols or codes are recommended in their messages. Seventh, most interpersonal strategies promoted confidentially, which is most valued in women's communication especially on sexual issues. Eighth, most rural women form social networks faster and this is why most support groups which were effective were run by women. Ninth, most interpersonal forms of communication could be accompanied by preventative measures such as HIV testing and recruitment into ARVs as well as foster nutritional adherences. Tenth, most

interpersonal forms of communication were conducted by members of the community who could be trusted by rural women because they were popular and well-known to many people unlike the strategies implemented by strangers. Lastly, women in rural areas could be easily reached through interpersonal forms of communication than mass media due to economic, access and literacy factors.

The responses from the key informants concurred with the sentiments and assertions of the women respondents indicating that most interventions for HIV and AIDs had changed from the linear to more cultural or social approaches. This was effective because it was realised that locally-based strategies reached more people cost-effectively than the linear, individualized approaches using mass media and public information campaigns. They indicated that the more cultural approaches were necessary in cases such as this where interventions are proposed for homogeneous groups of women in rural areas. In this approach, they noted that the social and cultural factors that influenced behaviour change and effective communication strategies were those that considered the social and cultural norms of the community, not for their weakness, but for them to be vantage points for rationalizing effective and appropriate communication interventions.

Another very vital element of the social and cultural approaches lay in the utilization of multiple techniques at the local level which could effectively be used for creating impacts. The experts also observed that the socio-cultural approaches were context-specific remedies which were effective. The idea of participation and involvement of the community at all levels of initiation; implementation and evaluation improved the goodwill of the community making them to own the interventions leading

to their success. As one key informant observed, it was a demonstration that effective strategies were borne by the target population themselves:

G1: The solutions of a problem primarily lie in the people with the problem and not those subordinate to the challenges. This is why it's practical that members of the community if effectively involved can provide immediate solutions to their immediate problems. This makes community-based solutions more effective than foreign solutions.

The sentiments above are the likely reasons why one woman who had relapsed responded reluctantly to the question as to whether she would change after enough money was accumulated for her business. She was very categorical that as soon as enough money for her business was accumulated she would leave prostitution and embark on her business. This suggests that remedies for local problems lie with the affected groups, who have local ideas for solving them.

D4: You may not know, but I represent change when empowered by myself. These people aren't brighter or holier than some of us. I will make it (change)!

The key informant representing HIV and AIDs NGOs indicated that the developing trend where young women had begun taking initiatives was good for the HIV and AIDs intervention. They indicated that soon, the fight against the HIV and AIDS pandemic would be by the community and in the community. This would mark the period when the rates of HIV infection or death would be edging towards zero. If such initiatives at the community level could be replicated in most villages with high prevalence rate in Kenya, the fight against HIV and AIDs would have been fought and won:

H2: Most community initiatives in Uganda, Tanzania, Rwanda, South Africa.....name it, have succeeded in reducing infections and death, and similar ones in Kenya will no doubt succeed so we can say goodbye to HIV and AIDs.

4.9 Chapter Summary

The major findings from the study are summarized as follows, which are discussed in the next chapter in terms of their relationships with the reviewed literature in chapter three and the theoretical framework discussed in chapter two:

- Women had high HIV and AIDS knowledge due to mass media and interpersonal communication strategies
- Most of the previous HIV and AIDS communication relied on the linear communication approaches
- The linear communication approaches were not effective in promoting attitude and behaviour change, but increased HIV and AIDS awareness and knowledge among the women of low socio-economic status in the district.
- The most effective HIV and AIDS behaviour change communication approach for poor rural women in Karachuonyo was interpersonal communication approach that promoted participation, empowerment, social learning, culture sensitivity and local creativity
- The most effective structure or model of communication was integrative model where all stakeholders participate in initiating, funding, implementing, and evaluating communication programmes
- The processes of the effective communication for attitude and behaviour change were interpersonal and social networking, social modeling, participation and informal education among the high risk persons which had positive impact.

Chapter Five: Implications of Findings to Theories and Literature

5.0 Introduction

This chapter is a discussion of the relationship between the study findings, reviewed literature and theoretical framework. It discusses the findings within the contexts revealed in the previous studies that provided the background to the study. In this chapter it is shown how the present study findings relates to the existing information with a view to showing their consistencies or otherwise for new information to be explained. It also seeks to explain the findings within the theoretical framework and assumptions set at the initial stages of the study as well as whether the study objectives were met.

5.1 Women's Knowledge of HIV and AIDS Predisposing Behavioural Practices.

Through an overwhelming majority, women respondents demonstrated in-depth knowledge of the factors that exposed them to HIV and AIDs. This confirms the first central assumption that most of the women in the rural poor societies have adequate awareness about HIV and AIDS. The respondents also demonstrated the knowledge of preventive attitudes and behaviours. In addition, most women also recognised the challenges associated with taking action to reduce HIV and AIDs prevalence and adherence to medication. This finding confirms the problem statement that HIV and AIDs infection among women continues despite high knowledge and awareness among the women and most sections of Kenyan population. These assertions confirm the statement that there is high HIV and AIDs awareness in women.

The study by Govender (2010) indicates that most members of the population in South Africa had information on the causative factors, preventive measures and management of HIV and AIDs. The same views held by Karim (2005) study of Ghanaian women attending VCT clinics in Ghana would report that lack of status knowledge could affect their unborn babies. Studies from Nigeria (Okigbo, 2007), Eritria (Tanja, 2006) and Malawi (Mulwo, 2008) demonstrated that HIV and AIDs awareness was high due to the concerted efforts of both the government and non-state agencies. In Kenya, most studies have revealed the rates of HIV and AIDs infection to be on the increase especially among women in the low socio-economic statuses which the present study has confirmed from both focus groups and life story interviews. NACC (2010) noted that HIV and AIDs prevalence was shifting to the married couples due to alternative sexual partnering (*mpango wa kando*), prostitution and promiscuity. The present study established the factual nature of this statement because the women under the study were between 18-35 years either single or within marriages, where a similar trend was noted from the participants.

The present study also found that unprotected sexual practices among single or widowed women were responsible for the high HIV and AIDs prevalence in the district. This confirms the statement of the problem that the high HIV and AIDs prevalence in rural women was associated with unprotected sexual behaviour as shown in KAIS (2009), KDHS (2008/2009) and NACC (2012). Most of the local studies assert that among the married women, promiscuity and infidelity are the major causative practices for the HIV and AIDs prevalence in the women (KAIS, 2007/2009; KDHS, 2008/2009; NACC, 2012). The assertion by Ndati (2012) and Mulwo (2008) that there was

significant level of HIV and AIDs knowledge among students in high school and universities in Kenya and South Africa, respectively, are confirmed by this study since some respondents indicated that they got HIV and AIDs information from schools or informal education set-ups. From the study, a total of 60 percent of the respondents attributed the high HIV and AIDs prevalence to the factors such as poverty, women inheritance, promiscuity, peer pressure, polygamy, drug and alcohol abuse, over-reliance on birth control pills and risky lifestyles. These factors reflect the ones documented in many studies such as NACC (2012), KAIS (2007/09), Ndati (2012), Kiai (2009), Nzioka (1994), Egesah & Ondiege, (2002) and IPAR (2005) which make the present findings consistent and accurate.

The experts' explanations that there existed a knowledge-behaviour gap in HIV and AIDS communication for behaviour change confirms the assumption in this study and in Ndati (2012) that despite awareness level being high, most women and youth continued to engage in HIV and AIDs predisposing behaviours at a high rate. The present study had the assumption that the forms of communications being used were not appropriate for attitude and behaviour change while Ndati (2012) indicated that the mass media or linear approaches being used gave information, but did not reflect on the group or social construction of the youth of the messages in the adverts. This had initially been suggested by Nzioki (1994) as the major reason for the wide knowledge-behaviour gap.

The present study asserts that besides giving information, both linear and social network communication can foster attitude and behaviour change in rural women as described by findings. This has especially been possible considering the low literacy of rural women and inaccessibility of most of the mass media strategies. In the present

study, both the linear and interpersonal communication have different but complementary roles in attitudes and behaviour change process, such that while the linear forms mainly improve awareness, the interpersonal forms bridge the gap by promoting attitudes and behaviour change. The present study also demonstrates the circumstances where the linear approaches may promote attitude change that is insinuated in Ndati (2012) and Kiai (2009).

5.2 Forms and Strategies of Previous HIV and AIDS Communication in Women.

The findings confirm the second central assumption by the study that most of the forms and strategies of communication previously and currently used in HIV and AIDs intervention for women in rural areas were based on the linear models. All sections of the women interviewed listed radios, televisions, films, mural pictures, bill boards, posters, pamphlets, fliers, magazines, message from moving vehicles, message from school curriculum, messages from provincial administrators, road shows, guidance and counseling sessions in health centers, books, flip-charts, radio, community drama and speeches by community health workers and volunteers as the main sources of HIV and AIDs behaviour change communication.

Studies by Govender (2010), Ndati (2012), Kiai (2009), Joram (2010) and Mulwo (2008) demonstrated that most communication interventions have been based on linear approaches that utilised mass media and public communication campaign strategies. These strategies have reached many people with needed information for awareness creation. Many of the reviewed studies have indicated that the linear approaches have the advantage of increasing awareness but are not very effective in promoting attitudes and behaviour change (Freire, 1972; Govender, 2010; Kunda &Tomaseli, 2009).

The present study also confirmed the belief that the mass media promote awareness much more effectively than they promote change in attitude and behaviour. However, about ten percent of the women indicated that mass media also promoted change in their attitudes although such a change in behaviour was influenced by some intervening factors such culture, poverty and powerlessness which needed to be contained for such communication to make sense to the women.

The implication of the finding that some women in rural areas could be impacted by the mass media to change behaviour because of the pervasive nature of media has been reinforced by the traditional media effects theory called the magic bullet theory and the cultivation theory (Hovland & Janis, 1954; McQuail, 1997/ 2005; Griffin, 2010; Tan, 1985).

The present study findings have also demonstrated that the mass media and cultural strategies performed different but complementary roles in attitude and behaviour change and indicated that the linear models should not be rebuked. This directly challenges the arguments advanced by scholars like Govender (2010) and Kunda & Tomaseli (2009) that the role of mass media in attitude and behaviour change process is only limited to that of creating awareness. This brings to the surface the idea of integration of both the linear and socio-cultural communication strategies in communication for attitude change which is fully supported by the women in this study.

5.3 The Impact of the Linear Model in HIV Communication among Women

As described above, the linear strategies have been demonstrated to have very little impact on attitude and behaviour change among rural women. This has been demonstrated by some few women respondents. This notion has generally confirmed the present study's assumption that the linear approaches were not very effective in attitude and behavior change. Respondents in this study demonstrated how their current attitude change has been a result of integrating mass media and public campaigns with some cultural and interpersonal approaches. In some few instances the women have indicated that they changed their attitudes and behaviour due to available message source like vernacular radio, which ordinarily belongs to the category of the linear approaches. This argument has prompted the experts to argue that both the linear and interpersonal approaches have distinctive and complementary roles in the change process, which are instrumental for the success of the communication interventions.

The above assertion attempts to challenge Freire's (1972) and Govender (2010) absolute standpoints that the linear approaches are full of serious assumptions which are epistemologically and psychosocially dangerous in asserting that they can be effective to promote attitudes and behaviour change. The same position is held by Kunda and Tomaseli (2009) who argue that the most effective communication interventions mobilise the entire community using interpersonal forms of communication which are more central than the linear communication strategies. Such arguments have reduced the power of linear strategies to that of awareness creation alone. The challenge was, however, meant for this study to delineate the boundary of the two models in the change process as a gap that serves to complement Kiai (2009) and Ndati (2012) assertions.

The present study isolated specific reasons why the mass media messages could not be effective. For instance, people could not afford them; they would not be applicable where there was language barrier, where one already had HIV and AIDs information and where accessibility and identity of messaging posed cultural challenges. The present study observed that in places where most of the media were integrated the impact was higher than where a specific kind of media existed in isolation of others. This implies that an effective model of communication ought to integrate both the linear and interpersonal forms for effectiveness to be achieved.

5.4 The Effective Forms and Strategies of HIV Communication for Women.

As described above, forms and strategies of interpersonal communication were identified as the most effective in promoting attitude and behaviour change among rural women to control HIV and AIDS prevalence. There was a consensus in the value of interpersonal communication in relationship building, fostering participation, empowerment and cultural observance of social norms. This confirmed the study's major assumption that the most effective forms of communication are interpersonal in nature which help to build social ties and networks among women to create action for solutions.

All the key respondents agreed to this sentiment where women listed several strategies which were responsible for their attitude and behaviour change such as interpersonal discussions, using support groups, involving volunteers in communication, using people living with AIDS and par-professionals, integrating mass media with interpersonal approaches, relying on community creativity, relying on local dialects, participation in interventional activities by women, empowering women with

information and finances for self reliance, social role modeling and consciousness raising activities. All these forms and strategies of communication belong to the interpersonal or social or cultural strategies that are confirmed by Govender (2010), Ndeti (2012), Joram (2010), Kiai (2009), Morris (2003), Freire (1972) and Kunda & Tomaeseli (2009) as the most effective communication methods that promote attitude and behaviour change especially among poor women in the rural sub-Saharan countries such as in Kenya.

Freire (1972) observed that an effective communication intervention for behaviour change must be that which considers the social, cultural, economic and political establishment of an individual. He noted that it is one where the whole community is involved at all stages of the initiation, implementation and evaluation of intervention. This argument has been supported by Rogers & Kincaid (1981), Fishbein & Joseph (2006), Kiai (2009), Mulwo (2008) and Govender (2010).

From the present study most of the dimensions of the convergence and social cognitive theories have been applicable in putting together the elements of the intervention in the proposed model of communication. According to Rogers & Kincaid (1981) an effective communication strategy for attitude and behaviour change must have the following features (1) participation and involvement of women in activities to make them active. This aspect has been severally mentioned by women respondents as a feature making their intervention of choice more effective than others (2) community empowerment with both information and finances for rational decisions as well as promote self-sustenance through own business or income generating projects to remove poverty (3) social role modeling of good behaviour by fellow women or para-professionals whose behaviours were approved by most of the members of the

community for learning of rewarded behaviours to take place and (4) reliance on local creativity such as starting community dramas, sports, business enterprises, practicing culturally approved lifestyles and engaging in art and designs that promote HIV and AIDs preventive attitudes and behaviours.

In the present study, the women demonstrated that participation and involvement placed the behaviour change intervention at the local community level. This gave the women the freedom for own empowerment, where they could decide how to initiate and proceed on with the communication that benefitted them. This made them to be fully engaged in responsibilities that reduced their free time. The collective participation led the women to share the coping and preventive tactics available in the community because such avenue formed a free learning environment for the affected women. In the groups, there was also the encouragement of a common lifestyle and norm that regulated the women's sexual behaviours. All these were instrumental in keeping the women away from behavioural practices that initially exposed them to sexual risks in the community. The idea of participation and involvement was an instrumental dimension that aided effective interpersonal relations among the women to reduce and manage the HIV and AIDS prevalence (Kincaid and Rogers, 1981).

Community empowerment was another important interpersonal communication strategy employed among the women who changed their behaviour. This was possible when the women formed small groups for both financial and informational empowerment. This strategy ensured that all the women within the support group network got information on self-sustenance and socio-economic assistance. The two main impediments to sexual behaviour change included questionable cultural traditions and the

susceptibility of women to male sexual abusers due to poverty in the community. The socio-economic and informational empowerment created both HIV awareness and financial stability to avoid the risky over-dependence of women on men through risky sexual behaviours.

Role modeling also proved useful in the attitudes and behaviour change process. The study revealed that role models enabled the local women to copy admirable behaviours from the PLHWAs, mid wives, community leaders, para-professionals and other local and foreign models. The study also indicated that the models motivated the affected women to change behaviour through imitation of admirable behaviour of models, guidance and counseling that they provided voluntarily to fellow women, financial support and available change-based information to the needy women in the community. This facilitated self and social efficacy formation in most women to reduce risky sexual behaviours associated with contracting HIV and AIDS.

The utilization of the local creativity in solving social challenges also promoted attitudes and behaviour change among the women. Relying on local creativity is a significant method of promoting community ownership of HIV and AIDS communication programmes. From the study, most of the women joined drama groups, choirs, folk and community initiatives, interpersonal discussions and the door to door social marketing of the cultural norms and behaviours. These were important in reducing the cost of the communication intervention as well as integrating the traditional culture with the modern strategies to make them culturally appropriate within the Luo context. The reliance on the integration of new communication and message approaches with the underlying cultural communication specifications were vital in giving goodwill to most

of the attitudes and behaviour change strategies that were successful with the local women in the study site. This was also advanced by people who preferred community-approach to HIV and AIDS communication intervention.

Most scholars have advocated for the community-based communication interventions due to the fact that they occur at community level, with reduced cost and appeal for the cultural norms of the community. However, some scholars observed that it poses complications due to internal conflicts and supervisory technicalities which might limit their success in changing lifestyles (KAIS, 2009).

5.5 The Process of Communication which Promoted Attitude & Behaviour Change

The findings from the study indicated that various structural models of communication had different impact on HIV and AIDS behaviour change. From the study the integrated model proved more effective. This was because all stakeholders in the communication process collaborated and participated in the process of initiating, implementing and controlling communication programmes. From the study it was also found that interpersonal strategies of communication were appropriate and effective with women from low socio-economic statuses, as such appropriateness was due to the fact that interpersonal communication encouraged participatory involvement, social learning processes, interactional exchanges, empowerment of participants, culture sensitive communication and motivation for local creativity. All these fit into the dimensions of the convergence model (Rogers and Kincaid, 1981) and the social cognitive theory (Bandura 1986), which have been used to explain the forms, channels, structure and process of HIV and AIDS behaviour change communication.

From the study, it was revealed that the most effective communication was that which fully involved the people at risk and the process involved the horizontal exchange of ideas, participation in all activities, reliance on lay knowledge and innovations which are distributed among all stakeholders through interpersonal discussions. The findings also demonstrate how women got to change their behaviours through building communication networks where social and financial supports are assured. These networks diffused relevant information that led to change of lifestyles. All these are echoed by studies of Muturi (2007), Joram (2010), Govender (2010), Morris (2003), freire (1972) and Rogers and Kincaid (1981) who maintain that interpersonal processes are effective in promoting attitude and behaviour change.

The study has also reinforced the Bandura's (Bandura, 1986) concept of social modeling where most women indicated that they imitated socially and culturally approved behaviours through both local and foreign role models. The study by Rogers and Kincaid (1981) on the Oryu Li women initiative reinforces the fact that social learning is an important behaviour adoption process. The same sentiments are shared by Joram (2010) who indicates the role of para-professionals in motivating lifestyle change to adopt preventive and management practices for HIV and AIDS among rural communities in Iringa Province in Tanzania.

The findings also reveal that informal education conducted with the high risk persons by the culturally competent members of the community can be very effective in infusing cultural expectations into modern HIV and AIDS interventions. This argument reinforces Freire (1972) notion of culture-sensitivity and its influence in attitudes and behaviour change process. The findings indicate that the process of effective behaviour

change in a community is non-linear horizontal and continuous process that is began by the community for addressing their socio-economic problems while relying on the local resources and knowledge (Rogers and Kincaid, 1981; Morris, 2003).

5.6 The Structure of the Effective or Preferred Communication Approach

The last assumption of the present study was that communication interventions that fully involve the community members are more effective than those using top-down approaches. The findings from the present study confirmed this assumption and it is clear that women's involvement and participation were important ingredients in the communication interventions which were successful in promoting behaviour change.

From the study it was revealed that there existed two models of HIV and AIDs communication management in the district, namely the government's model and community-based model. The government's model was being implemented by government agencies at national level (NACC), provincial level (PAAC), at the district level (DAAC) and at the constituency level (CAAC), where the community was at the lowest receiving end. Most scholars have observed that such a model glorifies one-way communication process that relies on mass media and public health campaigns with minimal impact on attitudes and behaviour change (Govender, 2010; Kiai, 2009; Morris, 2003). Some scholars have also noted that politicians infiltrate into government models with personal political interests that lead to corruption and nepotism, which make such models ineffective in the long run (Tanja, 2006).

The representation of people living with HIV and AIDS in the communication programmes meant for them have proved effective since most interventions without such

inclusion of the target population have been misused and people have lost confidence in the intervention. It has however, been argued that the government's model was still important due to its supervisory and funding roles. This has been confirmed by NACC (2012), KAIS (2007/2009) and IPAR (2005).

The second model has been advanced by the non-state actors such as NGOs, FBOs, CBOs and the civil societies called community-based model. Most of the descriptions of what constitutes an effective model for all community members comprise the community-based model (Govender, 2010; Joram, 2010; Kunda and Tomaseli, 2009; Kiai; 2009). According to this model, members of the community who are at high risk of HIV and AIDs are the main stakeholders. They are very important since they help initiate the communication programmes as well as implement them while the non-state actors fund and supervise the on-going projects. Even though there is limited autonomy for the community members, this approach has succeeded because it includes key elements such as participation, involvement, empowerment, social learning and cultural sensitivity in the entire project cycle (Govender, 2010; Morris, 2003).

The community-based approach was based on Paulo Freire's approach to community development through the community themselves due to their involvement, and participation, social interaction, community empowerment and cultural creativity (Rogers and Kincaid, 1981; Campbell, 2003; Freire, 1972; Morris, 2003).

The findings from the respondents in most parts of the district indicated that neither of the models worked in isolation of the other. For instance, where the government's model existed, the community-based model also occurred. The implication

of this is that there was need for a structured integration where the two different models could operate together. In such scenarios, therefore, five main stakeholders to the intervention are noted. These include the initiators and implementers, financiers, targets, supervisors and strategies/methodologies, which constitute the proposed Integrated Community HIV and AIDs Communication Model. From this new model community members occupy the central position in all stakeholder categories which implies that they are the most important factors for communication intervention and are responsible for the formulation and implementation stage, funding, monitoring and evaluation, and as targets in the process. Equally, the government, NGOs, FBOs, CBOs and civil societies also occupy the financial and supervisory categories. This represents a communication approach with involvement, participation, empowerment, cultural sensitivity and local initiative characteristics that are associated with effectiveness in attitudes and behaviour change to reduce the HIV and AIDS prevalence.

Most of the women respondents, the health practitioners, health communicators, representatives of NGOs, opinion leaders and representatives of the provincial administration in the district endorsed this model as having the most potential for improving HIV and AID behaviour change communication for young poor women in rural areas of Kenya.

5.7 The Effectiveness of the Integrated Communication Model for Women

The findings on whether the proposed forms and strategies of communication would be effective were unanimously affirmative with both women respondents and experts confirming that there were several instances where such approach had succeeded

in Uganda, South Africa and Eritrea. Most reviewed studies recommended community-based interventions as effective (Kiai, 2009; Govender, 2010; Fishbein & Joseph, 2006; Rogers and Kincaid, 1981; Morris, 2003; Freire, 1972).

There were also factual observations that the current interventions in Rachuonyo North as well as other districts relied on arrangements such as the one envisioned by the proposed model despite the connection of the two models being loosely linked and unsystematic. Most of the testimonies of young women concerning aspects of communication which were responsible for their attitude and behaviour change pointed towards a combination of the government efforts and the community-based interventions applied at the community level.

The limitations that these arrangements have include competition of interests of the government and the non-state actors which might delay their implementation. Secondly, the government's bureaucratic systems would affect the efficiency of the programmes. Thirdly, the community's empowerment processes might be compromised by the bottlenecks that arise from such integrations, and lastly, the obvious differences between state and non-state actors are likely to occur, and in such cases, the community members are the 'battlefields' which might hinder development and the HIV and AIDS reduction.

The findings from this study are important in the consideration of a paradigm shift in communication interventions by specialists depending on the variables unearthed by the study. More importantly, the study findings suggest that all HIV and AIDs interventions for rural women in the country should use the community-based model

integrating major stakeholders like the government, NGOs and community members which would necessitate a change from the use of linear approaches which target individual members of the community in isolation (Govender, 2010).

5.8 Chapter Summary

From the findings on the effective forms and strategies of HIV and AIDS communication the study revealed that interpersonal communication at the community level encouraged attitude change which leads to the avoidance of risky sexual behaviour in several ways.

Firstly, vernacular communication promoted free exchange of ideas among women in the low socio-economic class, the para-professionals, CBOs and the government agents. Secondly it promoted the adoption of the community's normative expectations regarding sex such as avoidance of premarital sex, casual sex and promiscuity. Thirdly, community drama and role modeling enabled the young women to develop the high socio-economic status aspirations which necessitated a lifestyle change to that of the real social models as well as those portrayed in the community folk stories and dramas.

Fourthly, the community talk forums were learning avenues associated with instilling social values and norms to individuals for collective social change. Fifth, the folk media were associated with distinct identification with new roles which lead to the acceptance of new attitudes, behaviours and social change. Sixth, community drama and popular music were the vehicles of exchanging HIV and AIDS information which generated the social consciousness among the young women to discuss issues and

challenges in HIV and AIDS prevention. Lastly, interpersonal communication promoted the development of the culturally appropriate interventions such as placing premium on women virginity for prestigious marriage; promote social efficacy and collective compliance for attitude and behaviour change.

Chapter Six: Summary, Conclusion and Recommendations

6.0 Introduction

This chapter provides a summary of the whole study. It reviews the problem statement, research objectives and assumptions, study methodology, the study findings, main contributions to theory and methodology, conclusion and recommendations of the study. The chapter also presents the methodological challenges encountered in the field and the suggested solutions for future mitigations.

6.1 Overview of the Study

The purpose of this study was to find out the most effective forms and strategies of communication in promoting attitudes leading to reduction of risky sexual behaviours associated with the HIV and AIDs prevalence among young women from the low socio-economic statuses in Rachuonyo North District in Kenya. The research problem that necessitated this study was that despite the intensive communication efforts to change attitudes and behaviour many women still engaged in risky sexual practices such as unprotected sex and alternative sexual partnering that exposed them to high HIV and AIDs risks. This was especially high among women aged 18 and 35 years in the district.

The study was guided by four research objectives (1) to find out the knowledge level of low status women from Rachuonyo North District iabout the HIV and AIDS predisposing behavioural practices (2) to find out previous HIV and AIDs communication efforts used to promote attitude and behaviour change (3) To find out the forms and strategies of communication that the young women reported were effective in

promoting their attitude and behaviour change and (4) to determine the model of communication that would be effective in HIV and AIDs communication for rural women. The study was controlled by four assumptions (1) that the knowledge level of women was high concerning the HIV and AIDS predisposing behavioural practices (2) that previous and current strategies were based on linear models utilizing mass media hence were not very effective in changing attitudes (3) that the most effective forms and strategies of communication are based in interpersonal communication and (4) that the effective model allows for participation, involvement, social learning, empowerment and reliance on cultural norm which raises consciences of women and such approaches were based on the convergence model.

The study was conducted among 100 young women and twenty experts on HIV and AIDS and health and development communication in Rachuonyo North District. All the respondents were purposively selected due to their relevance to the study. Key respondent interviews, life story interviews and focus group discussions were used to gather the qualitative data from which conclusions and recommendations were made. For women respondents, a comparative case study design was used to conduct both life story interviews and focus group discussions among women who reported a changed behaviour and those who relapsed in behaviour due to some forms of communication. The experts were subjected to in-depth personal or key informant interviews.

6.2 Summary of Major Findings

This is the summary of the major findings and discussions of the study according to the four research objectives on which the study was based. Under the proposed

effective HIV and AIDS communication, a number of divisions have been identified based on the objectives which this section summarizes each in few paragraphs.

6.2.1 Women's Knowledge on the Predisposing factors for HIV and AIDS

The study revealed that most of the women had high awareness and knowledge of HIV and AIDS. This included knowledge of the causative and preventive behavioural practices (Table 4.2), the knowledge of rate of exposure to HIV and AIDS for each factor (Table 4.3), the knowledge of the overall variables determining disposition to HIV and AIDS (Table 4.4) and the specific information that the women had about HIV and AIDS (Table 4.5). From the study, women knew unprotected sexual behaviours, prostitution, casual sex, wife inheritance as well as the more hidden factors such as home deliveries and trans-generational sex which are uncommon means, depicting that their knowledge of HIV and AIDS was very advanced. Some women also insisted that with appropriate communication for behaviour change, factors such as poverty, cultural practices and illiteracy could be surmounted. This was evident in the fact that the very poor, illiterate and culturally immersed women still evaded the behaviour that exposed them to HIV and AIDS.

The study also revealed that despite the high knowledge due to abundance of HIV and AIDS information from the government and non-state actors, some women still engaged in risky sexual practices which exposed them to more HIV contraction risks. Poverty, questionable cultural practices and inappropriate strategies of communication to change attitudes, beliefs and behaviour were listed as the hindrance factors; and more importantly the study confirmed that certain forms and strategies of communication

promoted attitudes and behaviour more than others to control HIV and AIDS prevalence among women in the low socio-economic statuses in rural parts of Kenya.

The implication of the findings on the knowledge of women concerning HIV and AIDS is that an effective communication strategy is all that is needed to promote attitude and behaviour change. This will reduce risky behaviours responsible for the high HIV prevalence. Accurate knowledge about HIV and AIDS also empowers women to find strategies of evading the adverse effects of the cultural practices as well as devise mechanisms for socio-economic sustenance. With these, the factors like culture, illiteracy and poverty are merely predisposing and can be over-ridden with adequate and appropriate forms and strategies of communication. This confirms the first study assumption that HIV and AIDS knowledge is factually high among rural women.

6.2.2 The Previous HIV and AIDS Communication Efforts

The study revealed that most of the previous forms and strategies of communication for attitude and behaviour change to promote HIV and AIDS reduction were based on the linear model which relied on the mass media and public communication campaigns. However, there were some cases where such forms and strategies were augmented with forms of interpersonal communication, where the latter promoted some positive impact both in awareness creation and attitude change . Table 4.6 is a summary of the various forms and strategies of communication that provided the awareness to the women of the HIV and AIDS pandemic. From the table, it can be seen that the linear strategies dominated the list such as English and Swahili radio programmes, television, cinemas, school curricula, moving vehicles, billboards and

others. A careful study of the table shows that more women indicated that their high awareness level was associated more with the few interpersonal forms of communication such as vernacular media, women groups, social workers, HIV and AIDS volunteers and the folk media as summarized in Table 4.7 concerning the media that prompted change. This shows that even in creating awareness, often considered a reserve for linear models, the interpersonal communication was more effective. The fact that many linear methods of communication dominated the list of media for information to women suggests that they were the most common means of HIV and AIDS communication for the women, and Table 4.8 clearly shows that most women did not find them to have facilitated attitude and behaviour change.

The linear communication strategies were driven by government, non-state actors and sometimes by some CBOs to provide information which could enable women to reduce the risky sexual behaviour associated with the high AIDS prevalence. The findings on the forms of communication in the previous HIV and AIDS intervention imply that the previous interventions relied principally on the linear approach, which confirms the second assumption of the study that most of the previous communication interventions for HIV and AIDS among women were based on the linear approach that made use of the mass media and campaigns to reach women, with limited effects.

6.2.3 The Impact and Challenges of the Previous Communication Efforts

In terms of the effectiveness of the previous communication approaches, it was observed that the linear approaches were not very effective in promoting attitudes and behaviour change. Instead, most women indicated that they were only appropriate for

increasing awareness on the causes, effects and preventive measures of HIV and AIDS. While the majority of the respondents indicated that linear forms of communication were not very effective in promoting behaviour change, some few respondents indicated they were effective in the process of change, whereas a few women indicated that they were both effective and ineffective at the same time (Table 4.9). The majority of the respondents who indicated that they were not very effective gave various reasons for their assertions, such as difficulty of the messages, high cost of accessing them, lack of detail and feedback and generalized and culture insensitive communication styles (Table 4.10). The minority of the respondents who observed they were effective indicated that the current high awareness levels was attributed to the linear communication hence an evidence for their position.

In general, both women and expert respondents agreed that both the linear and interpersonal approaches were important in the change process because each served distinctive but complementary functions in the process. For instance, the linear approaches increased knowledge needed while the interpersonal approaches acted as a bridge in the HIV and AIDS knowledge and behaviour gap. The findings both confirm the assumption that linear methods were not very effective for behaviour change. The study also found that both the linear and interpersonal approaches were complementary and very useful at different levels where there existed integration of stakeholders and communication approaches. This has lent credence to the proposed model called Integrated Community HIV and AIDS Communication Model (Figure 4.1) which indicates the value of the integration of both approaches in HIV and AIDS communication intervention for women at the community level.

6.2.4 The Preferred and Effective Forms and Strategies of Communication

Nearly all the respondents preferred the interpersonal forms and strategies of communication as the most effective in promoting attitudes and behaviour change to reduce HIV and AIDS behavioural risks among rural low status women. This is because interpersonal strategies encouraged empowerment of women, participation in the local HIV and AIDS intervention activities, provided social role models which facilitated social learning of approved behaviour among community members, encouraged local creativity and cultural sensitivity in messaging the interventions for specific cultures and populations, which were important for encouraging attitudes and behaviour change. The respondents also indicated that interpersonal communication encouraged the initiation, implementation, evaluation and funding of the communication intervention at the community level where the target population took full responsibility for their actions.

The forms and strategies of communication that the women proposed to be effective in promoting attitude and behaviour change include interpersonal discussions, formation of and working with support groups, using PLWHAs volunteers to communication with the community, using HIV and AIDS paraprofessionals as models, relying on vernacular radios for mobilisation, community involvements in local intervention projects, economic and informational empowerment of women, social role modeling even from within the community, using door-to-door campaigns, utilizing the community folk media and encouraging local cultural creativity to address local problems such as the HIV and AIDS pandemic, which are presented in Table 4.11 in terms of how the respondents polled for them.

The preference was made to the forms and strategies of interpersonal communication for various reasons. For instance, the use of vernacular language which was accessible to all women in the community, readily available message details and feedback, embodiment of cultural relevance and appropriateness of information, cost-effectiveness of materials, promotion of the culture of sharing and free experiential learning to the members, empowerment of women to take charge of their destiny, involvement and participation in all activities which promote goodwill and responsibility and well as bringing the communication services to the people who are concerned with them as opposed relying on foreign conceived and implemented interventions.

The Finding on the preference of the forms and strategies of communication for behavior change among low status women was important in demystifying the reasons why the previous communication efforts were unsuccessful with this category of people. It confirms the study's central assumption that forms of interpersonal communication are more effective in promoting attitude and behaviour change to reduce HIV and AIDS prevalence among rural low status women. It also sheds light on the value of choosing appropriate communication in dealing with difficult variables for change such as attitudes, norms, beliefs and prejudices as well as exposing the limitations of the linear approach to communication.

6.2.5 The Process of Effective Interpersonal Communication among Women

The study revealed that the process that ensured effective communication for attitude and behaviour change involves interaction of all participants in producing and distributing information among themselves. It also involves horizontal processes that

promote consultation in the initiation, implementation and control of the communication process by all participants. Interpersonal networks, social learning and informal exchanges constitute the effective processes of communication at the community contexts. Linear methods of communication proved to be instrumental mainly in increasing the awareness of women about HIV and AIDS and the study demonstrated that interpersonal strategies help in bridging the knowledge-behaviour gap in communication for behaviour and attitude change.

6.2.6 The Structure of Effective Communication Model

As evident in Table 4.12, the integrative approach to communication was preferred because the government and community-based approaches are complementary. This led to the proposition of the Integrated Community HIV and AIDS Communication Model as the most effective style of communication management that promotes attitudes and behaviour change to reduce HIV and AIDS prevalence among low status women. It includes the government, community members and the non-state actors' efforts in initiating, implementing, funding and supervising and evaluating the communication programmes at the local level.

The study revealed that initially there existed two models of health communication in the district, namely, government model which was one-way and coordinated at national (NACC), provincial (PAAC), district (DAAC) and the constituency (CAAC) levels where the community members were at the lowest receiving end. The other model was community-based approach which was being championed by NGOs, CBOs, FBOs and the community members where initiation, implementation,

funding and supervision were done by both the community and the NGOs. The integration of the two models led to the development of the Integrated Community HIV and AIDs Communication Model (Figure 4.1) which the study proposes as the most effective.

The value of the integrative approach to HIV and AIDS communication which this study identified is that it acknowledges the cooperation between the government and the non-state actors in the fight against HIV and AIDS which is regarded for success. It also facilitates the performance of all interventional activities since each party has a role to play in the change process. It also acknowledges the fact that both parties converge at the community who is the sole beneficiary of the communication efforts. Lastly, integration reasserts the value of togetherness in creating solutions to the local problems as noted by Rogers and Kincaid (1981) and Paulo Freire (1972). The findings confirm the study's assumption that communication within the convergence theory is more effective in promoting change for all participants.

6.2.7 The Effectiveness of the Preferred Communication Model

According to the findings on Table 4.11, all forms and strategies of interpersonal communication were effective. The same is approved by the findings on Table 4.13 that most of the strategies based on the linear model and the mass media strategy were not very effective in promoting change in attitudes and behaviour. A discussion following Table 4.11 also gives the reasons why the linear approaches were less effective. All the findings confirm the assumption that the interpersonal forms and strategies of communication are more effective than the linear approaches in promoting behaviour

change to reduce HIV and AIDS prevalence among rural women in the low socio-economic statuses in Kenya. All the respondents were unanimously convinced that the approach that integrated the key stakeholders in the HIV and AIDS prevention like community members, non-state actors and the government was more effective especially when the community members who are the beneficiaries were placed at the centre of the intervention with some kinds of autonomy. Most of the women respondents and HIV and AIDS communication experts agreed that community-based initiatives were the most effective since they had been applied in other countries with sustained impacts on attitudes and behaviour change. It was, however, agreed that each model of intervention had limitations and challenges which an integrative approach would compensate hence improving the effectiveness.

6.3 Conclusions of the Study

This study has come up with a number of conclusions which are vital in understanding the strategies of effective HIV and AIDS communication for women. These conclusions are important in analyzing the objectives of the research as well as informing the direction of future policy direction and research studies in health and development communication fields. These conclusions are summarized below.

6.3.1 Knowledge of Rural Women about HIV and AIDS is currently High

The study noted that the HIV and AIDs knowledge was high among rural women although behaviour change remains a major challenge. This had been due to the application of the forms of linear communication with little impacts in promoting attitude change among women to adopt preventive and adherence behaviour to reduce HIV and

AIDS prevalence. This conclusion contradicts the findings of many studies whose assumption that women in rural areas being illiterate do not have information concerning the HIV and AIDS predisposing factors. It supports the assertions that HIV and AIDS awareness is high but the corresponding behavioural change has a gap (Ndati, 2012; Fishbein & Joseph, 2006; Chandler, 2008).

The high knowledge level of women is attributed to both the linear and interpersonal forms and strategies of communication either given to women or conducted amongst the womenfolk in the social setting. From the study it was evident that the linear strategies co-existed with interpersonal approaches, and that the linear strategies dominated the list of the forms of communication used so far. It is clear from the findings that interpersonal forms of communication were more effective than the linear strategies in both awareness creation and behavior change among the low status women. The main reason for the minimal behavior change despite the communication efforts so far was due to the application of and placing of significance on the linear approach as the dominant paradigm over the interpersonal communication for the low status women.

6.3.2 Previous Communication Efforts were for Women Not by Women

The study noted that women were thought to be devoid of communication ability hence communication was transmitted to them, especially through the linear approach of mass media and campaigns. These were not very effective because of their epistemological assumption of linear causation in the communication process (Rogers & Kincaid, 1981). The women continued to engage in risky sexual behaviours since the forms of communication could not promote attitude, belief, normative and behaviour

change. The strategies also targeted individuals in isolation of the society, whereas this study proves that a sustained attitude and behaviour change occurs in social networks of the women. This study therefore reaffirms that forms of interpersonal communication are more effective in promoting attitude and behaviour change especial among women in the low socio-economic statuses in rural areas, although the linear approaches were also instrumental in awareness creation and forming the basic for the process of change in some situations. This study therefore suggests that both the linear and interpersonal approaches should be used complementarily for the full communication impact to be achieved, since both serve different but complementary roles in the change process.

6.3.3 Challenges with Developing Communication for Women

The study noted that communication that was developed for women was not very effective because such innovations were grounded on the assumption that women were helpless and devoid of any creativity (Muturi, 2008). Most of these strategies always fail since they lack the goodwill and support of most women. In many cases, women in the study mentioned that the developed communication was top-down, generalized, diffused, foreign and culturally inappropriate for them. Therefore the study noted that any successful intervention for women needed their participation and involvement for impact to be felt (Govender, 2010). The study suggests that poverty, illiteracy, retrogressive cultural practices should not be the basis for the decisions to work for the women since the study chronicles how illiterate women in the low socio-economic statuses created solutions to their problems with little support from the external sources. The study also found that the women who changed attitudes and behavior produced and distributed information among them. The study also found that in such successful interventions,

women played crucial roles at the initiation, implementation, funding and control stages in the HIV and AIDS communication intervention and management.

6.3.4 Forms and Strategies of Communication which work for low statuses women

Analysis of the forms of communication so far used in behaviour change strongly pointed towards interpersonal communication as the most appropriate and effective for the women. This happens despite the widespread notion that modernity which comes with new ways of communication changes the social networks. From the study, the traditional means of communication in the community setting are what work for the women as opposed to mass media and other linear strategies. The social media, as it grows quickly is an extension of the community's social networks and the public sphere or platforms for informal conversations and not a replacement of the traditional communication networks as many linear approaches suggest. From the findings, the linear strategies which have dominated communication interventions for HIV and AIDS from its discovery to date have been partly responsible for the continued knowledge-behaviour gap, even though it has been responsible for the high awareness level as well as promoting behavior change among the youth and other persons in urban areas.

6.3.5 Effective Communication Process for HIV/AIDS among Low Status Women

The study concludes that an effective communication process is horizontal, consultative, localized in the community context, involves multi-directional production and exchange of information through interpersonal networks, involvement and participation, encourages social learning of approved norms and behaviours and occurs through informal education resulting from social learning and the guidance of the

culturally competent members of the community takes place. This kind of communication is sensitive to the dominant culture of the target group.

The process of effective communication for behavior change is a natural process of interaction of all participants through consciousness raising processes, formation of small groups and networks and the reliance on collective dialogue for local solutions to local problems. The findings revealed that the networks are either formed by enlightened community members or through community para-professionals who raise consciousness of the members of that community. The groups and networks then expand due to interpersonal influence and social efficacy of the members of the community.

In the process of attitude and behaviour change, from the findings, the main role of the linear communication approaches is to provide information to create awareness while the interpersonal forms of communication or activities bridge the knowledge-behaviour gap through promotion of attitudes, belief and normative changes that promote the adoption of the required behavior.

6.3.6 Effective Communication Structure for Low Status Women in Karachuonyo

This study proposes the Integrated Community HIV and AIDS Communication Model which is a combination of the government and community-based models, founded within the premise of integration of the state, non-state and community initiatives at the local levels. This collaboration is important in the initiation, implementation, and evaluation and funding of the communication programmes. In this integrative arrangement, the community, which is the major beneficiary of HIV and AIDS communication programmes, is centralized as an intermediary between the state and non-

state actors in HIV and AIDS interventions because the process occurs in the community. The integrated model puts the community members at the heart of the intervention. For instance, the community exists at the initiation, implementation and evaluation stages of the projects.

From the findings, PLWHAs, paraprofessional, community leaders, the government representatives and the CBOs/FBOs and NGOs representative identify risks, decide on the course of action, roll out the programmes as well as evaluate the extent to which the interventional objectives are being met. Each group mobilises the funds for the project in their own way to facilitate the activities meant to achieve the HIV and AIDS interventional goals.

The major strength of this approach is that it always takes the collaboration of both the government and non-state agencies for the success of community initiatives and this would not be an exception. It is also not reliable to depend on one element in a society since each party benefits the intervention in its special and unique way, which alludes to the cybernetic thinking adopted in this study.

6.3.7 The Value of Interpersonal Communication for HIV/AIDS with Low Status Women

The key finding of the study is that interpersonal forms and strategies of communication are effective with the low status women in promoting change in attitudes and behavior associated with reduced behavioural risks. All the respondents indicated the various dimensions of the use of interpersonal processes, which were a limitation of the linear approaches to communication for development and behavior change. In general the

respondents gave the following reasons to justify their preference of interpersonal approaches to behavior transformation:

- Interpersonal processes are instrumental in building informal networks among women which were effective in producing and sharing information, attitudes, social norms and behaviours, which are associated with reduction of risky sexual behavior.

- Through interpersonal communication in the networks, consciousness raising occurs, which empowers community members to recognize their threats, hence encourage the thinking to device local means for solutions

- Within the interpersonal networks created by interpersonal processes, the local women are assigned responsibilities in the intervention programmes, which empower and reduce their free time, through what they call 'meaningful involvement'. This promotes social efficacy associated with social transformation.

- Informal networks encourage platforms of free expression and dialogue among the marginalized women, where they discuss their issues as women from their status group listen and provide the possible interventions. They discuss issues on HIV and AIDS to clarify their numerous questions on AIDS.

- Women networks called support groups encouraged localized information creation and distribution as well as the initiation of economic projects,

both which raise they knowledge and ensure socio-economic sustainability. The finding revealed that women began agricultural and financial projects such as poultry farming and 'chamas'(merry-go-rounds) which were very important for the HIV and AIDS intervention

- Through interpersonal processes in the women networks, social learning of culturally acceptable behavior and norms has been possible. The women indicated that they imitated the acceptable behaviours of paraprofessionals, PLWHAs, community and religious leaders. This is important because it promotes adoption of the required change.

- From the finding, interpersonal communication has led to the appreciation of the role of culture in the process of social change. This is because of the specificity of interpersonal processes to various contexts. Social facts of the community have been seen as instrumental especially as local creativity and norms which are macro-variables to individuals. Culturally appropriate interventions have been encouraged, and

- The idea of integration at the community level has been a reality due to interpersonal dialogue among the local stakeholders. For instance, it has been easier to converge all parties to the HIV and AIDS interventions at the grass-root level due to sharing of the context and effective relationships among people due to local community networking skills.

All these reasons make interpersonal processes more preferable to the linear approaches in all intervention due to participation and involvement of all members of the community in their affairs as opposed to creating interventions for the community.

6.4 Contributions to Theory and Research

This study has many contributions to theory and research in the field of communication. These contributions are on how to fill existing research gaps, on clarifying misconceptions, coming up with appropriate strategies, practical applications of theory and the new model of solving the communication problems.

Firstly, this study was meant to determine the knowledge level of women in the low socio-economic statuses concerning HIV and AIDS. The reason for this was to find out whether the lack of knowledge was responsible for the prevalence of HIV and AIDS among women from low socio-economic statuses. Contrary to the findings of most studies, the level of knowledge of women about HIV and AIDS including the preventive behaviour is very high among poor and illiterate women. This is an important contribution to future research since it will form the first step in developing effective strategies for the interventions. Future studies will proceed from the fact that there exists HIV and AIDS knowledge among the women, which implies that the study advances a shift from quantitative to qualitative studies in the area of HIV and AIDS. The qualitative studies concentrate on explaining the state of affairs rather than delving in descriptions of the state of affairs (Baileys, 1994).

Secondly, this study concisely explained the gap between HIV and AIDS knowledge and preventive behaviour. It has been seen that despite the many

communication interventions put in place for HIV and AIDS the infection, the prevalence trend has continued unabated, especially among women (KAIS, 2009). Other factors such as poverty, illiteracy and retrogressive cultures have been blamed (Agadjanian, 2008; Kohler, 2005; Tessler, 2006; Egesah & Ondiege, 2002). This study found that these were but just predisposing factors which had no direct relationship with required behaviour since this study found that even the very poor and illiterate women were not devoid of preventive skills. From the study, it is the communication variables that make the difference, and interpersonal forms of communication bridge the knowledge-behaviour gap among the low socio-economic statuses women effectively.

Thirdly, the study found that the traditional and cultural forms and strategies of communication still have unique relevance in societies, contrary to the push for new media seen in the modern society. For instance, the mass media, which have been believed to have powerful influence on human behaviour (Lowery & De Fleur, 1995), do not, after all, effectively impact on the attitudes and behaviour to the extent that interpersonal forms do. This finding is important because it will shift communication focus to interpersonal forms so as to inform the communication interventions for behavior change. The present study therefore is instrumental in reasserting the position of cultural or informal media in the society, especially in a collectivist or socialist sub-Saharan African intervention as opposed to the adoption of individualist interventional approaches. This in the long run will lead to the support of the 'Africanization' of communication for health interventions, where the African philosophy, culture and theories will inform interventions to make them more relevant to the context.

Fourthly, the study underscored the value of using specific strategies of communication for specific audiences, a concept which has largely remained a text-book feature, although many NGOs have used audience segmentation in Information Education and Communication (IEC) with little practical evidence. This study demonstrated that most of the forms of communication that the government and non-state actors have used have not been culturally, socially and linguistically appropriate with the low status women with certain African contexts. This finding is important since any future interventions will be scrutinized based on their specificity to particular audiences. Therefore, the major contribution here will be to observe communication for specific audience and culture for success of health and other future interventions.

Fifthly, this study has demonstrated how the convergence model of communication can practically be applied in Africa. The first and probably the most exhaustive elaboration of the centrality of the model in attitude and behaviour change were done by Rogers and Kincaid in 1981 in the South Korean Republic. In Africa most of the human behaviour has been explained by invoking the individualistic models from the west, which have informed most of the communication interventions. The present study was within what most communication scholars currently refer to as the *future paradigm* in communication since it places communication with social and cultural contexts, which appears appropriate given the philosophy of Africans.

Sixthly, the study utilised a comparative case study design which is a proposed framework for conducting behaviour change studies developed by Fishbein & Joseph in 2006. This model has hardly been utilised in most behaviour change studies, which is probably the reason why most interventions for attitude and behaviour change have

failed. From the Fishbein's and Joseph's model, communication for interventions targets the discriminatory behaviours as opposed to individuals, and the forms of communication rather than the predisposing variables are manipulated for their effectiveness to be learnt. Most interventions based on the analysis of variables and their influences prove effective.

Lastly, the study has proposed a new model of managing HIV and AIDS communication in the community, from the integration of the government and community models. Known as the *Integrated Community HIV and AIDS Communication Model,* the framework acknowledges the existence of two separate styles of HIV and AIDS communication management by the government and by non-state actors. The new framework proposes an integration of the two models, plus community members as a major stakeholder at the initiation, implementation, and funding and evaluation levels of communication programmes. This model is a comprehensive approach that takes into account the value of all the stakeholders in the process of interventions, which has been missing in many strategies previously applied.

6.5 Recommendations for Policy Makers, Communicators and Researchers.

The study has two kinds of recommendations which are important for policy makers, health and development communicators and future research prospects. These are outlined in the subsections that follow.

6.5.1 Policy Recommendations

From the study it was revealed that most of the previous communication interventions from either the government or non-state actors did not include the

suggestions and contributions of the key stakeholders who are members of the community. This made such interventions to lack the goodwill and support hence led to their failure to impact change. Any future interventions should have the input of the target community for full impact to be realised.

Secondly, future communication interventions for HIV and AIDs and other pandemics should be specific to the target groups using specific media for accessibility to be improved. Most of the government's and non-state actors' interventions through mass media were diffused, which made them both audience and culturally inappropriate. For instance the case of "mpango wa kando" or alternative sexual partnering campaigns which was met with strong opposition in the debates of the various focus group discussions needed society's input for effectiveness to be reached.

Lastly, most interventions needed the integration of all stakeholders in a structured fashion and in form of memoranda of understanding and clear terms of references in order to be sustained. This will resolve the conflicts that emanate due to differing interests of the government and the non-state actors to reduce the impact of such conflict on communities as has been the case with many interventions.

6.5.2 Suggestions for Further Research

1. The present study examined the effective forms of HIV and AIDS communication among women from low socio-economic status in rural areas. Another study is recommended to determine the effective forms of communication for the urban educated women because high education and socio-economic status highly associated with urban lifestyle have been fronted to promote preventive behaviour

(KNBS, 2010). There is need to focus on their communication for behavior change to reduce HIV prevalence in urban set-ups.

2. A comparative study could be conducted between low status and high socio-economic status men with regards to how effective HIV and AIDs communication can be initiated and implemented. This is because men have also been shown to suffer HIV and AIDS incidences, hence the need to analyse the appropriate communication for them in the two contexts.

References

Agadjanian & Menjívar (2008): *Talking about the "Epidemic of the Millennium": Religion, Informal Communication, and HIV/AIDS in Sub-Saharan Africa,* University of California Press: Social Problems, Vol. 55, 3, 301-321.

Airhihenbuwa, C. et al. (1992). *HIV and AIDS* education and prevention among African-Americans: A focus on culture. *AIDS Education and Prevention, 4*, 267-276.

Airhihenbuwa, C. et al, (2000). A critical assessment of theories/models used in health communication for HIV. *Journal of Health Communication,* 5 (Supplement), 101-111.

Airhihenbuwa, C. et al, (2000): Toward a new communication framework for HIV/AIDS. *Journal of Health Communication*, 5, 101-111.

Bandura, A. (1986*). Social Foundations of Thought and Action: A social Cognitive theory*. Eaglewood Cliffs, NJ: Prentice Hall.

Bandura, A. (1994). *Self-Efficacy: The Exercise of Control.* New York: Freeman Press

Bailey, Kenneth D. (1994). *Methods of Social Research*. 4th Edition. The Free Press; New York, USA.

Barker, T. L. (1999): *Doing Social Research*, New York: Mc Graw Hill.

Basu, A. & Mohan, J.D. (2008). *Sex Work and HIV/AIDS: Analyzing Participatory Culture-Centered Communication Strategies.* University of Florida Press

Bateson, G. (1972). *Steps to an Ecology of Mind: Connected Essays in Anthropology, Psychiatry, Evolution and Epistemology:* University of Chicago Press.

Bekele, S., et al. (1990): Profile of AIDS cases in Ethiopia. *Ethiopia Journal for Health Development, 1990; 4(2): 213-217.*

Black, B., (1997*). HIV/AIDS and the church: Kenya religious leaders become partners in preventing AIDS captions,* 4(13):23-26)

Boafo, K., (1986): *Formulating Comprehensive National Communication Policy for Development in African Countries. A Framework for African Media Review* 1(1): 35-47

Bryant, J. and Heath, R. L., (2000): *Human Communication Theory and Research: concepts, contexts, challenge.* Mahwah, New Jersey: Lawrence Erlbaum Associates.

Castañeda, D. (2005*)*: HIV and AIDS Risk Behaviour among Mexican Women in Maquiladora. *Inter American Journal of Psychology*. Vol. 39, 2, 267-274.

Caldwell, John C., et al. (1989): The social context of AIDS in sub-Saharan Africa, *Population and Development Review 15(2): 185-234.*

Campbell, D., (2003). The Relative risks of HIV infection among young men and women in a South African township. *International Journal of STD & AIDS, 13, 331-342*

Centers for Disease Control and Prevention (2002 b). *Unrecognised HIV infection, risk behaviours, and perceptions of risk among young black men who have sex with men in*.U.S cities, 1994–1998. *MMWR, 51*, 733-736.

Centers for Disease Control and Prevention (2002a, 2003a): *HIV/AIDS Report*. Atlanta, GA: CDC. Retrieved January 3, 2003

Centers for Disease Control and Prevention (2002c): *HIV/AIDS surveillance report*. Department of Health and Human Services, Public Health Service, 13(2), 1-44.

Center for Strategic and International Studies (CSIS) and Global Health Policy Center (GHPC 2013): *Rural Service Delivery and Ground Breaking Research in Nyanza Province, Kenya*.

Chandler, R. (2008*) Communication systems and HIV/AIDS sexual decision making in older adolescent and young adult females,* University of South Florida (USF) Scholar Commons Graduate School Theses and Dissertations.

Chavallier, E. and Floury D. (1996): *The Socio-economic Impact of AIDS in Sub-Saharan Africa*, AIDS (10) .Geneva: UNAIDS.

Chinakale, et al. (2002): *Intergenerational sex among adolescents in Zimbabwe."* Paper presented at the Fourteenth International AIDS Conference, Barcelona, 7-12 July.

Coker et al. (2001): Turkish University Students' Sexual Behaviour, Knowledge, Attitudes and Perceptions of Risk Related to HIV/AIDS. *Journal of Culture, Health & Sexuality, Vol. 3 ,1, 81-99.*

Coker, W. (2005): *Overcoming the Stigma: A Conversational Analysis of interviews with people living with HIV/AIDS ON Ghana Television,* Department of Communication Studies University of Cape Coast; Ghana.

Constituency AIDS Advisory Committee Report 2010: Government Printers.

Dutta-Bergman,M.J (2005). The Readership of health Magazines: The role of health orientation. *Health Marketing Quartely*.22, 27-49.

Egesah,O., Helene, V. and Ondiege, M. (2002). Clients of Female Sex Workers in Nyanza Province, Kenya: A Core Group in STD/HIV Transmission. Regal Press; Nairobi

Ethiopian Ministry of Health (2001): *AIDS in Ethiopia: Background Projections, Impacts and Interventions*.3rd Edition. Government Press

Food and Agricultural Organization/Dimitra (2005): Women Fighting AIDS in Uganda: Rural Women, Dynamisation of Networks and the Fight Against AIDS: Kampala, Uganda.

Fishbein, M. & Joseph, N.C (2006): The Role of theory in Developing Effective Health Communications. *Journal of International Communication Association* (S1-S17)

Freire, P. (1972). *Pedagogy of the Oppressed:* Penguin Books; Middlesex. New York.

Govender, E. (2010) *How* Effective is HIV/AIDS communication in Africa? *African Communication Research.*3, 206-236.

Govender, E. (2010). How participatory is participatory communication for HIV/AIDS Awareness in South Africa? *Journal of African Communication Research (3) 281-303.*

Government of Kenya & UNICEF, (2000): *Guidelines for HIV Counseling and Testing in Clinical Setting*, MOH, Nairobi

Government of Kenya (2007): Office of Public Information and Government Spokesperson. Government Press: Nairobi, Kenya.

Government of Kenya (2011) *Kenya Gazette Supplement: Administrative Boundaries.* Government Press: Nairobi.

Green, E.C, et al, (2006): *Uganda's HIV/AIDS prevention Success; The role of sexual behaviour change and the national response.* AIDS and Behaviour, 10(4), 335-346

Griffin, E. (2009): A *First Look at Communication Theory.* Seventh Edition; McGraw Hill Inc.: New York

Hanan, M.A. (1994): HIV/AIDS prevention campaigns: A critical analysis. *Canadian Journal of Media Studies,* 5 129-158.

Hovland, C.I, Janis, I.L & Kelly, H.H (1953): *Communication and Persuasion: Psychological Studies of Opinion Change.* New Haven, CT: Yale University Press

Iliffe, J. (1998). *Africans: The History of a Continent*. Cambridge Press

Institute of Economic Affairs (2008): *Profile of Women's Socio-economic Status in Kenya.* Regal Press; Nairobi

Institute of Policy Analysis & Research (2004): HIV/AIDS Scourge in Nyanza Province: Poverty, culture and Behaviour Change. Regal Press: Nairobi.

Joram, N. (2010): the effectiveness of interpersonal communication for HIV/AIDS positive persons in Tanzania. *Journal of African Communication Research, 3, 305-339.*

Kalugendo, J. & McLeod, P., (2012): Creating a Participatory Communication Model of engagement of local communities to enhance development effectiveness in Tanzania. *Journal of the East African Communication Association.Vol.1 (2012)*

Karim,S.S (2005).*Heterosexual Transmission of HIV: The Importance of gendered perspectives in HIV prevention*. Cambridge: Cambridge University Press.

Kenya Demographic Health Survey (2003): Report on HIV Prevalence. Government Printers: Nairobi Kenya.

Kenya Demographic Health Survey (2008/2009): Report on HIV Prevalence: Government Printers, Nairobi; Kenya.

Keene, T.P, (2006*) Stopping the Spread of AIDS among Women in Sub-Saharan Africa, What Works and what does not: A Comparative Study of Uganda and Botswana*, Blacksburg, Virginia

Kelly, K. et al. (2005): *Tsha Tsha: Key findings of the evaluation of Episodes 1-26.* Pretoria: CADRE.

Kenya AIDS NGOs Council, (KANCO, 2011). The Aids NGOs in Kenya. www.kanco.org

Kenya Aids and STI Control Programmes and MOH, (2003): *Kenya Demographic and Health Survey.* Calverton, MD: CBS, MOH and ORC Macro.

Kenya Aids Indicator Survey (KAIS), (2007): *Preliminary Report 2007*: Government of Kenya, Nairobi.

Kenya Aids Indicator Survey (KAIS), 2009: *Final Report*: Government Press, Nairobi.

Kenya Aids Indicator Survey (KAIS), 2012): Report on Kenyan HIV and AIDS Prevalence Rate. Government Press, Nairobi.

Kenya Bureau of Statistics (2010): 2009 *Population and Housing Census: Constituency Population by sex, number of Households, area and Density*, Government Press: Nairobi.

Kenya Institute of Education (1999): *AIDS Education Facilitator Handbook*: KIE, Nairobi

Kenya Medical Research Institute/Center for Disease Control (2012) *Research Factsheet*.www.cdckemri.org

Kiai, W., (2009): *An Analysis of the Planning and Implementation of HIV/AIDS Communication Interventions by NGOs in Kenya*. An unpublished PhD dissertation submitted to University of Nairobi.

Kiragu & Muruli, (1997): *Reproductive Health Communication in Kenya: Results of a National Information, Communication, and Education Situation Survey;* Country Reports. *Baltimore:* Johns Hopkins Center for Communication Programmes.

Kohler, Hans-Peter, al. (2005) *Social networks, perceptions of risk, and changing attitudes towards HIV/AIDS: New evidence from a longitudinal study using fixed-effects*

analysis, Population Investigation Committee: Population Studies, Vol. 59, No. 3 (Nov., 2005), pp. 265-282

Kohler, Hans-Peter, et al (2001): *Fertility and Social Interaction: An Economic Perspective.* Oxford: Oxford University Press.

Kombo, D.K and Delno L.A.T (2006): *Proposal and Thesis Writing: An Introduction;* Pauline's Publication Africa, Nairobi.

Kohler, Hans-Peter & Christoph, B (2002): Talking About AIDS: The influence of Communication Networks on Individual Risk Perceptions of HIV/AIDS infection and Favoured Protection Behaviour in South Nyanza District, Kenya. Rostock; Nairobi

Kothari, C.R. (2004). *Research Methodology: Methods and Techniques.* New Delhi: New Age International Publishers.

Kumar, R. (1996) *Research Methodology: a step-by-step Guide for Beginners*, Longman, Australia

Kunda, J. & Tomaseli K.G, (2009): Social representations of HIV/AIDS in South Africa and Zambia: Lessons for Health Communication. In Lagerwerf, H. and Wasserman. H. (Eds), *Health Communication in South Africa: Engaging with social and cultural diversity.* Amsterdam: Rozenberg Publishers.

Markos, E. et al, (2007*) HIV positive status disclosure to sexual partner among women attending ART clinic at University Referral Hospital*, SNNPR, Ethiopia, Hawassa College of Health Sciences.

McQuail, D. (2005): *Mass Communication Theory: An Introduction*; 5th Ed. Sage Publication: London

Mehret, Y & Teshome, L. (2002).*Assessment of Awareness of HIV/AIDS among Selected Target Groups in and around Addis Ababa, Ethiopia.* Published by Women's Health and Action Research Centre (WHARC): *African Journal of Reproductive Health, Vol. 6, No. 2 (Aug., 2002), pp. 30-38.*

Melkote, S.R, et al (2000): Social and economic factors in an integrated behavioural and societal approach to communications in HIV/AIDS. *Journal of Health communication.5*, (supplement), 17-27.

Mercer, M.B, et al., (1996): HIV Risk Behaviours among Women Living in Low-Income, Inner-City Housing Developments, *American Journal of Public Health, August 1996,*

Ministry of Health (1994): *Aids in Kenya: Background, projection, impacts and intervention.* Nairobi; NASCOP

Ministry of Health (1994): *Sessional Paper number 4 on AIDS in Kenya.* Nairobi: Government Printer

Ministry of Health (2001): *AIDS in Kenya*: Government Printer, Nairobi.

Ministry of Health (2010): *HIV/AIDS in Kenya: Analysis of Prevalence*. Nairobi: NASCOP

Ministry of Health and NASCOP (1998): *Programme and Abstract Book*. The second National HIV/AIDS/STD Conferences, 28th-30th October 1998

Molly Sauer (2009) *Health Communication for HIV/AIDS and Tuberculosis in South Africa,* University Honors in Public Communication

Morris, N (2003). A Comparative Analysis of Diffusion and Participatory Methods in Development Communication Theory, 13 (2), 225-248

Mugenda, O.M and Abel, G.N (2003): *Research Methods: Qualitative and Quantitative Approach*, Acts Press: Nairobi.

Mulwo, A.K (2008) Analysis of Students Responses to the ABC and VCT Messages at the Three Universities in KwaZulu-Natal Province, South Africa. A Published PhD Thesis Submitted to the University of KwaZulu- Natal, South Africa.

Mureithi, F. (23 April, 2008) *looking for a reason to keep living: Conditions of IDPS living with AIDS.* Daily Nations, NMG, Nairobi.

Muturi, N., (2008) *Faith*-Based initiatives in Response to HIV/AIDS in Jamaica, Kansas State University: *International Journal of Communication, 2, (2008), 108-131.*

National Aids Control Council (2008): *Kenya National HIV& AIDS communication strategy for the youth 2008.* Government Printers: Nairobi, Kenya.

National Aids Control Council (2008): *The Overlooked Epidemic: Addressing HIV prevention and treatment among men who have sex with men in sub-Saharan Africa*; Population Council of Kenya, Nairobi.

National Aids Control Council (2009) *Kenya Analysis of HIV Prevention Response and Models of HIV Transmission Study*; Kenya Aids Research & Study Committee, Nairobi

National Aids Control Council (2009) *Kenya National Aids Strategic Plan 2009/10 – 2012/13: Delivering On Universal Access To Services.* Government press: Nairobi.

National Aids Control Council (2012) *A Study in Kenya to Assess the Progress of the War against AIDS.* Kenya AIDS Research and Study Committee: Nairobi, Kenya.

Ndati, N. (2012): Social Construction of meaning and values regarding HIV/AIDS through Interpersonal Communication networks: A case study of high school students in Nairobi. *Journal of the East African Communication Association 1, No. 1 (2012)*

Nzioka, C., (1994): *The Social Construction and management of HIV/AIDS among Low income patients in Nairobi.* Unpublished PhD Thesis submitted to University of London

Odimegwu, C. (2005) Influence of Religion on Adolescent Sexual Attitudes and Behaviour among Nigerian University Students: Affiliation or Commitment? Women's Health and Action Research Centre (WHARC): *African Journal of Reproductive Health, Vol. 9, No. 2 (Aug., 2005), pp. 125-140.*

Okigbo, C.A et al, (2002) AIDS Communication in Africa: Towards a practical framework. In Alali, et al (Eds.), *Health Communication in Africa: Contexts, Constraints and Lessons*. Lanham,MD: University Press of America Inc.

Oloo, P.A (2005): Representations of HIV and AIDS in Discourse in Nyanza Province, Kenya. Regal Press, Nairobi.

Pallikadavath, C. et al, (2006): *Sources of AIDS awareness among women in India.* Centre for AIDS Research, University of Southampton, UK and Bournemouth Media School, Bournemouth University, UK: AIDS Care, January 2006; 18(1): 44-48

Peltzer, K. (2003): HIV/AIDS/STD's knowledge, attitudes, beliefs and behaviours in rural South African adult population. *South African Journal of Psychology, 33(4), 250-260.*

Rice, E.R and Charles, K.A (2003): *Public Communication Campaigns.* (2ND Edition), OUP: London.

Rogers,E.M & Kincaid,D.L (1981). *Communication Networks: Toward a new paradigm for Research.* New York: The Free Press.

Ruglass ,L et al, (2009) Addressing the Unique Needs of African American Women in HIV Prevention, *American Journal of Public Health June 2009. Vol. 99, No. 6*

Santrock, W. J. (1996): *Adolescents: an Introduction*. Brown & Benchmark publishers, USA

Schiavo,S. (2007). *Health Communication: From Theory to Practice.* New York: John Wiley and Sons.

Schutt-Russel, K. (1996): *Investigating the Social World: The Process and Practice of Research* A Thousand Oaks, California; Pine Forge Press.

Shearon A. L & Melvin, L.D (1995): *Milestones in Mass Communication Research: Media effects* (3rd edition) Longman publishers, USA

Singhal, A & Rogers, E.M (1999*): Entertainment Education: A Communication Strategy for Social Change.* Mahwah, NJ: Lawrence Earlbaum Associations.

Singhal, A.and Rodgers, E. (2003). *Combating AIDS: Communication Strategies in Action*, New Delhi: Sage Publications.

Singhal, A. & Rogers, E. (1999): *Soul City in Africa: Where theory meets Practice;* UNAIDS-PRS Communications.

Tan, A.S (1985): *Mass Communication Theory and Research*, John Wiley & Sons, New York Ltd

Tanja, R.M (2005). *Responding to HIV/AIDS Epidemic: Lessons from the case of Eritrea.* The Progress in Development Studies, 5(3) 199-212

Tessler, L, et al, (2006), *Older Women's Attitudes, Behaviour, and Communication about Sex and HIV: A Community-Based Study,* Mary Ann Liebert, Inc.: Journal of women's health: Volume 15, Number 6, 2006.

United Nations AIDS Programme (2000*): Report on the global HIV/AIDS Epidemic.*Geniva: UNAIDS.

United Nations AIDS Programmes (2006): *Keeping the Promise: An agenda for action on women and AIDS.* Geneva: UNAIDS.

United Nations AIDS Programme (2006*): Report on the Global AIDS Epidemic.* Geneva: UNAIDS.

United Nations AIDS Programme (2009): *Report on the global Social Change Communication.* Geneva: UNAIDS.

United Nations AIDS Programme, (1999): *Communications Framework for HIV/AIDS: A new Direction. Geneva:* UNAIDS.

United Nations AIDS Programmes (2001): *HIV/AIDS and Communication for Behaviour and Social Change: Programmes Experiences, Examples and the way forward.* A Paper presented at the International Workshop of UNAIDS Department of Policy, Strategy and Research, Geneva, Switzerland. July 25-27, 2001.

United Nations AIDS Programmes (2004): *Report on the Global HIV/AIDS Epidemic.* Geneva: UNAIDS.

United Nations AIDS Programmes (2007): *Report of the UNAIDS Technical Consultation* in Tufte, T. (2003): HIV*/AIDS Communication and Prevention: A Health Communication Research Project for DANIDA*, 2001-2003.Copen Hagen: University of Copenhagen.

United Nations Development Programmes (2007): Development Programmes Worksheet. Geneva: UNDP.

World Health Organization, (2005): *AIDS Epidemic Update, December 2005. Geneva.* UNAIDs

Windahl, et al (1985): *Using Communication Theory: An introduction to planned communication*, Oxford University Press, London.

World Health Organization (2000*): Fact Sheets on HIV/AIDS for nurses and midwives.* Geneva: WHO, 2000.

Appendix 1: A Life Story Interview Guide for Young Women

An invitation to tell the life story on the personal efforts made to change attitudes and sexual practices to control HIV and AIDS prevalence in the district

1. An elaboration of the story by the interviewee on the following points

    - What attitudes and behavioural practices were dominant before the adoption of preventive behaviours and attitudes by the interviewee
    - When, where and how attitude and behaviour started in the interviewee
    - Key influencers and their roles in the behaviour change process
    - Specific forms of communication that caused the change. Who started the communication, where and how it was started and who was involved
    - The flow of the communication and participants
    - What activities the interviewee engages in now to reduce risks
    - The present attitudes and behaviours of the interviewee after the communication has been given

2. Interviewers probes after the story is told and elaborated by interviewee:

    - Prior attitudes and behaviours of interviewee before the communication were given.
    - How the concerned bodies communicated HIV and AIDS behaviour change in the district and whether it had any impact.
    - The challenges with previous communication for change.
    - How the change being practiced now came about: who brought it, when, where and how the interviewee received and began practicing it.

- What specific aspects of the communication led to attitudes and lifestyle change in the interviewee
- Who or what were the agents of the change to the interviewee?
- The flow and stakeholders in the communication that created attitude and behaviour change to avoid HIV and AIDS risks.
- The key features or characteristics that made the communication to be effective in promoting attitudes and behaviour change to eradicate AIDS prevalence
- The interviewee's recommendations to ensure the communication to used with women in this village is effective in promoting change from risky behaviours

Appendix 2: Focus Group Discussions Guide for female respondents

1. What risky behaviours or activities the women were initially exposed to in this community that led to high HIV and AIDS prevalence

1. What communication efforts have been used by women and the concerned bodies to promote change in attitudes and behaviour to control HIV and AIDS prevalence in the community

2. What impacts such communication efforts have had in the change in attitudes and behaviour. Whether the women changed their sexual behaviour or did not changed the attitudes and behaviour due to the communication efforts so far used. What reasons the women gave for the responses given.

3. What attitudes the women had before and after these HIV and AIDS communication efforts

4. What challenges or problems were noted in the previous and current communication efforts and what were the results of these challenges on role communication in promoting attitude and behaviour change

5. What forms of communication, other than the ones mentioned above, are appropriate and effective in promoting attitude and behaviour change leading to the control of HIV and AIDS prevalence among women in the location

6. The participants in the proposed communication efforts from their initiation and implementation stages for them to be effective. When and how these communication efforts can be conducted to guarantee their success in promoting the needed change

7. Why the women think the communication efforts they have proposed will be effective in promoting the needed change in women's attitudes and behaviour to control HIV and AIDS prevalence

8. Some of the cases in the district or elsewhere where the proposed forms of communication have been effectively used to promote HIV and AIDS prevention change hence making them worth consideration in communication strategy building for women.

9. What advice the women can give to the concerned bodies to promote effective communication with high risk women in developing effective communication efforts that work.

Appendix 3: In-depth Personal Interview Guide for Key Respondents

1. Briefly share with me the practices, activities and behaviours which you think expose women in this village to high HIV and AIDS prevalence.

2. What communication efforts have been used by the concerned bodies in Rachuoyo North District to promote attitude and behaviour change to control HIV and AIDS risks among young women?

3. In your assessment, have these communication efforts been effective in promoting attitude and behaviour change among the high risk women to control HIV prevalence. Please explain your responses.

4. What have been the attitudes of women in this district about the need for HIV and AIDS behaviour change and has behaviour change communication been effective in the change process?

5. What have been the challenges in previous and current HIV and AIDS communication efforts that have affected their effectiveness in promoting attitude and behaviour change in women in this community? I will appreciate the details in your response.

6. What forms and/ or strategies of communication do you think can be effective in promoting attitudes and behaviour change to control HIV and AIDS prevalence in women in this district? Please describe these communication efforts in terms of who should initiate and implement them, through which media, where should they be appropriately conducted?

7. What are the unique reasons why you think these communication efforts will be effective over the previous communication in promoting HIV and AIDS behaviour change among women in this district?

8. What local examples of the application of your proposed forms or strategies of communication can you give to prove the effectiveness of using them to promote attitude and behaviour change in women to control HIV and AIDS prevalence?

9. What special impacts will your proposed forms or strategies of communication have on the local women in their attitude and behaviour change to control HIV and AIDS prevalence?

10. What recommendations can you give to the concerned bodies to ensure that communication used with women in this village is effective in promoting change from risky behaviours to control HIV and AIDS prevalence?