The 3 E's – Education, Enterprise and Empowerment – Behaviour Change Communication response to the HIV/Aids Crisis in Kenya: The Case of a woman-led grassroots Non-Governmental Organization.

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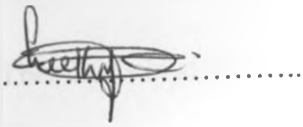
Declaration

This thesis is my original work and has not been presented for a degree in any other university.



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Supervisor's Declaration

I confirm that the work reported in this thesis was carried out by the candidate under my supervision as University supervisor. This thesis has been submitted for review with my approval as University supervisor.

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Dedication

I dedicate this thesis to my Mother Lydia Nzomo for giving me roots and my son Russell Kiilu, for giving me wings.

This thesis is also dedicated to the memory of Rodney "Tots" Mwendwa – neighbour, friend and brother.

Acknowledgement

I must begin by thanking Dr. Karambu Ringera, founder and Executive Director of International Peace Initiatives (IPI), who so graciously allowed me to focus this thesis on IPI. Everyone should have the privilege and blessing of meeting someone as generous and gracious as Dr. Karambu.

I wish to thank the entire IPI family for making me feel at home whenever I visited to collect data for this project.

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Abstract

According to Shisanya, 2008, the five measures currently being promoted in Kenya, for awareness of HIV/AIDS prevention measures and patterns are:

1) The use of condoms;
2) Screening for HIV at Voluntary Counseling and Testing (VCT) Centers;
3) Prevention of mother-to-child transmission (PMTCT);
4) The use of post-exposure prophylaxis (PEP); and
5) The prompt treatment for sexually transmitted infections (STIs).

The core problem facing Kenya today, related to poverty, disease and lack of development, is the exclusion of a large population from accessing means and engaging decisions that would transform their lives. This void is what led to the 3Es. These are Education, Enterprise and Empowerment. "Lack of the 3 Es generally leads to exclusion from the process of empowerment" (Ringera, personal communication, September, 2010). Specifically, however, lack of education disenfranchises an individual overall, and among other things, leads to lack of employment opportunities. This then renders the individual unable to meet their basic needs. This inability subsequently leads to lack of empowerment. Empowerment refers to an individual's ability to take control of their life and attain self-reliance.

Kenya is a low-income country, with approximately 80 per cent of its 38.6 million people living in rural areas, subsidizing on agricultural production. The HIV/Aids pandemic has deepened poverty among the already impoverished. This research examined the workings of International Peace Initiatives - Kenya (IPI-K) in relation to applying the 3Es as an effective and sustainable Behaviour Change Communication model, in response to mitigating the effects of HIV/AIDS in rural Kenya.

This study concludes that knowledge of a community's economic activities as well as their accessibility coupled with knowledge especially of women is paramount, to those planning HIV/AIDS interventions. If HIV/AIDS interventions do not take cognizance of the fact that a community needs to be educated and facilitated to engage in income generating activities, then the empowerment that is needed to reduce HIV infections as well as ensure those already infected live positively, cannot occur. Also directing HIV/AIDS BCC strategies to focus on prevention measures and strategies which target the married and elderly men, will enable them protect their spouses and allow a possible reversal of the current tragic trend, where marriage is actually heightening the risk of HIV infection.

Abbreviations and Acronyms

ACHs	- Amani Children's Homes
AIDS	- Acquired Immune Deficiency Syndrome
AMREF	- African Medical and Research Foundation
BCC	- Behaviour Change Communication
CSOs	- Civil Society Organizations
CSWs	- Commercial sex workers
FGD	- Focus Group Discussion
GFTAM	- Global Fund for Tuberculosis, AIDS and Malaria
HIV	- Human Immunodeficiency Virus
IAVI	- International AIDS Vaccine Initiative
IPI-K	- International Peace Initiatives - Kenya
KACH	- Kithoka Amani Community Home
KAIS	- Kenya Aids Indicator Survey
KDHS	- Kenya Demographic and Health Survey
KNASP III	- Kenya National Aids Strategic Plan III
KNBS	- Kenya National Bureau of Statistics
NACC	- National Aids Control Council
NGO	- Non Governmental Organization
OI	- Opportunistic Infections
OVC	- Orphans and vulnerable children
OVCEF	- Orphans and Vulnerable Children's Education Fund
PEP	- Post-exposure Prophylaxis
PLWHA	- People living with HIV and AIDS
PMTCT	- Prevention of Mother to Child Transmission
RAs	- Research Assistants

STI	- Sexually Transmitted Infection
SP	- Strategic Plan
SPSS	- Statistical Package for Social Sciences
UNAIDS	- United Nations Center for HIV/Aids
VCT	- Voluntary Counseling and Testing Center

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CHAPTER ONE
Introduction

1.1 Background

On June 5th, 1981, American epidemiologists reported a baffling event: five young gay men in Los Angeles, all previously healthy had fallen ill with pneumonia (Cohen, 2000). Two had died. They would be the first casualties of a new virus which has now claimed more lives than a world war. Nearly 30 million people have been killed by Acquired Immune Deficiency Syndrome (AIDS), and more than 33 million others have the virus that causes it (UNAIDS, 2008). Death, sickness and stigma are the hallmarks of its tale; but so are dazzling medical exploits, unexpected solidarity and smashed taboos.

"Aids has changed the world, without any doubt", Michel Sidibe, Executive Director of UNAIDS said ahead of the UN's June 8th – 10th high level forum in New York. "We have been able to break a conspiracy of silence", Sidibe added, "and a new social compact has been created between the north and the south, which has never happened before with any disease of this kind." (UNAIDS, 2008).

The early years of the Aids war are a dark chapter of fear, ignorance and homophobia. However, the tendency to associate Aids to gay lifestyles swiftly faded, when it was discovered Aids could also be contracted through blood transfusion and heterosexual intercourse as well as from an infected mother to her unborn child. Mercifully, though, the fight against Aids began almost instantly, thanks to gay groups who lobbied for research funds in the United States and campaigned against stigma and for safe sex (Kolata, 1987).

According to Cohen (2000) as swiftly as 1983, French doctors pinpointed the cause: a pathogen which became known as the Human Immunodeficiency Virus (HIV). Transmitted in semen, vaginal secretions, breast milk or blood, HIV hijacks key immune cells to reproduce itself, destroying the cell in the process.

Identifying HIV led to a test to help identify those infected and weed out contaminated blood samples. It also unleashed optimism that in a couple of years a vaccine would be found, just as it had been found for smallpox and polio. But the world is still waiting. The virus has so far eluded vaccine engineers, for it comes with a slippery sugary coating and an astonishing ability to mutate. With no vaccine, cure or treatment in sight, the death toll from Aids amounted nightmarishly in the 1980s and 90s.

"I walked into the women's ward for general medicine. The women were all wasted, emaciated and dying", Peter Piot, Sidibe's predecessor, recalled of his grim experience as a doctor in Africa in 1983. "I said to myself, 'Oh my God, this is a catastrophe!' It was a moment of realization. It changed my life" (UNAIDS, 2008).

In 1996 came the great news: the first effective anti-HIV drugs were available at last. The "cocktail" represses HIV to below detectable levels, although it is not a cure, and can have hefty side-effects. As their immune system miraculously rebounded, people who had literally been under a death sentence returned to life. But the previous drugs were so expensive that for half a dozen years, only rich countries could afford them. Today, more than 5 million people in low and middle-income countries, have grasped the lifeline, though an estimated 10 million more await treatment (UNAIDS, 2008). By 2015 – when the UN has set a target of "zero new infections, zero discrimination and zero deaths" – it will be 13 million.

Therein lies the dilemma; the more lives that are saved, the more money that is needed, for the drugs have to be taken every day for the rest of one's life. By 2015, an additional six billion dollars will be needed for innovative financing and help from China and other emerging giants. "We have got to stop the transmission of the virus, otherwise it is impossible, impossible to conceive of treating your way out of the epidemic or even treating all the people who need to be treated", said Seth Berkely, head of the International AIDS Vaccine Initiative (IAVI).

Table 1: Key dates in fight against Aids – Chronology

1981	New disease that destroys the immune system appears among homosexuals in the US.
1982	Acquired Immune Deficiency Syndrome seen on all continents. Transmission by blood transfusion is detected.
1983	French team isolates the virus that causes AIDS. Signs that heterosexuals can become infected triggers widespread anxiety.
1985	Tests for the virus help clear blood banks of contaminated blood.
1986	AIDS pathogen is officially named the Human Immunodeficiency Virus (HIV).
1987	AZT becomes the first drug to slow – but not cure – the virus.
1991	**The red ribbon is adopted as the international symbol of awareness about the disease**. WHO says 10 million people worldwide have HIV or AIDS.
1996	Introduction of HAART – cocktail of 3 ARVs that suppress HIV.
1999	AIDS becomes the 4th largest cause of death worldwide after HAART shows it cannot cure the virus. Thailand tests the 1st vaccine.
2000	Pharmaceutical labs lower the ARVs in poor nations. South Africa becomes the epicenter of the global pandemic.
2001	Indian firm Cipla starts producing cheap generic anti-AIDS drugs
2002	Launch of Global Fund to Fight AIDS, Tuberculosis and Malaria, with support of Microsoft philanthropist Bill Gates.
2003	US President George W. Bush establishes 15-billion dollar, five-year AIDS assistance programme. Price of drugs falls through international trade agreements and pressure on

	pharmaceutical giants.
2004	South Africa begins distributing free ARVs in hospitals
2006	Sub-Saharan Africa becomes the region most affected by AIDS
2010	33.3 million people around the world live with AIDS

Source: 2010 report by UNAIDS

According to a 2010 Report by UNAIDS – based on 2009 figures – global HIV infection by Regions stands as follows:

- Sub-Saharan Africa 22.5 million
- South and Southeast Asia 4.1 million
- North America 1.5 million
- Central and South America 1.4 million
- Eastern Europe and Central Asia 1.4 million
- Western and Central Europe 820,000
- East Asia 770,000
- Middle East and North Africa 460,000
- Caribbean 240,000
- Oceania 57,000

The future course of Kenya's AIDS epidemic depends on a number of variables including levels of HIV/AIDS – related knowledge among the general population; social stigmatization; risk behaviour modification; access to quality health care services for sexually transmitted infections (STIs); provision and uptake of HIV counseling and testing; and access to care and antiretroviral

therapy (ART), including prevention and treatment of opportunistic infections source (NACC, 2005).

To meet the challenge of the HIV/AIDS epidemic in the country, the Government, in September 1997, approved Sessional Paper No.4 on AIDS in Kenya. The Government sought to support effective programmes to control the spread of AIDS, to protect the human rights of those with HIV or AIDS, and to provide care for those infected and affected by HIV/AIDS. Specifically, it had the following objectives:

- Give direction on how to handle controversial issues while taking into account prevailing circumstances and the socio-cultural environment;
- Enable the government to play the leadership role in AIDS prevention and control activities;
- Recommend an appropriate institutional framework for effective management and coordination of HIV/AIDS programme activities.

The Sessional Paper recognizes that responding effectively to the HIV/AIDS crisis will require "a strong political commitment at the highest level, implementation of a multisectoral prevention and control strategy focused on young people, mobilization of resources for financing HIV prevention, care and support, and establishment of a National Aids Control Council [NACC] to provide leadership at the highest level" (KDHS, 2008-9).

Against this background, then, this study sought to ascertain whether a Behaviour Change Communication (BCC) strategy that provided grassroots populations the opportunity to access education, skills to engage in an income generating activity and, consequently, the ability to take control of their lives thereby guaranteeing self-reliance, was an effective intervention to respond

to the HIV/AIDS scourge in Kenya's rural communities. The BCC strategy tested in this study, is referred to as the 3Es – Education, Enterprise and Empowerment.

1.2 Problem Statement

Although much has been said on the effects of HIV/AIDS in the country, little has been done to analyze which interventions are most effective in reducing the rate of new infections or mitigating the effects of the pandemic on communities, such that sustainability of those infected and affected is ensured. Therefore, more studies in the field of communication, with regard to behavior change and the role played by grassroots communities need to be done. While it is widely understood that the effects of the pandemic cut across all areas of the economy, the effects at the grassroots do not seem to be as highlighted as they should.

Earlier interventions that have been put to use in Kenya have been centered on providing answers to problems, as opposed to empowering people to enable them solve their problems, while at the same time, improving the quality of their lives. Some examples of such interventions include:-

- The Forum for African Women Educationalists (FAWE - Kenya Chapter) Best Practice Study, that focused on protecting girls in school form HIV/AIDS, by emphasizing abstinence from pre-marital sex;
- The Kenya AIDS Intervention Prevention Project Group – a community based nonprofit organization located in Mumias, which addresses poverty, malnutrition, human rights advocacy and environmental sustainability;

- The Nestle Kenya in partnership with Kenya Red Cross Society, which since 2003, has been addressing HIV/AIDS intervention programs. The programme assists in the prevention, control and management of appropriate nutritional care for infected people;
- The Kisumu Urban Apostolate Programme, which works with a view to highlight the value of ensuring that a strong referral system is an integral part of the community's HIV/AIDS response.

Unless interventions adequately address the plight of those in rural areas, by providing mediums through which solutions may be sought, as opposed to prescriptive solutions, it will be very difficult for Kenya to effectively reduce the number of people infected with the virus and eventually, those succumbing to its devastating effects.

In Kenya, various Non-Governmental Organizations (NGOs) have adopted various behaviour change communication interventions to the epidemic. Studies such as those done by Servaes (1996), Rogers (1976), Melkote (1991), and others, recommend that behavior change communication approaches that lean on participatory approaches are more effective, in bringing about sustained change. The overriding outcomes of these studies show that people are not only aware of their problems, but also know what needs to be done to solve them. What these communities need, is some education and economic empowerment in the form of entrepreneurial skills, with which they can develop themselves and escape poverty. "It has been established that the spread of the virus is fuelled by poverty, precarious health conditions, illiteracy, the inferior social status of women, as well as other socio-cultural, structural and environmental factors" (Ricardo, 1997a : 30).

1.3 Purpose of the study

The purpose of the study is to test the workability of a grassroots NGO's 3Es – Education, Enterprise and Empowerment - Behaviour Change Communication (BCC) strategy that ensures empowerment and sustainability among the rural community.

1.4 Objective

The specific objective of the study is:

a) Establish the connection between the 3Es - Education, Enterprise and Empowerment - as a workable and sustainable mitigating response to the HIV/Aids scourge.

1.5 Hypothesis

The following hypothesis will be tested in the study:

a) There are no discernible ways in which the community can be empowered through 3 E's Behavior Change Communication approach.
b) Devoid of guided donor support, interventions crumble.

Guided donor support refers to the fact that donors determine the direction their support will take. For instance, donors may instruct that the support be geared towards certain projects, which they (donors) deem as most appropriate. This does not adequately assist the recipients, as they are the ones who know what is of priority.

1.6 Significance of the Study

This study is significant as it will test whether the 3 E's – Education, Enterprise and Empowerment, is a workable behavior change strategy that adequately mitigates the effects of

HIV/Aids on grassroots populations. This is significant, because earlier interventions, examples of which have been cited earlier in this research, seem dependent on donor support, such that once the funding is withdrawn; communities are left without a means of sustaining the already established structures. This dependency that is encouraged by the thought of donor funding, regresses the response to HIV/AIDS interventions. Communities need to be reminded that they can generate solutions to the problem of HIV/AIDS that afflicts them; but also, equally important, is their comprehension that without some education, an economically viable activity and the ability to take control of their lives, they cannot adequately and sustainably respond to the HIV/AIDS scourge.

1.7 Limitations

There are some aspects of the study, which the researcher had no control over, that threatened to negatively affect the results. The most common that the researcher faced were sample size, length of the study and data collection. As the intended sample was large – 200 respondents – the researcher had to elicit the help of research assistants (RAs). Five RAs, fluent in both Swahili and Ameru language, were trained prior to administering the questionnaire. Due to culture, which still holds sex and sexuality discussions as taboo, it was not easy for the RAs to get the information they required in the stipulated time. This resulted in the research team making upto four trips to Meru, for the purposes of data collection. This was both time consuming and costly. Also, due to the geographical terrain of the area in which the study was concentrated, unfavourable weather conditions such as extreme heat and rainfall further exacerbated the condition. In cases where respondents had moved to other locations, it was difficult for the research team to locate them, hence the need to seek assistance from guides familiar with the terrain. This also elongated the data collection time-frame. Finally, since the sample included

people living with HIV and AIDS (PLWHA), there were cases where the respondents were too ill to respond to the questionnaire, or in some instances, they had succumbed to the pandemic. The loss of respondents was devastating to the research team.

1.8 Assumptions

The researcher assumed that the conditions remained constant during and after data collection, as this was the only way to guarantee that the results of the analysis of the data reflect the conditions in the sample under study.

Chapter 2

Literature Review

The answer is not just another series of projects, a bit more money to send from developed countries to developing countries...the answer clearly, is knowledge, partnership and opportunity, brought about by this new knowledge and digital revolution.
James Wolfensohn, President, World Bank, at the Second Global, Knowledge Conference in Kuala Lumpur, March, 2000

2.1 Introduction

Acquired Immune Deficiency Syndrome (AIDS) is caused by a Human Immunodeficiency Virus (HIV) that weakens the immune system, rendering the body susceptible to and unable to recover from other opportunistic infections (OI) and diseases, leading to death. The predominant mode of HIV transmission is through heterosexual contact, followed by a magnitude of perinatal transmission, in which a mother passes the virus to her unborn child during pregnancy, during delivery or while breastfeeding. Other modes of transmission are through infected blood and unsafe injections, as well as homosexual contact.

The future course of Kenya's AIDS epidemic depends on a number of variables, which according to the Kenya Demographic and Health Survey (KDHS) 2008-09 include, levels of HIV/AIDS related knowledge among the general population; social stigmatization; risk behavior modification; access to quality healthcare services for sexually transmitted infections (STIs); provision and uptake of HIV counseling and testing; and access to care and antiretroviral therapy (ART), including prevention and treatment of OI.

In this chapter, the researcher has attempted a review of the literature on the HIV/AIDS pandemic, with reference to the efforts the country has put in place to mitigate its effects, as well

as the various behavior change communication strategies that have been implemented globally. Tied in to this, is the significance of community mobilization: ensuring that grassroots communities are placed at the core of any intervention program designed for their benefit. In light of this, the researcher introduces the 3Es (Education, Enterprise and Empowerment) behavior change communication model, that one rural NGO in Kenya is applying, as a response to the HIV/AIDS scourge.

2.2 The Case of Kenya

Kenya is experiencing a mixed and geographically heterogeneous HIV epidemic. Its characteristics are both those of a generalized epidemic among the mainstream population and a concentrated epidemic among the most at risk population. The pandemic affects all sectors of the economy. It is equally a developmental and an epidemiological challenge, encompassing identification and development of a series of appropriate sectoral responses and their applications at the local level. The National Aids Control Council (NACC) launched the third Kenya National Aids Strategic Plan (KNASP III) in 2009, to address the challenges posed by HIV infection. The KNASP III aims to achieve Kenya's universal access targets for quality integrated services at all levels to prevent new HIV infections, reduce HIV - related illnesses and deaths, and mitigate the effects of the epidemic on households and communities (NACC, 2009, p16).

By the end of 2007, close to 33 million people were living with HIV globally (UNAIDS, 2008). During the year, a total of 2.7 million people were newly infected with HIV, and the AIDS epidemic had killed 2.1 million people. Over two-thirds of people living with HIV/AIDS (PLWHA) are from sub-Saharan Africa. The region accounts for almost three-quarters of all

AIDS-related deaths globally. In sub-Saharan Africa, the epidemic is characterized by marked gender inequalities, with 59% of PLWHA being female.

Since its formation in 1999, NACC has coordinated the country's HIV/AIDS response. It has led the formulation and implementation of two National AIDS Strategic Plans (SP) for the periods 2000-2005 and 2005-2010. The current SP provides the overall direction for HIV/AIDS programming in Kenya and advocates for a multisectoral and comprehensive approach, encompassing prevention, care, treatment and support, and socio-economic mitigation (NACC, 2005).

Through NACC's leadership, Kenya's HIV response has evolved in both geographic and conceptual terms. Conceptually, the country has progressed from managing HIV and AIDS as a medical problem, to recognizing the public health significance of the epidemic, and today, applies a social model to HIV/AIDS programming. Key stakeholders in Kenya recognize that the pandemic has enormous negative social and economic effects, and can only be effectively addressed through a response based on partnerships among stakeholders.

This shift has led to considerable changes in HIV/AIDS programming including a shift from largely health-facility-based activities to a greater balance between health facility and community-based interventions. There is greater involvement of communities including beneficiaries, civil society and the private sector. However, gaps abound regarding optimal approaches for coordinating and harmonizing the response while fostering genuine involvement and empowerment of communities.

Kenya has been grappling with the HIV/AIDS pandemic for the last three decades. The country is among the high HIV and AIDS burden nations, with prevalence above 5 percent since 1990.

For instance, the prevalence of HIV among adults aged 15-49 years has risen from 5.3 in 1990 to 7.4 in 2007, translating to more than 1.4 million PLWHA (NASCOP MoH, 2008). Data from the 2008-09 Kenya Demographic and Health Survey (KDHS) carried out by the Kenya National Bureau of Statistics (KNBS) in partnership with NACC, Kenya Medical Research Institute (KEMRI), United States Agency for International Development (USAID) and ICF Macro, indicate that in Kenya, "HIV prevalence has not changed significantly in the past five years" (KDHS, KNBS, 2008-09: 15). According to the 2008-09 KDHS, HIV prevalence is at 6.3 percent for women and men aged between 15-49, compared with 6.7 percent in the 2003 KDHS, and 7.4 percent in the 2007 Kenya AIDS Indicator Survey (KAIS). The 2008-09 KDHS findings also indicate that in Kenya, 8.0 percent of women and 4.3 percent of men are HIV-positive. By comparison, in 2003, 8.7 percent of women and 4.6 percent of men had HIV. In the 2007 KAIS, 8.8 percent of women and 5.5 percent of men aged between 15-49 were HIV positive. In addition, the epidemic is marked by considerable gender and geographic disparities. Five females are infected with HIV for every three males infected in the 15-64 years age bracket (*Ibid*). This feminization of HIV is an established pattern since the 1990s and has been attributed to interplay of physiological susceptibility and power relations (Longfield et al. 2002).

In 2006, 140,000 people died from AIDS, leaving a cumulative total of 1.1 million orphans aged 0-17 in Kenya (NACC, 2007). Worse still, there are about 150,000 children aged 0-14 living with HIV. The country has witnessed a decline in life expectancy from 61.9 years in the period 1979-1989 to 59.6 years in the period 1989-1999, and to 58.5 years in 2006 (KNBS, 2002; NACC, 2007). Currently, life expectancy in Kenya stands at 57 years (Obudho, M. Director, Population and Social Statistics Directorate, KNBS, Personal Communication, July 2011). The falling life expectancy is largely attributed to the interplay between HIV/AIDS and poverty.

Poverty is prevalent, with over half of the population (66%) surviving on less than 1 $US a day (KNBS, et al., 2004).

An assessment undertaken by AMREF (2004) in the Lake Victoria Basin region of Kenya and baseline assessment undertaken one year later (AMREF, 2005) revealed that the country's HIV/AIDS response was hampered by constraints in five areas, namely:

- Coordination
- Communities' capacity
- Participation of communities in HIV/AIDS mitigation
- Availability of resources to communities
- Challenges in addressing factors underlying the high prevalence and negative impact of HIV among the most-at-risk categories of the country's population.

Most-at-risk populations include PLWHA, widows, youth, commercial sex workers (CSWs), truck drivers, men who have sex with men, injecting drug users and people with disabilities.

These findings corroborate those found in other assessments of Kenya's past national response to HIV/AIDS (Delion et al, 2004).

In the last decade, the response to HIV/AIDS in Kenya has received more funding and commitment from the government, Global Fund to fight Tuberculosis, AIDS and Malaria (GFTAM), the World Bank, bilateral donors and private sector foundations. However, the increase in the number of actors at both country and local levels has resulted in vertical and piecemeal interventions that are unsustainable. The efforts require greater coordination among partners to ensure that resources are not wasted and actions are not duplicated. This resulted in the formation of the "Three Ones" Principle.

On 25th April, 2004, UNAIDS and other stakeholders co-hosted a Consultation on Harmonization of International AIDS Funding, and formally endorsed the "Three Ones" Principle. This Principle calls for the following components related to HIV/AIDS programming:

a) One agreed AIDS action framework that provides the basis for coordinating the work of all partners;
b) One national AIDS coordinating authority, with a broad-based multisectoral mandate;
c) One agreed country-level monitoring and evaluation system (UNAIDS, 2008)

Although Kenya is a signatory to the Principle, findings from the assessment undertaken by AMREF revealed that a third of CSOs were not following the national guidelines as stipulated in HIV/AIDS implementation (AMREF, 2004). Further, many neither rarely reported to NACC nor used the harmonized HIV/AIDS indicators stipulated in the national monitoring and evaluation framework. Hence, the response was weak with district NACC structures citing duplication of roles, inadequacy of resources to facilitate coordination, and low monitoring and evaluation capacity.

On the other hand, the capacities of communities to mount effective responses were weak (AMREF, 2004). In Kenya, organized communities such as local CSOs have tried to address local needs, including those that have arisen as a result of HIV infections. While the emergence of these groupings ought to provide the continuity and long-term commitment required for sustainable development, many CSOs lack the organizational and technical capacities needed for designing, implementing and monitoring effective HIV and AIDS interventions.

For instance, among the 70 CSOs surveyed, only 20% had elected leaders, 15% had annual plans to guide implementation, 53% had financial procedures in place, 22% used finances effectively,

and 68% had a constitution (*Ibid*). It can therefore be deduced, that the CSOs lacked systems of tracking their performance and resource utilization, a situation that made it difficult to assess the efficiency and effectiveness of community interventions. Effective HIV/AIDS programming calls for adequate coordination by NACC at all levels, coupled with participation and empowerment of communities.

Equally, linkages between the CSOs and government structures were very weak and were characterized by a palpable disconnect between what the CSOs were doing and what the formal health system desired (AMREF, 2004). It was difficult for CSOs to implement HIV/AIDS interventions in line with government policies and guidelines, simply because they did not have the information. In order to promote sustainable health development, communities should be proactive participants in any system designed to serve them.

2.3 Development Communication

Development communication has its origins "in post-war international aid programs to countries in Latin America, Asia and Africa, that were struggling with poverty, illiteracy, poor health and a lack of economic, political and social infrastructures" (Waisbord, 1994:1). In light of this, then, the term development communication, refers to the application of communication strategies and principles in the developing world. Waisbord (1994) argues that development communication is derived from theories of development and social change that identified the main problems of the post-war world in terms of a lack of development or progress equivalent to Western countries.

As a result, development theories are rooted in mid-century optimism about the prospects that large parts of the post-colonial world could eventually "catch-up" and resemble Western countries. "After the last remains of European empires in Africa and Asia crumbled in the 1950s

and 1960s, a dominant question in policy and academic quarters, was how to address the abysmal disparities between the developed and underdeveloped worlds" (Inkeles & Smith, 1974:32). Development originally meant the process by which Third World societies could become more like Western developed societies, as measured in terms of political system, economic growth and educational levels. Development was synonymous with political democracy, rising levels of productivity and industrialization, high literacy rates and longer life expectancy. "The implicit assumption was that there was one form of development as expressed in developed countries that underdeveloped societies needed to replicate" (Inkeles & Smith, 1974: 34).

Since then, studies have provided diverse definitions of development communication. As Melkote (1991) states, it has been commonly agreed that the ultimate goal of development communication is "to raise the quality of life for populations, including increase income and well-being, eradicate social injustice, promote land reform and freedom of speech, and establish community centers for leisure and entertainment" (Melkote, 1991:229).

It is against this background that the researcher embarks on the next discussion of behavior change communication models, and in so doing, introduces the concept of the 3Es – Education, Empowerment and Enterprise. This succeeding discussion seeks to introduce the concept of BCC interventions in development communication, as well as demonstrate the interplay between effective BCC interventions and development. This is necessary because development is the ultimate goal of interventions designed to assist grassroots (and other) communities.

2.4 Behaviour Change Communication (BCC)

Behaviour change models have been the dominant paradigm in the field of development communication. Different theories and strategies shared the premise that problems of development were basically rooted in lack of knowledge and that, consequently, interventions needed to provide people with information to change behavior.

In the early 1970s, modernization theory was the dominant paradigm of development communication (Waisbord, 1994). The climate of enthusiasm and missionary zeal, as Wilbur Schramm (1997) described it, that had existed a decade earlier, had notably receded, but the notion that the diffusion of information and innovations could solve problems of underdevelopment prevailed. This led to the birth of social marketing.

One of the definitions of social marketing states that "it is the design, implementation and control of programs calculated to influence the acceptability of social ideas and involving consideration of product planning, pricing, communication, distribution and marketing research" (Kotler & Zaltman, 1971:59).

Andreasen (1994:110) has defined social marketing as "the adaptation of commercial marketing technologies to programs designed to influence the voluntary behaviour of target audiences, to improve their personal welfare and that of the society, of which they are a part." Still others have defined it as "the application of management and marketing technologies to pro-social and nonprofit programs" (Meyer & Dearing, 1966:27).

Social marketing has been one of the approaches that carried forward the premises of diffusion of innovation and behaviour change models. Since the 1970s, social marketing has been one of the most influential strategies in the field of development communication.

The origins of social marketing can be traced back to the intention of marketing to expand its disciplinary boundaries. It was clearly a product of specific political and academic developments in the United States that were later incorporated into development projects (Waisbord, 1990). Social marketing was marketing's response to the need to be "socially relevant" and "socially responsible" (Elliot, 1991). It was a reaction of marketing as both discipline and industry to be sensitive to social issues and to strive towards the social good, but it was also a way for marketing to provide intervention tools to organizations whose business was the promotion of social change.

Social marketing consisted in putting into practice standard techniques in commercial marketing to promote pro-social behaviour. From marketing and advertising, it imported theories of consumer behaviour into development communication. The analysis of consumer behaviour required an understanding of the complexities, conflicts and influences that create consumer needs and how those needs can be met (Novelli, 1990). Influences include environmental, individual, information processing and decision making. At the core of social marketing theory is the exchange model according to which individuals, groups and organizations exchange resources for perceived benefits of purchasing products. Hence, the aim of interventions is to create voluntary exchanges.

Social marketing's focus on behaviour change, understanding of communication as persuasion ("transmission of information") and top-down approach to instrument change suggested an affinity with modernization and diffusion of innovation theories. Similar to diffusion theory, it conceptually subscribed to a sequential model of behaviour change in which individuals cognitively move from acquisition of knowledge to adjustment of attitudes toward behaviour change.

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What social marketing contributed was a focus on using marketing techniques such as market segmentation and formative research to maximize the effectiveness of interventions.

Social marketing suggested that the emphasis should be put not so much on getting ideas out or transforming attitudes but influencing behaviour. Behaviour change is social marketing's bottom line. Unlike commercial marketing, which is not concerned with the social consequences of its actions, the social marketing model centers on communication campaigns designed to promote socially beneficial practices or products in a target group.

Taken this way, then, social marketing's goal is to position a product such as condoms, by providing information that could help fulfill, rather than create, uncovered demand. It intends to "reduce the psychological, social, economic and practical distance between the consumer and the behaviour" (Wallack et al. 1993: 21). Therefore, the goal in this regard would be to make condom-use affordable, available and attractive (Steson & David, 1999).

For instance, if couples of reproductive age do not want more children but do not use any contraceptives, the task of social marketing is to find out why and what information needs to be provided so they can make informed choices. This may require sorting out cultural beliefs that account for such behaviour or finding out why people are unwilling to engage in certain health practices even when they are informed of their positive results. This knowledge is the baseline that allows for successful positioning of a product. Therefore, the task in this case, would be to position a product in the context of community beliefs.

According to Novelli (1990: 121), "problems arose with the social marketing approach, over the motives of their sponsors, the effectiveness of their applications and the validity of their results".

Critics have lambasted social marketing for manipulating populations and being solely concerned with goals without regard for means. For much of its concerns about ethics, critics argue, social marketing subscribes to a utilitarian ethical approach that prioritizes ends over means. In the name of achieving certain goals, social marketing justifies any methods. Like marketing, social marketing deceives and manipulates people into certain behaviors (Buchanan, Reddy & Hossain, 1994).

Theorists and practitioners identified with participatory communication have criticized of social marketing. Beltran and Diaz-Bordenave (1976), argue that social marketing approach intends to persuade people to engage in certain behaviors already decided by agencies and planners. It does not involve communities in deciding problems and courses of action. The goal should be, instead, to assist populations in changing their actions based on critical analysis of social reality. This is imperative as "change does not happen when communities are not actively engaged in development projects and lack a sense of ownership" (Beltran & Diaz-Bordenave, 1976: 21).

2.5 Participatory theories and approaches

Participatory theorists have criticized the modernization paradigm on the grounds that it promoted a top-down, ethnocentric and paternalistic view of development. They argue that the diffusion model proposes a conception of development associated with a Western vision of progress. This is so, as the approaches are "designed and executed in the capital cities by local elites with guidance from foreign specialists" (White, 1994: 90). As a result, local people are not involved in the preparation and design of development interventions. The resulting interventions basically conceived of local residents as passive receivers of decisions made outside of their communities, and in many cases, designed ill-conceived plans to achieve development.

For participatory theorists and practitioners, development communication required sensitivity to cultural diversity and specific contexts that were ignored by modernization theories. The lack of such sensitivity accounted for the problems and failures of many projects.

As a result, participatory theorists considered necessary a redefinition of development communication. Agunga (1997:5) defines development communication as "a process of creating and stimulating understanding as the basis for development rather than information transmission." Agunga argues that since communication is the articulation of social relations among people, therefore people should not be forced to adopt new practices no matter how beneficial they seem in the eyes of agencies and governments. Instead, people need to be encouraged to participate rather than adopt new practices based on information.

Most strategic, social marketing campaigns are concerned with individual behaviour change. As sweeping structural change in society is not always realistic, individual change may be significant in gradually leading to progressive social change. However, social divisions such as class, gender and race need to be adequately considered in research and strategies.

According to Melkote (2000), race, class and gender largely determine a person's health status. "In concert they will affect perception of health and illness, kinds and availability of care, and modes of delivery. This unequal distribution of access to health care mirrors the manner in which social and political power, resources, labour and services are distributed in society" (Melkote, 2000:63).

In exploring the interaction of race, class and gender in the context of HIV/AIDS preventive behaviour, (Schneider, 1992) found that social factors push risk reduction behaviours outside the control of certain individuals. For instance, the use of condoms assumes an equal distribution of

power in sexual relationships: the woman may have the intention and the self-efficacy to adopt this behaviour, but the actual act requires the active cooperation of the male partner.

Poor women are especially vulnerable to their male partners' views, since they are economically and emotionally dependent on them (Bandura, 1994). Other scholars have noted that poor women are limited in their choices about relationships and living situations, in ways that middle-class women may not be, and that they may not experience the freedom to regulate sexual practices or to separate from their husbands. Concerns regarding food, shelter and care of their children take precedence over worries about AIDS.

Developing countries offer a conducive environment for HIV to flourish. In Asia and Africa, poverty, malnutrition, unemployment, illiteracy, lack of infrastructure and basic primary healthcare systems, rural-urban migration, poor sanitation, cultural factors [such as low status accorded women], and war, among other factors, create a favourable setting for the large-scale spread of HIV.

The social impediments to safer sex and knowledge regarding AIDS are also prodigious. In Zimbabwe, Kenya and South Africa, the increasing financial insecurity that exists among a large number of female-headed households make transactional sex a "rational means of making ends meet" (Gill and Mohammed, 1994: iii). Further, women in these societies have smaller landholdings, less income and less access to agricultural training, which sometimes make the exchange of sex for money their only survival mechanism.

Therefore, the social context is an important mediating factor in shaping individuals' behaviours and attitudes related to HIV/AIDS. Also, HIV/AIDS is not just a health issue or a sexual behaviour-related issue. Presently, the emphasis in communication campaigns usually are on

short-term goals: get tested, use condoms, choose partners carefully, and abstain. While these goals are very important for containing the spread of AIDS, they are not sufficient. An effective strategy for HIV/AIDS prevention will require long-term and sustained strategies that should also address the social, cultural, economic and political factors that influence the spread of AIDS.

2.6 Participation and Communication

Communication constitutes an indispensable part of participatory approaches. If development is to have nay relevance to the people who need it most, it must start where the real needs and problems exist, that is, in the rural areas urban informal settlements and other depressed sectors. People living in such peripheries must perceive their real needs and identify their real problems

To a large extent, these people have been unable to do so due to a lack of genuine participation in development strategies, ostensibly setup to ameliorate their problems. Also, bottom-up communication strategies have often turned out to be mere clichés, lacking in substance.

Many scholars and practitioners have favoured active participation of the people at the grassroots. On the surface, this signaled a positive departure from the earlier overly top-down prescriptive approaches. However, the stucture of elite domination was not disturbed. Diaz-Bordenave (1980), noted that in these new approaches, the participation that was expected was often directly by the sources and change agents. In these so-called bottom-up approaches to development, people were induced to participate in self-help activities, but the basic solutions to local problems were already selected by the external development agencies.

The participation of the people was directed because, often the aim of the development projects was to achieve widespread cooperation in increasing agricultural production, improving formal

and non-formal education, limiting family size, etc. Thus, people at the grassroots were co-opted in activities that, in the end, would make consumers of them for industrial goods and services. Participation, therefore, was a means to an end: the end being greater dependence of the people on a market controlled by elites, both nationally and internationally.

True participation, however, should go beyond such pragmatic goals as higher productivity, higher formal education, or high consumption patterns to social and political action by the people at all levels. The goal of participation efforts should be to facilitate conscientization of marginalized people. It is through conscientization and collective action that people perceive their needs, identify constraints to addressing their needs and plan to overcome problems.

The concept of conscientization was first introduced by Paulo Freire (1970). He advocated a replacement of the communication practices of the time with a more liberating type of communication that contains more dialogue and would be both receiver-centered and more conscious of social structure. Armed with new knowledge of their existential situation, the people could then come up with action plans to liberate them from their dependent and exploited status.

In this approach, communication channels are used to generate dialogue, to help people understand each other and identify their collective problems. Communication then becomes a vehicle for liberation from mental and psychological shackles that bind communities to structures and processes of dependency.

Communication on a co-equal basis is ethically preferable and more relevant and useful. By allowing a symmetrical exchange of ideas between senders and receivers, it provides access to the useful information and ideas of people at the grassroots. Some development agencies have

benefitted greatly from such knowledge. Hornick (1988:19) notes "the International Fund for Agricultural Development has found that much that is innovative in rural development stems from the traditions and practices of the poor themselves who have experience in the demands of survival in harsh environment."

However, in development communication, "the experts and policy-makers have often neglected to listen, understand and incorporate the innate wisdom and knowledge of the rural and urban poor concerning their environment, with which they are intimately familiar" (Hornick 1988:20). The diffusion of innovations research reinforced the stereotype constructed earlier by modernization theories, that the rural people in developing nations had little useful knowledge or skills to contribute to real development.

In the 1980s, however, development scholars discovered the complexity, depth and sharpness of rural people's knowledge. "Rural people's knowledge is often superior to that of outsiders. Examples can be found in mixed cropping, knowledge of the environment, abilities to observe and discriminate, and results of rural people's experiments. Rural people's knowledge and modern scientific knowledge are complimentary in their strengths and weaknesses. Combined they may achieve what neither would alone. For such combinations, outsider professionals have to step down off their pedestals, and sit down, listen and learn (Chambers, 1983: 27).

2.7 International Peace Initiatives (IPI) and the genesis of the 3Es – Education, Enterprise and Empowerment

The researcher held a series of interviews with Dr. Karambu Ringera, the Founder and Executive Director of International Peace Initiatives – Kenya, in order to better understand the 3Es BCC model that the organization applies.

International Peace Initiatives (IPI) is a United States and Kenya – based organization, dedicated to funding and supporting initiatives that mitigate the effects of poverty, disease, discrimination and violence. IPI provides homes for orphans and vulnerable children, supports African grassroots organizations and community leaders, and provides trainings in peace education and conflict resolution. The IPI tools are education, enterprise and empowerment.

Disease, conflict and poverty continue to devastate many communities around the world, particularly in Africa, where IPI's efforts are focused. Little wonder then, that the bulk of new HIV/Aids cases are found in women and children. As a result, they not only face debilitating physical illness, but also poverty, ostracism as well as serious challenges in raising their children and keeping them in school. The United Nations estimated that by 2010, there would be 23 million children orphaned by HIV/Aids.

In 2002, Dr. Karambu Ringera visited a small group of HIV positive women in Meru, Kenya. She was extremely moved by their courage and determination in circumstances of extraordinary challenges. As one of the women, Beatrice, was dying, she said, "Please promise me that my child will go to school." At the time, Dr. Karambu was a doctoral student in the US. However, she resolved to keep her promise. She organized an event with Kenyan music, cooked Kenyan food and showed a slide show. After hearing her story, the audience contributed US $400. That was the beginning of International Peace Initiatives – Kenya (IPI-K).

IPI has been operational in Imenti North District since the year 2003. It is an organization committed to effective partnerships with grassroots community efforts to respond to the HIV/AIDS crisis. IPI places special focus on children orphaned by AIDS. "In related program areas we also address and respond to many of the social issues that created this crisis, such as

poverty, unemployment, lack of education, prostitution, child sexual abuse, and the low status of women culturally, that prevents them from having control over their lives" (K. Ringera, personal communication, January 2010).

"Since we believe that peace is not merely the absence of war, but access to basic needs such as food, education, shelter, as well as health, economic freedom and life, IPI works for peace in the form of social, spiritual, economic stability, health and transformation of people and communities through education, enterprise and empowerment" (Ringera, Personal Communication, 2011).

As IPI endeavors to strengthen the capacity of women living with HIV/AIDS, their families and communities to care for women and children made vulnerable by HIV, IPI has created a number of core programs that support these marginalized groups. These programs are:

- The Amani Children's Homes
- The Orphans and Vulnerable Children's Educational Fund
- The Grass Seeds Fund
- The Institute for Non-violence and Peace
- The Network for Enterprise Initiative

2.7.1 The Amani Children's Homes (ACHs)

The first of these homes is based in Kithoka sub-location of Chugu Location, Imenti North District. It is aptly named Kithoka Amani Children's Home (KACH). KACH is a child rights-focused, community supported home for children who have lost parents to AIDS as well as other afflictions related to poverty. It is KACH which inspired this research. The Home provides love,

care, shelter, food, clothing, education and security for the children, aged between six and eighteen. KACH admitted the first fifteen orphans in August, 2009.

By providing staff-supervised housing in a children's home environment, the orphans are able to stay close to extended family, thereby remaining in familiar surrounding as they attend school. As a result, the home does not operate as an orphanage. By researching enterprises that are interdependent and that take advantage of community resources and needs, ACHs will be largely self-sustaining, while providing opportunities for child-residents to engage in meaningful experiences that promote Education, Enterprise and Empowerment, and instill life skills that translate to independence, building self-esteem and self-reliance. Moreover, the community is involved in the maintenance of the home by providing food and labour in the farm, as well as other projects.

2.7.2 The Orphans and Vulnerable Children's Educational Fund (OEF)

For the poor in Kenya, education equals hope. Education creates options for enterprise and empowerment. OEF funds education for orphans and vulnerable children. Funding is directly channeled to school fees, uniforms, books and school supplies for primary and secondary school students. The IPI College Scholars Program identifies and funds undergraduate degrees for students who have completed high school education, with exceptional determination, promise and commitment to community. With a high school and college education, youth can prevent exploitation and lift their families and communities from the vicious cycle of poverty.

2.7.3 The Institute for Non-violence and Peace

The mission of INPEACE is to aid in the prevention and transformation of conflict through research, education and training programs. IPI believes that only homegrown peace initiatives

will save Africa from the current quagmire of persistent conflicts. Therefore, training and sensitizing civic, social and governmental groups, as well as including traditional peace processes adapted to contemporary use, are significant aspects of peace building in Africa. INPEACE convenes transformative conferences that highlight gains made by women fighting HIV/AIDS, poverty and violence at the grassroots level, initiates training in HIV/AIDS awareness creation and reduction of stigma and discrimination, conducts effective inter-conflict transformation and peace building workshops through people-focused, human rights based and participatory approaches.

2.7.4 The Grass Seeds Fund

This community support initiative is designed to support multiple projects enabling women to become financially independent. Examples of the activities carried out under the Fund are: the Firewood Women's Group, which sells firewood to buy food and medication; the Bettering our Lives through Design (BOLD) Project, in which women engage in making jewellery which they sell to both local and international markets and a bee keeping project. Additionally, IPI partners with other NGOs and organizations, such as Balm Touch, to support trauma management groups by engaging in various programs and projects.

2.7.5 The Network for Enterprise Initiative

This Initiative is a strategy for sustainability in IPI-K projects. This was established to create a planned, sustainable network of agricultural products and cottage industries to support IPI-K's projects, such as the pig and rabbit projects.

In order to ensure community support and ownership of KACH, Ksh. 100 was collected from every home in the location, as a sign of support for the project. In addition, community members

offered building materials and free labour during construction of the Home. This is an indication that KACH has embraced a holistic and participatory community-based approach that encourages the community to come up with solutions to their afflictions, thereby resulting in empowerment and sustainability of the community.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This Chapter details the research methodology including the research design, variables under study, target population, sampling procedures as well as data collection, data analysis procedures, data management and ethical considerations

3.2 Research Design

This study used both a correlational design as well as a descriptive quantitative design. According to Creswell (2002), a correlational design is used to describe the statistical association between two or more variables. In the study, data was collected on the population's levels of education and levels of enterprise and empowerment, (with regards to HIV/AIDS in particular as well as other afflictions in general) in order to test the nature and extent of the relationship (if any) between exposure to education, engagement in enterprise and empowerment, in grassroots communities. The descriptive aspect of the research design aimed at providing a background to the situation and also a detailed relative accurate picture, thereby being descriptive. According to Kombo and Tromp (2006), a descriptive study is concerned with finding out the who, what, where and how of a phenomenon.

3.3 Location of the Study

The field study was conducted in two places. The first was in Kithoka, Imenti North District, Meru, Eastern Province; and the second was in selected areas in Meru town, where part of the population resides. The Kithoka area is a rural area. The main economic activity the populace engage in is agriculture, mainly, subsistence farming. They either work on their farms or provide

labour for others' farms, especially during peak seasons such as preparing land for planting, planting, weeding and harvesting. The types of crops grown here are maize, beans, fruits such as oranges, pawpaws, avocados, as well as vegetables such as cabbages, carrots and kales. There are local trade centers where the farmers sell their produce and purchase refined foodstuff such as bread, sugar and salt. Some keep livestock such as cows, goats and pigs. The education scenario in Kithoka is hopeful. There are at least six Primary Schools within reach, three of them being boarding schools. There are a couple of Secondary Schools, and one University, the Kenya Methodist University, which is near Meru Town. The urban area of Meru Town, was chosen due to its cosmopolite value-add to the Study. This would ensure the data collected included that of the high risk members of the sample, such as the commercial sex workers (CSW) as well as men with multiple sex partners.

3.4 Target Population

The population targeted by the study comprised the following groups: Employed women, Employed men, Married women, Married men, Unmarried women, Unmarried men, Women living with HIV/AIDS, Men living with HIV/AIDS, HIV-Negative women and HIV-Negative men. Given the scope of the study, it was important to include these categories in the sample, considering the sampling was purposive. In addition, the cross-cutting nature of HIV/Aids, which impacts on all areas of a population, necessitated inclusion of a sample which brings together all the demographics of a people.

3.5 Sample Size and Sample Design

The study used a survey to determine the most efficient BCC strategy with regards to empowerment and sustainability. Purposive sampling technique was employed. A second

independent sample was drawn from the HIV negative participants, to compare whether a difference exists between the two groups with regard to empowerment and dependency. A total sample of 168 respondents was used for this study. This was a 90 percent response rate.

3.6 Variables under Study

The variables under study were education, enterprise and empowerment (3Es) and prevalence of HIV/Aids. Other variables were sex, age, educational qualifications, employment type, knowledge of HIV status and transmission modes. In the analysis of the relationship between the 3Es and HIV/Aids prevalence, the 3Es of Education, Enterprise and Empowerment were the independent variables while prevalence of HIV/Aids was the dependent variable. The other variables were treated as the intervening variables. In the analysis of data on the two variables (the 3Es and HIV/Aids prevalence), the variables sex, age, educational qualifications, knowledge of HIV status and transmission modes, were treated as independent variables, while the 3Es and HIV/Aids prevalence were treated as dependent variables.

3.7 Research Instruments

A total of two instruments were used to collect data for this study; namely a two-part questionnaire and a Focus Group Discussion template. Each of the instruments is described below:

3.7.1 Questionnaire

The questionnaire is designed in two parts. The first section captured the demographic characteristics of the population. Included herein was sex, age, education level, marital status, number of sexual partners, HIV status, knowledge of spouse's HIV status (for the married and

those in relationships), mode of contracting HIV (for the HIV positive) employment type and average annual income. The second part of the questionnaire had 34 questions on a liket scale as follows: *Never, Rarely, Sometimes, Mostly* and *Always*.

To score, numerical scores of 1 to 5 were assigned to each possible response for each item, as follows: a score of 5 for *"always"*, 4 for *"mostly"*, 3 for *"sometimes"*, 2 for *"rarely"* and 1 for *"never"*. These items were reversely scored with a score of 5 being assigned to "never" and a score of 1 to *"always"*. Hence for each item, a respondent was assigned the score corresponding to his/her specific response. A respondent's total score on the scale was then computed by adding the numerical scores for all the 34 items. Since the lowest possible score per item was 1 and the highest possible score per item was 5, and there were a total of 34 items, the lowest possible score for any respondent was 1 x 34 = 34, while the highest possible score was 5 x 34 = 170. The scores were then converted to percentages. Therefore, the lowest possible score was 34/170 x 100 = 20, while the highest possible score was 170/170 x 100 = 100.

For the purposes of this rating scale, "*Always*" meant the behaviour was exhibited nearly all the time (about 90% - 100% of the time), while "*Mostly*" meant the behaviour was exhibited several times but not all the time (about 75% of the time). "*Sometimes*" implied the behaviour was exhibited a satisfactory number of times (about 50% of the time), "*Rarely*" meant the behaviour was exhibited few times (about 25% of the time) and "*Never*" meant the behaviour was not exhibited (0% of the time).

3.7.2 Focus Group Discussion Template

The focus group discussion template is a set of "things to observe" that the researcher put together. This includes: number of participants in a FGD session, composition (whether female-

only, male-only or mixed), age of participants, ways of identifying a leader for the group (whether it is pre-determined, on a rotational basis or whether participants decide during the sessions), language in which discussions are conducted, time of day when discussions are held (this would determine how much time participants allocated to other activities, such as income generating activities/entrepreneurial activities), duration of discussion, content of discussion and other aspects the research team would notice. The researchers would attend the FGDs passively and write down their observations.

3.8 Pilot Study

To check the appropriateness of the instruments, a pilot study was conducted using 20 randomly sampled members of the target population. This pilot population included members in each of the target groups, that is, Employed women, Employed men, Married women, Married men, Unmarried women, Unmarried men, Women living with HIV/AIDS, Men living with HIV/AIDS, HIV-Negative women and HIV-Negative men. Those who participated in the pilot were excluded from the final sample. The pilot study was used to enhance the validity and reliability of the research instruments. Areas in the instruments, identified as unclear or ambiguous were improved and clarified before final administration of the instruments.

3.9 Validity and Reliability

In the development of the research instruments, efforts were made to enhance the validity and reliability of the tests through generating sufficient number of items to cover the key areas, without making the tests too long as to cause respondent fatigue and boredom. In developing the second part of the questionnaire, the researcher worked closely with selected monitoring and evaluation experts both in government and in NGOs. These officers were considered experts in

the relating programs with sustainability. This helped to enhance the validity of the questionnaire.

Test-retest reliability was used to check the reliability of the 3Es and HIV/Aids prevalence. During piloting, the instruments were administered on two successive occasions, with a time lag of three weeks between each administration period. The researcher assumed that a three-week interval was long enough to ensure the respondents did not accurately recall their responses, from the first testing, and short enough to ensure there were no substantial changes in the behavior under investigation.

Reliability coefficients of *rxx* =.79 and *rxx* =.84 were obtained for the 3Es and HIV/Aids prevalence scales, respectively. These correlations were considered accurate since researchers such as Cohen (1988) and Gravetter and Forzano (2009) recommend values of *r* =.80, or larger, as ideal when using correlation to measure the reliability of measurement.

To enhance validity and reliability during test administration, the researcher ensured that the research assistants (RAs) were fluent in both Swahili and Ameru languages. The researcher and RAs assistants established the necessary rapport with the respondents and gave clear written and verbal instructions. This was to ensure tasks were clearly understood. Bearing in mind the challenges posed to validity and reliability by self-report methods, the purpose of the study was clearly explained to the respondents. They were assured that their responses would be treated with confidentiality and be used only for statistical purposes of the study. This assurance was significant as it encouraged honest responses, which further enhanced validity and reliability.

3.10 Data Collection

Data used in this thesis were derived from both primary sources and a review of empirical studies. The field study was conducted in Imenti North district, Meru, Eastern Province. Both quantitative and qualitative data were generated using focus group discussions (FGDs), a survey, in-depth interviews with respondents and participant observation methods. Five focus group discussions were conducted, each comprising of respondents drawn from the following groups: Employed women, Employed men, Married women, Married men, Unmarried women, Unmarried men, Women living with HIV/AIDS, Men living with HIV/AIDS, HIV-Negative women and HIV-Negative men. The FGD data were analyzed using the Nudist 6 computer package. A survey questionnaire was then administered to 168 respondents in the rural and urban area in which IPI operates. The two settings were targeted with a view to determining the workability of the 3Es, as an effective BCC strategy that can adequately and effectively be applied to respond to the HIV/AIDS scourge at the grassroots level, by building the capacity of individuals and the Kithoka community, to become self-sufficient.

The researcher was aided in the data collection exercise, by a team of five research assistants (RAs). The RAs were well-inducted in advance to ensure they were well versed with the data collection procedures as well as to ensure consistent conditions of administration of the instruments. The RAs also needed to demonstrate proficiency in both Swahili and Ameru languages, as these were the languages spoken by the population. The questionnaire was individually administered to each member of the sample.

Considering the sensitivity of the subject under study, every effort was made to create the necessary rapport, to explain to the participants the nature of the study and the purpose for which

the results will be utilized, that is, for research purposes only. Participants were assured of confidentiality in the management of their responses. To avoid unwanted psychological trauma of the respondents, the RAs explained the purpose of the study and other ethical considerations of carrying out research. The RAs produced a copy of the covering letter, which introduced the researcher and identified the confidential nature of the study, and the support required. Although respondents were not required to indicate their names or contacts on the questionnaire, it was mandatory for them to indicate, via signature, that they had consented to participate in the study. After administration of the instrument, the RAs spent some time with the respondents, in an effort to debrief them of unwanted psychological effects of the process.

3.11 Data Analysis

The quantitative data were analyzed using the Statistical Package for Social Sciences (SPSS). The third phase of data collection comprised in-depth interviews with key respondents to gain greater insight into issues that had not been clarified during the initial phase of data collection. Content analysis was used to classify the data based on convergence and divergence of ideas on various aspects, followed by an examination of the relationships between these ideas.

The independence levels of participants were examined using a likert scale comprising 34-point questions scored from (1) *about never* to (5) *almost always*. The items were divided into income generating activities, saving practices, investment practices, self-sustenance, desire to better one's life and personal health management. A score on the scale will range from 25 to 125 with higher scores indicating a higher level of empowerment. The responses from each participant were used to calculate the mean percentage of scores for each question; The Students t-test was used to examine the data with the objective of determining whether there is a significant

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relationship between participatory BCC strategies and personal empowerment ability to ensure sustainability of both self and income generating activities.

Pearson product moment correlation coefficient was computed to determine whether there was a significant relationship between the 3Es and reduction in HIV/Aids prevalence. Partial correlations were also conducted to determine whether there was a relationship between the 3Es and reduced HIV/Aids prevalence, while controlling for effects of gender, age, educational qualifications and duration of employment. The statistical hypotheses were tested at the significance level of $p \leq .05$.

The in-depth analyses were used to clarify issues and assess the validity of the collected data; which informed the conclusions and recommendations of this thesis.

3.12 Data Management and Ethical Considerations

Prior to carrying out the study, authority was sought from Dr. Karambu Ringera, the Founder and Executive Director of International Peace Initiatives – Kenya, as well as the IPI Board of Directors, who approved both the questionnaire and the FGD template, in terms of appropriateness.

The research participants were duly informed of the nature of the research and their written informed consent was sought prior to data collection. The RAs were sensitized on the demographic characteristics of the population, the fact that some were living with HIV/Aids. Therefore they were urged to take cognizance of this fact while administering the instrument. In the event that a respondent was unwell or not in a frame to participate (probably a respondent would be overwhelmed and break down during the interviewing process, or would be too inebriated to participate, or for whatever other reason) the RAs would not administer the

instrument, but would return at a later date. Further, respondents were informed that they were at will to withdraw from the research at any stage, if they felt they lacked the physical and mental will to continue participating. Respondents' data was treated with utmost confidentiality during and after the research and used only for the intended research purpose. Finally, efforts were made to debrief the participants after administration of the instruments, so as to deal with any unwanted psychological effects of the testing.

CHAPTER FOUR

DATA ANALYSIS AND DISCUSSION

4.1 Introduction

This Chapter reflects the manner in which data was arranged and presented, in order to make it easily comprehensible. The presentation of data was representative of the outcome of the data collection exercise.

4.2 Presentation of Findings

Findings were presented graphically, in the form of histograms and polygons. The essence of presenting the data, was to illustrate the linkage of the 3Es to prevention of HIV/Aids transmission. The presentations begin with demographic data such as; the percentage of the participants, women to men; marital status. The data is then illustrated with regard to gender and number of sexual partners; gender and knowledge of HIV status; gender and knowledge of HIV/Aids transmission methods; attitude towards faithfulness and spread of HIV/Aids. Thereafter, presentation of findings with regard to the 3Es intervention was done. Here, the researcher was concerned with measuring how education and enterprise had ensured empowerment of the community. For this to be achieved, the relationship between IPI and the respondents was examined through the following lenses; participation and involvement, exposure to knowledge (through training), ability to cater for self and family's needs, decision to take charge of one's health and personal financial management practices such as budgeting, adhering to a budget and comparing prices before purchasing.

4.3 Demographic Data Presentation of the Sample

This sub-section illustrates the demographics of the sample. The demographic characteristics of the sample were analyzed under the following categories:

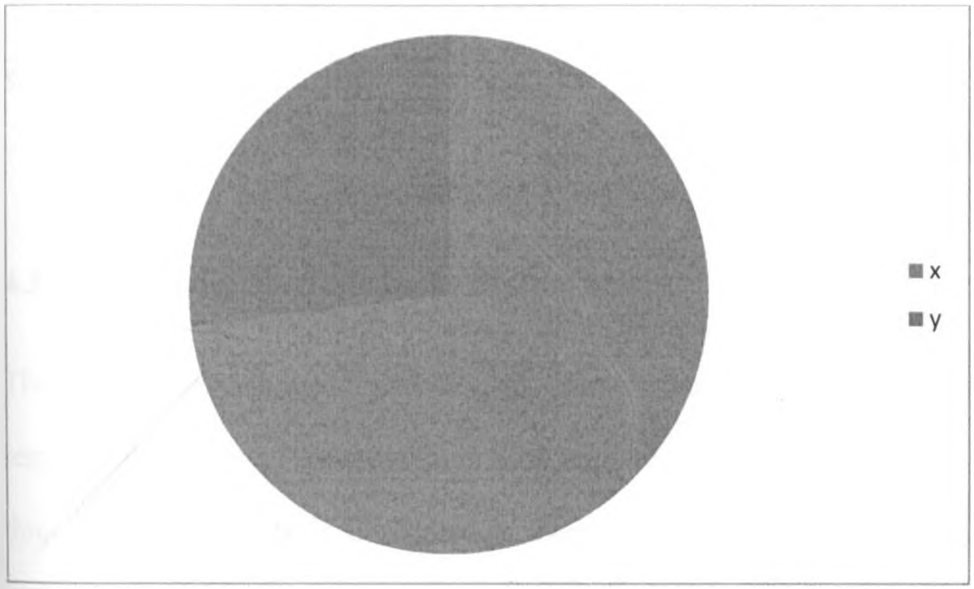
- Percentage of gender representation in the sample
- Percentage distribution by age and sex
- Percentage distribution by marital status
- Percentage distribution by profession
- Percentage distribution by education background
- Knowledge of HIV status
- Personal financial management practices

4.3.1 Percentage of gender representation in the sample under study

Female respondents totaled 122, which was 73 percent representation. Male respondents were 46, which was 27 percent representation. Much as the general trend in demography, is that women outnumber men, other factors were responsible for this outcome. The fact that women were part of the research team made it easier for women in the sample to participate in the study. Also, it was easier to interview women as they would be found in their homes, in the women's groups or in the farms. Men, on the other hand were harder to locate, considering it is male nature to spend less time at home than women. The men in the sample worked away from home. Save for those who worked in the farm, most worked either in Meru town or in areas far from the home. Other men would spend most of the day in the town centers, in bars and other settings, hence their low participation compared to women. Also evident during the data collection, is the fact that as opposed to women, men, especially those who were HIV positive, did not take their

health seriously. This was evident during administration of the FGD Template, in which some men indicated that they did not see the need to eat balanced meals, take ARVs (despite the fact that they had been advised by medical personnel). In addition, they engaged in harmful practices such as alcohol intake, cigarette smoking and unprotected sex, which they justified as being "manly". The representation is illustrated in *Figure 1* below.

Figure 1: Gender representation in the study



Source: Research Data, 2011

4.3.2 Distribution by Sex and Age

The age profile of the respondents ranged from 20 to 60 years. Majority of them were between 30 to 45 years. The distribution by age and sex is represented in Table 2 below.

Table 2: Distribution by Age and Sex

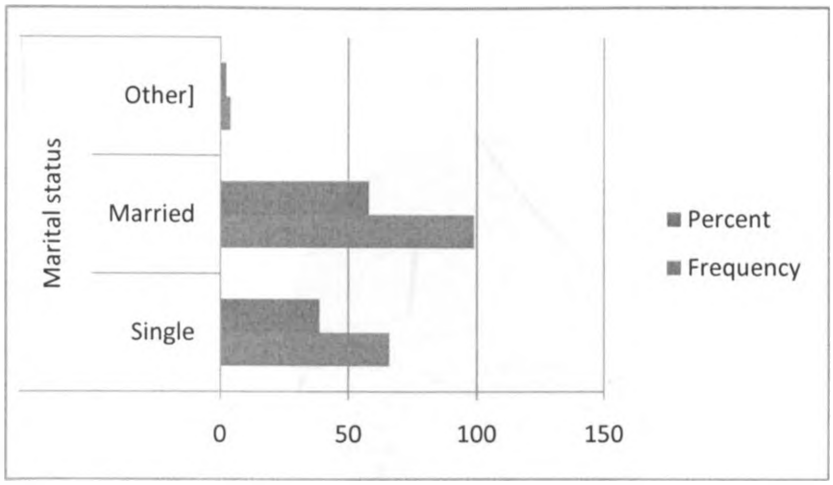
Age	Sex	
Age Bracket	% Women	% Men
20 – 30	58.67	41.33
31 – 40	49.12	50.88
41 – 50	55.88	44.12
51 – 60	66.67	33.33

Source: Research Data, 2011

4.3.3 Percentage distribution by Marital Status

The data collected indicates that 42 respondents were single, which represents 25 percent of the respondents, while of the remaining 126 respondents who represent 75 percent, one in every three is married. This is illustrated in *Figure 2* below. Compared to urban populations, the percentage of married respondents is higher than that of the unmarried. This is important to note, as in rural settings, women are married off early, either due to custom, or to "avoid" the humiliation of bearing children outside marriage. It is equally significant to note that since the Ameru culture does not consider women worthy of inheritance, the married women are left no choice but to be at the beck and call of their husbands, who are the owners of land and other capital.

Figure 2: Percentage distribution by Marital Status

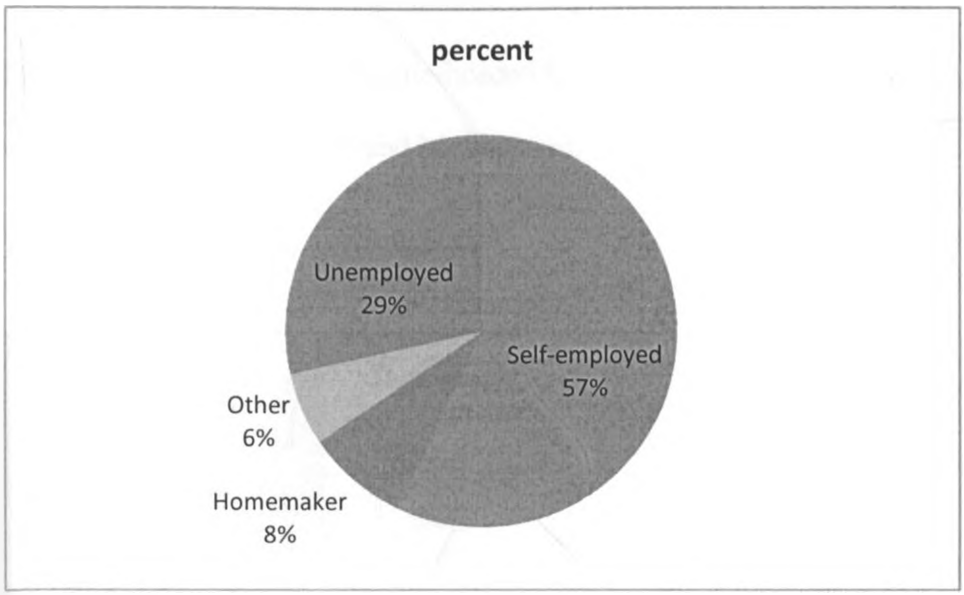


Source: Research Data, 2011

4.3.4 Percentage distribution by Profession

The options to the response had five categories that is Professional [e.g. teacher, nurse], Self employed [e.g. tailor, farmer], Homemaker, Unemployed and Other. 96 respondents, representing 57% of the sample, were self-employed due to the fact that data was collected from a grassroots community. 11 respondents representing 6% of the sample were professionals, working either in Kithoka or in Meru Town. The professionals were either employees of IPI, teachers, nurses, tailors and car mechanics or were employed in supermarket chains. These findings are illustrated in *Figure 3* below.

Figure 3: Percentage distribution by Profession



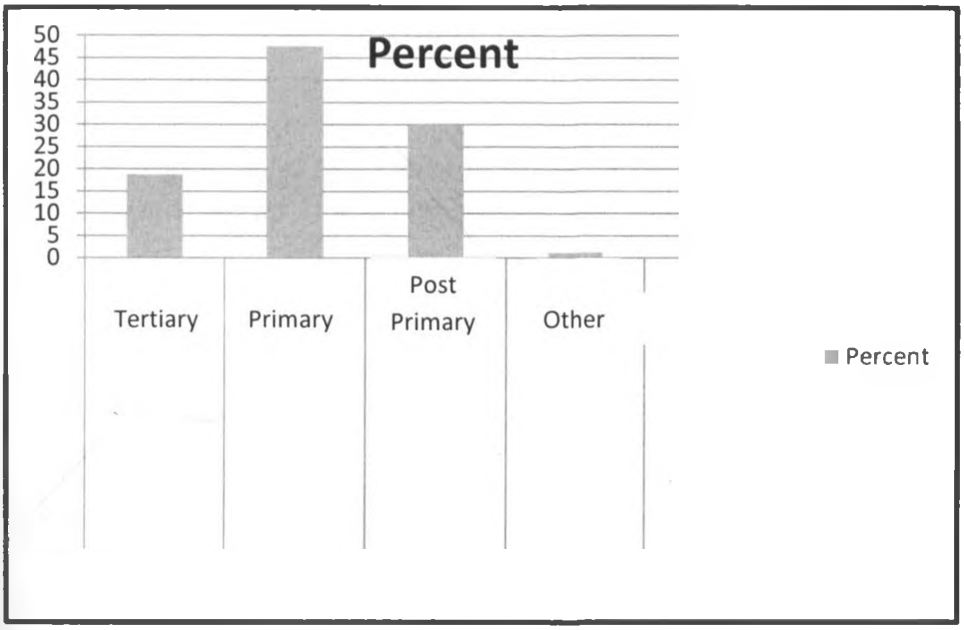
Source: Research Data, 2011

4.3.5 Education Background

The education variable was included in the study due to its relationship in predicting sexual behaviors. Figure 4 illustrates findings by Melkote (1980), that there was a strong positive relationship between educational attainment and empowerment. He further found out that having attained a high degree of educational achievement, made one more aware of their ability to be independent, hence less susceptible to dependency. Education creates income generating opportunities for the individual, hence enabling them to overcome the cycle of poverty. Melkote's sentiments have also been echoed by Bandura (1994) who notes that poor women are especially vulnerable to their male partners' views, since they are economically and emotionally dependent on them. Poor women are limited in their choices about relationships and living situations, in ways that middle-class women may not be, and that they may not experience the

freedom to regulate sexual practices or to separate from their husbands. Concerns regarding food, shelter and care of their children take precedence over worries about AIDS. Education also reduces the probability of female-headed households making transactional sex a "rational means of making ends meet" (Gill and Mohammed, 1994: iii).

Figure 4: Educational Achievement



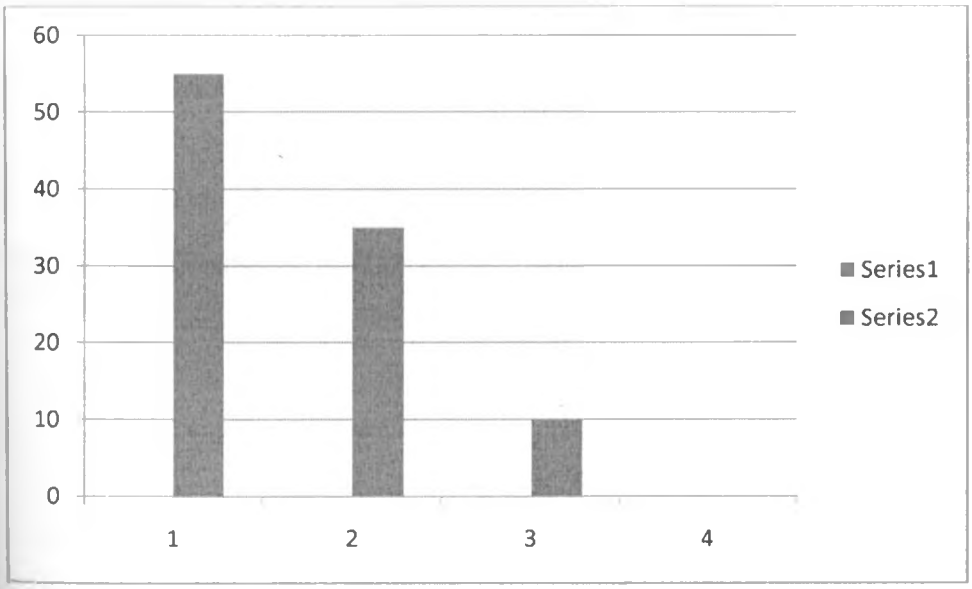
Source: Research Data, 2011

4.3.6 Knowledge of HIV Status

This was important for the study, as "if you cannot measure it then you cannot control it" (Karambu, Personal Communication, August 2009). It was therefore important to include knowledge of HIV status as a variable in the study. The findings reveal that more of the single respondents were knowledgeable of their HIV status compared to the married respondents. Also, of the married respondents, those who were literate or resided in Meru Town, were more knowledgeable of their HIV status. This could be attributed to the fact that cosmopolite

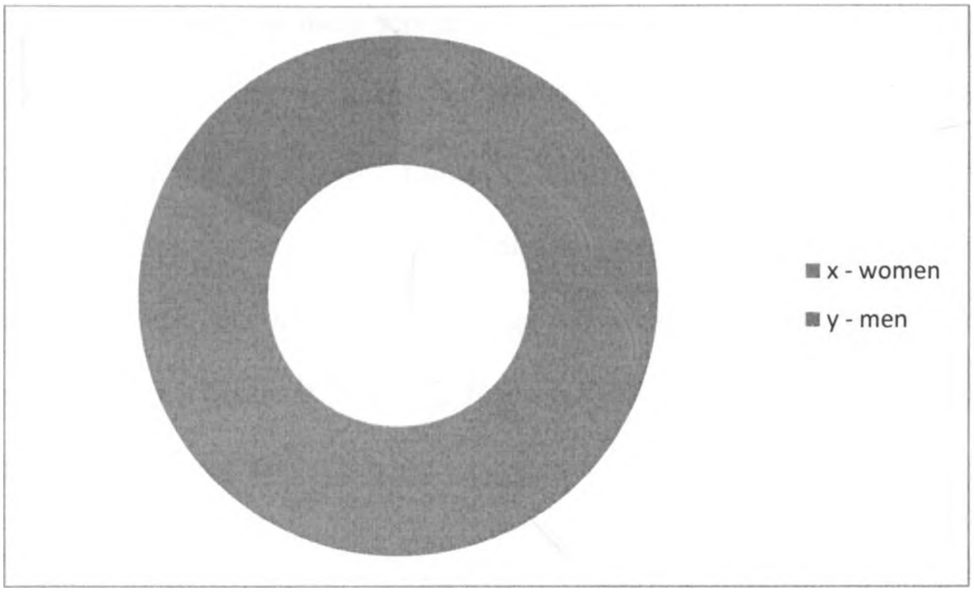
populations have greater access to mass media due to increased interaction with others from diverse backgrounds. Of the married respondents, women were more aware of their HIV status than men, who declined to get tested for fear of stigma. Women who knew their status totaled 83, making 55%, total men were 68, representing 35% and those who did not know (both men and women) were 17, marking 10%. Generally, women at 83% were more knowledgeable of their status than men at 17%. *Figures 5.0, 5.1* and *5.2* illustrate these findings.

Figure 5.1: Knowledge of HIV status among married respondents classified under women (series 1), men (series 2) and both women and men - "I don't know" category- (series 3)



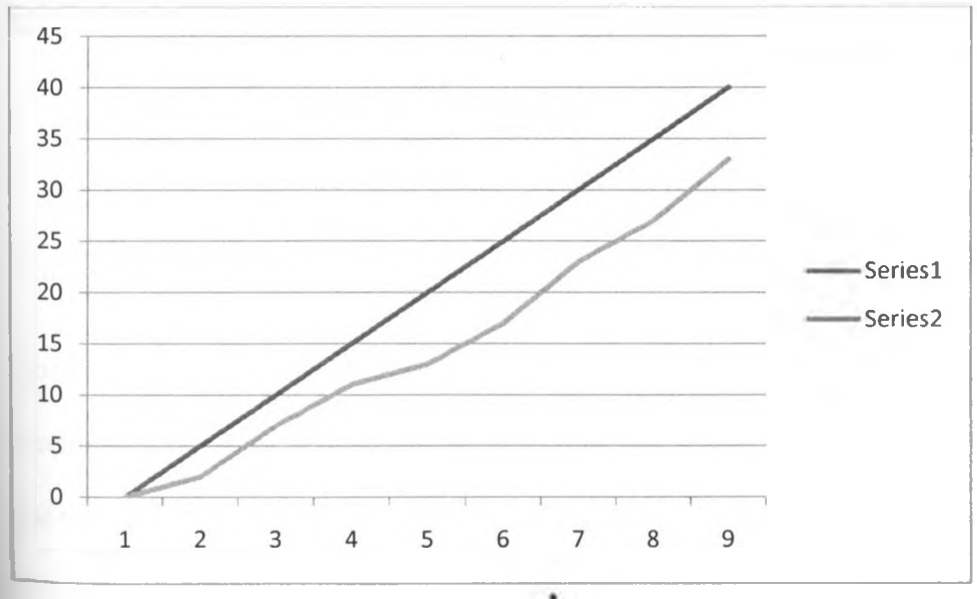
Source: Research Data, 2011

Figure 5.2: Knowledge of HIV status between single and married respondents



Source: Research Data, 2011

Figure 5.3: Knowledge of HIV status – urban literate (series 1) and rural illiterate/not as literate (series 2)



Source: Research Data, 2011

4.3.7 Personal Financial Management Practices

Poor financial management serves to reverse the gains an individual has made, despite being exposed to the 3Es. It is due to the fact that sound financial management is tied with development that the researcher included this variable in the study. The aim was to test whether, after receiving training and attending talks on financial management, as well as working together in the groups, the respondents had gained knowledge that they could apply to prudently managing their finances. Planning finances resulted in the respondents planning their incomes better and also reduced dependency brought on by debt burdens.

This variable was tested in two ways:

- Saving practices and
- Expenditure practices

The results are tabulated in *Tables 3* and *4* below

4.3.7.1 Saving Practices

For the purpose of this study, the term 'savings' referred to money put aside for emergencies. Lusardi (2006) defines savings as the difference between income and consumption, and goes further to explain that savings automatically decline as consumption increases.

Most female respondents reflected a savings culture with a high mean of 3.85 out of the maximum 5.0 points. It was interesting to note that majority of the female respondents indicated that they always sought ways of saving money. Women, compared to men, set aside money for future needs followed by saving out of each payment they received (3.73). *Table 3* illustrates these findings.

Table 3: Saving Practices between Female and Male respondents

Practice	Female	Male
I save/ invest out of each payment I receive	3.73	3.49
I save at least 10% of my gross monthly income	3.68	3.36
I set aside money for future needs/wants	3.76	3.55
I increase my savings when I receive a salary increase	3.63	3.22
I am the kind of person who always looks to save money	3.85	3.46

Source: Research Data, 2011

4.3.7.2 Expenditure Practices

Having a budget is critical in monitoring financial expenditure. A budget indicates sound financial management.

The research study showed that more female respondents tracked all or some of their expenses compared to their male counterparts with a mean of 3.71 compared to 3.66 respectively. Both male and female respondents, however, displayed the same trends with regard to comparing prices for all major expenses - 4.14 and 4.04 respectively. These findings are illustrated in *Table 4 below.*

Table 4: Expenditure Practices between Male and Female respondents

Practice	Women	Men
I track some or all my expenses	3.71	3.66
I compare prices for major expenses	4.04	4.14
I use a spending plan or budget	3.19	3.45
Sometimes I spend more than I can afford	1.96	1.87
I closely watch the amount I spend	3.54	3.91

Source: Research Data, 2011

CHAPTER FIVE

DISCUSSION OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

People cannot be liberated by a consciousness and knowledge other than their own
Fals-Borda (1991:14)

5.1 Introduction

This Chapter discusses the findings of the Study and draws conclusions from the data analyzed as well as suggesting recommendations for future research. The Chapter opens by discussing the relationship between communication and development, and closes by showing how findings from the previous chapter are connected to the 3Es – Education, Enterprise and Empowerment, and to HIV/AIDS prevention in particular, and development in general. Specifically, the discussion in this chapter centers on the importance of empowering women, as their suffering in the absence of education, enterprise and empowerment, is on a much grander scale than men.

5.2 Communication and Development

5.2.1 What is Development?

The dominant paradigm discussed in the literature review, assumed an ethnocentric conception of what progress should be. It described the type of modernization that has been achieved in Western Europe and North American countries. Also, it viewed development from a macroeconomic perspective, as economic growth obtained through greater industrialization and accompanying urbanization. In so doing, the dominant paradigm gauged development via measures such as Gross Domestic Product (GDP) and per capita income levels. Missing in this definition is the broad-based conception of development. Any discussion of development "must include the physical, mental, social, cultural and spiritual growth of individuals in an atmosphere

free from coercion or dependency" (Melkote & Steeves, 2001:332). Also, greater importance must be given to preserving and sustaining traditional cultures, as these constitute the media through which people at the grassroots structure their reality. This is true as local cultures harbor solutions to many of the problems at the grassroots. To talk, therefore, of uprooting local cultures "is not only naïve but also ethically indefensible" (Melkote & Steeves, 2001:333).

5.2.2 Development at what level?

More often than not, development work has been at the national level. Missing from this notion, has been the recognition that individuals, groups and communities require different strategies for development. As Barken and McNulty (1979:12) posit, "if development is not to create greater misery for the majority at the periphery, then we need a process by which not only the *mythical* concept of the nation is developed, but individuals and communities are also given the opportunity to create the type of society they want." Simply put, societies have different value systems and goals, and must be free to determine their own definitions of the good society – at each level of society – and how it may be achieved.

5.2.3 Who within society determines whether or when development is acceptable or unacceptable?

The elites in every society, usually men, have always had the prerogative of deciding what their societies need. In most developing countries, economic and political power is concentrated in the hands of a minority elite. In light of this, therefore, any definition of development by elites will almost always be in a direction opportune to their interests. Missing in this approach is participation by the people at the grassroots. People who are the objects of policy "need to be involved in the definition, design and execution of the development process" (Karambu, Personal Communication, January, 2011).

5.3 Communication and Participation

Communication constitutes an indispensable part of participatory approaches. If development is to have any relevance to the people who need it most "it must start where the real needs and problems exist, that is, in the rural areas, urban slums and other depressed sectors" (Chambers, 1983: 57). People living in such peripheries must perceive their real needs and identify their real problems. As is evident in the previous chapter, the locals needed to inform the researcher whether they are involved in decision making and whether their opinions are sought in interventions designed to offer them education and opportunities for engaging in entrepreneurial activities.

5.4 Communication and Empowerment

Empowerment as a construct has a set of core ideas; therefore, it may be defined at different levels including individual, organization and community. Given the nature of this study coupled with the fact that power inequities in societies are posited as the major impediments to achieving meaningful change, the researcher was of the opinion that the working definition of empowerment should be linked directly to the building and exercise of social power.

According to Fawcett, et al. (1984: 146), "community empowerment is the process of increasing control by groups over consequences that are important to their members and to others in the broader community." Another definition describes empowerment as "an intentional, ongoing process centered in the local community, involving mutual respect, critical reflection, caring and group participation, through which people lacking an equal share of valued resources gain greater access to and control over those resources" (Cornell Empowerment Group, 1989:2).

The findings led to an exploration of the construct of empowerment. The organizational value of communication, as opposed to its transmission value, emerged. This is significant, as it showed how communication may be harnessed to help empower marginalized groups and communities. The organizational value of communication is ethical and it is concerned with participation as a vehicle for empowerment and subsequently, development.

Findings from the study indicate that, in spite of a high level of knowledge concerning the modes of transmission of HIV, majority of the respondents were only familiar with: abstinence, being faithful to one sexual partner, and the consistent and correct use of condoms (ABC) approach to preventing transmission of the epidemic. The researcher concludes that this scenario could lead to HIV infection due to ignorance, for instance, from mother to child, despite the availability of appropriate interventions to avert such vertical transmissions.

Another outcome of the study is that knowledge about HIV prevention measures is higher among girls and women than among boys and men, due to the greater degree of the former with healthcare providers, as well as the fact that most of the women are stay-at-home-mothers, who then have more time with the children as opposed to the men, who spend most of their time at the market place or in local drinking dens. Also, most of the women are members of support groups, where they learn beadwork and other skills, as well as receiving training and motivational talks by guest speakers, they are able to share lessons learnt with other women. In addition, of the married respondents, women were more knowledgeable of their HIV status than men.

Furthermore, respondents with a primary-school and above level of education, as well as those below 30 years, were more knowledgeable about HIV prevention measures as compared to those with no formal schooling or those above 30 years. However, many male respondents did not

perceive faithfulness to one sexual partner as an efficient method of preventing HIV infection, due to cultural practices which allow boys and men to have multiple sex partners. Women respondents, as well, were divided on faithfulness to one sexual partner, thus they are rendered susceptible to infection.

The findings also reveal that while it is easier for girls to adopt HIV prevention measures when still single, the situation alters upon marriage. This is because married women are expected to procreate; therefore many women are exposed to HIV infections through unprotected sex for the sake of procreation. Other practices rendering girls and women especially vulnerable to HIV infection include: economic dependency on men as the sole breadwinners, polygamy, male preference for multiple sexual partners and preference for dry sex that causes abrasions, thereby increasing chances of HIV infection. This outcome has been echoed by Schneider (1992), in his exploration of the interaction of race, class and gender in the context of HIV/AIDS preventive behavior. Schneider found that social factors push risk reduction behaviours outside the control of certain individuals. For instance, the use of condoms assumes an equal distribution of power in sexual relationships; the woman may have the intention and the self-efficacy to adopt this behaviour, but the actual act requires the active cooperation of the male partner.

From the study, it is clear that at the beginning of the workings of IPI in empowering the Kithoka community, the populace underwent a process which involved a realization on the part of the individuals, of their inequitable position, their sense of powerlessness in the system, and the relative neglect of their needs by the larger society. As IPI provided opportunities to engage in enterprise, as well as access to education, "the attitude of the community members began to change, from a feeling of helplessness to that of action and a desire to better their lives" (Karambu, Personal Communication, August 2010).

5.5 Conclusion

Women, especially rural women, constitute one major audience segment ignored in most development interventions. Women usually have less access to media than men; women's illiteracy levels are higher than men's, thereby limiting women's access to print media. Also, in some cultures, men control the use of the radio, television and internet in the household. On average, women are poorer than men, reducing their economic ability.

To reverse this trend, there needs to be a concerted effort by all development practitioners who work with communities, to ensure that women are involved in any initiatives designed to assist communities. There are some important caveats, however. First, empowerment is a long-term process. The structures of domination and their cumulative effects on societies cannot be removed in a short-term frame. Second, empowerment is not something that can be acquired in a quick seminar or workshop setting. It evolves through practice in real-life situations. It is constructed primarily through actions in, and on, the environment. Third, it is a labour-intensive process. Last, the communication professional may be important, but is never the central figure in activities meant to empower communities. The role of the communication professional is that of facilitator, collaborator and advocate.

Communication channels must be seen to initiate dialogue between the users and the sources, helping them to "talk together". "Only when communication can build itself into the social structure, is it going to show any real hope of extensive results. Only when media channels can mix with interpersonal channels and with organizations in the village, are you going to have the kind of development you will like" (Schramm, 1977:3). Hence, in this approach, communication channels are used to generate dialogue, to help people understand each other and identify their collective problems as well as suggest workable solutions to their afflictions.

Communication is thus a vehicle for liberation from mental and psychological shackles that bind the people to structures and processes of oppression. Used in this way, communication is performing its true function, of building commonness among the members of a group or community striving to change their present situation.

5.6 Recommendations

Emanating from this study, the researcher feels more studies should be conducted in the following areas:

- Communitarian Theory – in this perspective, preservation of the community and emancipation from oppressive structures and external dependencies is the dominant theme.
- Modernization Theory – with respect to how the three qualities of modernization theory and practice: blaming the victim, social Darwinism and sustaining class structures of inequality, can be overcome
- Diffusion of Innovations Theory – this should be studied alongside the dynamic nature of local cultures. The fact that local cultures have survived centuries of hostile alien rule speaks volumes of their dynamic nature.
- Monitoring and Evaluation of Behaviour Change Communication programs, with a view to determining whether grassroots organizations have the organizational and technical capacities necessary to design, implement and monitor effective HIV/AIDS interventions. For instance, whether the organizations have a constitution which guides their operations, whether they elect their leaders, whether they have annual workplans and strategic plans to ensure effective use of finance, etcetera.

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Appendix I – Letter of Introduction

Letter of Introduction

My name is Katunge Kiilu. I am a Maters student at the University of Nairobi's School of Journalism. As a graduation requirement, I need to research on a topic, prepare a project and submit it for grading.

The purpose of this letter is to introduce myself as the researcher, and seek your permission to interview you as part of my sample.

I assure you that data collected will be held in confidence and used for research purposes only.

Please sign at the bottom to indicate you have consented to participate in this research.

Thank you.

....

Respondent Date

Appendix II - Questionnaire

A: PERSONAL DETAILS (please tick)

A01 Gender Male [ ] Female [ ]

A02 Age 20 -30 [ ] 31 – 40 [ ] 41 -50 [ ] 51 – 60[ ] Above 60 [ ]

A03 Marital Status Single [ ] Married [ ] Widowed [ ]

A04 Are you in a monogamous relationship Yes [ ] No [ ]

A05 Number of Children

a. One or two
b. Three or four
c. Five or six

A06 Education level

a. I did not attend formal schooling
b. Primary schooling
c. Secondary schooling
d. Post-secondary [diploma]

A07 Profession

a. Professional e.g. teacher, nurse, etc
b. Self employed e.g. tailor, handicrafts, pottery, farmer, etc
c. Homemaker [househelp]
d. Unemployed
e. Other (Please specify)

A08 Number of sexual partners

a. One
b. Two
c. Three
d. More than three

A09 My HIV Status

a. I am positive
b. I am negative
c. I do not know my HIV status [if C, please answer question 8]

A10 My spouse's HIV status is

a. Positive
b. Negative
c. I don't know

A11 I don't know my HIV status because

a. I am scared of knowing
b. I don't know where to go for testing
c. It doesn't make a difference

A12 I contracted the HIV virus from

a. My spouse
b. A sexual partner
c. A rape incident
d. I don't know where from

A13 How long have you been working at your profession/business?... (Years)

A14 Monthly Employment Income (Ksh)

a.) Less than 5,000 [ ]
b.) 5,000-10,000 [ ]
c.) 10,000- 15,000 [ ]
d.) 16,000 and above [ ]

A15 Alternative Income (Ksh)

a.) Less than 5,000 [ ]
b.) 5,000 – 10,000 [ ]
c.) 10,000 - 15,000 [ ]
d.) 16,000 and above [ ]

Section B: (Please Tick one)

Key

N – Never R – Rarely S – Sometimes M – Mostly A - Always

	Relationship with the organization	**N**	**R**	**S**	**M**	**A**
B 1	I am a voluntary member of my organization					
B2	My profession/business is sufficient to meet my needs					
B3	I find myself engaging in other activities to substitute my income					
B4	The approach the organization uses allows me to be creative					
B5	The people running the organization ask my opinion on issues					
B6	We have discussion periods with the management of the organization					
B7	The organization encourages us to engage in income generating activities					
B8	I am allowed to plan my finances and spend them according to my needs					
B9	I have been taught financial management practices at the organization					
B10	I am able to pay school fees for my child[ren]					
B12	The organization pays school fees for my child[ren]					
B13	I can sell some of my products to the organization and use the money to take care of my family					
B14	The organization has assigned a sponsor for my child[ren]					

B15	I buy school uniform and books for my child[ren]					
B16	I don't worry about money matters as the organization takes care of my child[ren] school needs					
B17	The organization arranges to have people give us talks on various subjects					
B18	The organization facilitates access to ARV drugs					
B19	When I do not have food the organization provides					
B20	I am a member of a financial support group at my organization					
B21	Since the organization began assisting me I have increased my assets [chicken, cows, etc]					
B22	The house I live in was constructed by the organization					
B23	In case of medical emergencies, I approach the organization for help					
B24	The organization encourages me to improve my skills and life					
B25	The organization provides answers to my problems					
B26	I save out of each payment I receive from my income					
B27	I increase my savings when I earn more					
B29	I always look for ways to save money					
B30	I track some or all of my expenses					
B31	I compare prices before buying					

B32	I use a budget for my expenses					
B33	I closely watch the amount I spend					
B34	I find myself spending more than I can afford					

THANK YOU FOR YOUR TIME

Appendix III - Focus Group Discussion Template

Before carrying out this exercise, please inform the participants that the information you will record is for research purposes only.

Please assess the Focus Group Discussions using the following guidelines:-

1. How large is the group (in terms of numbers)?
2. What is the composition (either males only / females only / mixed?

2a. If mixed, please indicate how many men and how many women are present?

3. Can you identify a leader?

3a. Is the leader elected or does the group decided before discussions?

4. What is the sitting arrangement of the participants (in a circle / classroom setting)?

4a. Where does the leader sit?

5. In what language are the discussions?
6. What is the agenda of the discussion?
7. Please use separate piece of paper to indicate any other observations.

Appendix IV- Activity Budget

Activity Budget			
Activity	Item/participants	Cost of carrying out activity	Total cost in Ksh.
Consolidation of literature	Library and internet search	Travelling expenses – Ksh.1000 per visit x 5 visits	5,000
Designing and developing research instruments	Typing and photocopying of research instruments	2 reams of photocopy paper at Ksh. 1,000 x 2	2,000
Induction and training for 5 Research Assistants for 5 days	Transport to and from the training venue + lunch for the Research Assistants	(100 + 75) x 5 per person x 5 people	4,375
Pilot survey for 10 days	Transport to and from Nairobi for the Researcher and research assistants	1000 x 6	6,000
Finalizing of research instruments	Typing and photocopying	2 reams of photocopy paper at 1,000 x 2	2,000
Main field data collection for 3 months	Travel, accommodation and subsistence for the researcher and the research assistants	(1000 + 5000 + 2000) x 6	48,000
Data processing, analysis and report writing for 30 days	Data coding and analysis and editing of the report	500 x 30	15,000
Purchases	5 Flash disks	1000 x 5	5,000
Miscellaneous costs			5,000
Total			92,375