

PERCEIVED IMPACT OF MASS MEDIA CAMPAIGNS ON HIV/AIDS

PREVENTION AMONG THE YOUTH IN OSHANA REGION,

NORTHERN NAMIBIA

**A DISSERTATION SUBMITTED IN FULFILMENT OF THE
REQUIREMENTS OF THE DEGREE OF DOCTOR OF PHILOSOPHY
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BY

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ABSTRACT

This study explores the perceived impact of mass media campaigns in communicating information on HIV/AIDS prevention to in-school (ISY) and out-of-school youth (OOSY) in Oshana Region, northern Namibia. Mass media campaigns have become one of the acknowledged means for stemming the rapid spread of HIV/AIDS in Africa. Since the first case of HIV/AIDS was diagnosed in Namibia in 1986, HIV/AIDS has become the number one cause of hospitalisation and death among people of all ages and of both sexes in the country. The mass media campaign organisations disseminate information through radio, television and printed materials based on the conventional health education model. Despite the high level of knowledge on HIV/AIDS which the youth were found to have, there is little change in their lifestyle and sexual behaviours and the HIV infections have continued at a high rate in the country. It is against this background that this study was conducted in Oshana Region, northern Namibia, one of the regions with a high HIV/AIDS infection rate in the country. The study employed a survey based on the probability sampling approach, using simple random and stratified sampling methods. Data were collected using self-administered questionnaires. Key theories and models of social behavioural change served as a cornerstone of the study in explaining how knowledge, belief and understanding influence behavioural change in young people towards HIV/AIDS prevention. Data analysis was conducted using Statistical Package in Social Science (SPSS) software and analysed in a descriptive manner. The data indicate that respondents have adequate knowledge of HIV/AIDS prevention.

The study findings also revealed that youth have a good understanding and moderately high self-efficacy concerning HIV/AIDS prevention. Moreover, the study results indicate that mass media campaigns organisations only use the conventional health education model to disseminate information on behaviour change. Based on the study findings, the researcher proposes an integrated dialogical health communication model to disseminate information to the youth. The proposed model promotes change in life style and sexual behaviours based on dialogue and participation that empowers the youth to understand issues and environments in which they live as individuals and members of communities.

DEDICATION

I dedicate this dissertation to:

- “The Lord is my Shepherd; I shall not want”. **Psalm: 23**
- My late mother, **Hilda Natshipolo Nuuyoma (1918 -2008)** and my late sister, **Evelina Tshalongo Tshikongo (1950-2008)** in memory of their love, kindness and endurance. My late mother and sister have been my good friends and both died while I was on study leave to pursue this study. May their souls rest in eternal life.

DECLARATION

- I, Regina Mpingana Shikongo, hereby declare that “**perceived impact of mass media campaigns on HIV/AIDS prevention among the youth in Oshana Region, northern Namibia**” is a true reflection of my own research, and that this work, or part thereof has not been submitted for a degree in any other institution of higher education.
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Date...22nd April 2010

Regina Mpingana Shikongo

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LIST OF ABBREVIATIONS

ABC	Abstinence, Be faithful and Condom use
AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante Natal Clinic
ARV	Anti Retroviral
CACO	Constituency AIDS Coordinating Committee
GDHS	Ghana Demographic Health Surveys
GRN	Government of the Republic of Namibia
HBM	Health Belief Model
HE	Health Education
HIV	Human Immunodeficiency Virus
IEC	Information Education and Communication
ISY	In-School Youth
KAP's	Knowledge, Attitudes and Practices
KAPB's	Knowledge, Attitudes, Practice and Behaviours
MDG	Millennium Development Goals
MoE	Ministry of Education
MoHSS	Ministry of Health and Social Services
MTP	Medium Term Programme
MFMC	My Future is My Choice
NAC	National AIDS Committee
NACP	National AIDS Control Programme
NACOP	National AIDS Coordination Programme
NDHS	Namibia Demographic Health Surveys

NBC	Namibia Broadcasting Corporation
NPC	National Planning Commission
NYEFU	Namibia Youth Enterprises Fighting Unemployment
OOSY	Out-of- School Youth
PHC	Primary Health Care
PMTCT	Prevention from mother to child transmission
RACOC	Regional AIDS Coordinating Committee
SADC	Southern African Development Community
SSA	Sub-Saharan Africa
STD's	Sexually Transmitted Diseases
STI's	Sexual Transmitted Infections
SRH	Sexual and Reproductive Health
SPSS	Statistical Package in Social Sciences
TKMOAMS	Tate Kalunga Mweneka Omukithi gwo AIDS Moshilongo Shetu
TV	Television
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNAM	University of Namibia
UNDP	United Nations Development Programme
UNESCO	United Nations Educational Scientific and Cultural Organisations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organisation

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CHAPTER 1

INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 Introduction

This chapter presents background information for the study and explores the perceived impact of mass media campaigns in communicating information on Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) prevention to in-school (ISY) and out-of-school youth (OOSY) in Oshana Region, northern Namibia. It includes background information on Namibia in relation to health issues, background information about HIV/AIDS, statement of the problem, purpose of the study, research objectives and questions. The last part of the chapter covers the significance of the study, scope and definitions of key concepts used in the study.

1.2 Background information on Namibia in relation to health issues

A brief overview of background on Namibia is presented below to give the country's profile and context of this study.

Population

Namibia is a vast country with a small population. The population is scattered and two-thirds of the population (67%) lives in rural areas (Ministry of Health and Social Services) (MoHSS, 2008b, p. 1).

The post independence Namibia Demographic Health Survey (NDHS) conducted in 1992 (MoHSS, 1993, p. 2) shows a high population growth rate of 3.16% per annum, but the 2001 Population and Housing Census according to the National Planning Commission (NPC) indicates a reduced annual average growth rate of 2.6% (NPC, 2003, p. V). This may be a sign that population growth may be influenced by HIV/AIDS through a combination of factors: increased mortality of adults and children, reduction in the number of women of childbearing age and reduced fertility of HIV-infected men and women (NPC, MoHSS, UNDP & UNAIDS, 2001). The regional population densities vary substantially with almost two-thirds of the total Namibian population living in the northern regions, namely Oshikoto, Oshana, Omusati, Ohangwena, Caprivi and Kavango and less than one-tenth in the south of the country.

The 2006/7 NDHS shows that the country has a relatively youthful population, with 43% of the population under 15 years of age (MoHSS & Macro, 2008). Overall, the population density is low; two persons per square kilometre (MoHSS, 2008a, p. 2). The increase in population implies the continuing pressure of demand for support services and facilities such as schools, food and clinics.

Ideally youths are perceived as the healthiest age group. However, with the high prevalence rate of HIV/AIDS and other Sexually Transmitted Diseases (STD's), this group has become the most vulnerable to frequent illness and prone to HIV/AIDS (MoHSS, 2007a, 2008a).

Socio-cultural and legal conditions

Namibia is a culturally diverse country with a rich diversity of ethnic groups.

The Constitution of the Government of the Republic of Namibia (GRN) (1990) recognises the importance of culture and guarantees “the right of every person to enjoy, practise, profess, maintain and promote any culture, language, tradition or religion without compromising the rights of others to national interest” (NPC, 1997, p. 5). Namibians believe in various cultures, traditions, norms, values, practices and religions, which in turn have some impact on their attitudes, beliefs, practices and health behaviours. Therefore, different cultural norms, values and practices influence health and health education activities (MoHSS, 1993, 2003; MoHSS & Macro, 2008).

The Oshana Region, where the study was conducted, is situated in the northern part of the country and has diverse cultural as well as ethnic groups. Currently, rural and urban lifestyles coexist in the region. Oshakati is the capital of the region merging with Ongwediva and Ondangwa as developing urban centres (NPC, 2003). These tripartite cities are stopovers for national and international migrants searching for educational, economic, health services and opportunities (Mufune, 2003). Oshana Region has experienced dramatic urban growth in recent years and forms an important commercial and industrial focus with urbanisation as one of its challenges (MoHSS & Macro, 2008). Oshana Region is one of the 13 political regions in the country with its 10 constituencies as illustrated in figure 1.1 and 1.2 respectively.

Health care services

At independence in 1990, Namibia inherited a fragmented structure of health care services, curative in nature and based on ethnic and racial lines. The colonial administration before independence created a two-tier health system, one for blacks and one for whites, resulting in an unequal wasteful allocation of resources and services. The black administration was an ethnic-based second-tier that was poorly funded and administrators could not raise the necessary income to provide basic health care services. This resulted in large inequities (ethnic and geographical) in the delivery of health services in the country (MoHSS, 1992, 2001, 2008a). Therefore, after independence, the Namibian Government adopted a Comprehensive Integrated Primary Health Care (PHC) approach, which forms the foundation for the provision of health care to all communities within the country (MoHSS, 1995).

The Government, through the MoHSS, (1992), committed themselves to the achievement of “Health for all Namibians by the year 2000 and beyond”. This commitment was difficult to achieve for various reasons such as the political legacy and inequities in the delivery of health care services. Therefore, currently many people in Namibia are sick and prone to many diseases including HIV/AIDS and its related complications and other social health problems such as poverty, ignorance and unemployment (MoHSS, 2004, 2007c, 2008b). In order for the MoHSS (2004) to achieve its goal and fully alleviate inherited disparities, the health policy has been translated into health programmes and action plans whereby the health care delivery system has been transformed.

The system changed from a “curative model” based on fragmented ethnic lines into a “comprehensive integrated health care system” based on the PHC approach (MoHSS, 1992, p. V). This commitment is difficult to achieve within a short time because of the historical legacy in the health care services and the country at large (MoHSS & Macro, 2008). The outbreak of epidemic and pandemic diseases including HIV/AIDS is the major obstacle which also impinges on the health care delivery services and fulfilment of health for all Namibians. However, the MoHSS claims that pursuing the PHC strategy is a means of reducing poverty, inequality and fostering economic growth, improved health services and more productive lives (MoHSS, 1995).

MoHSS further claims that it has made the health care services universally acceptable, available, affordable, accessible and appropriate to the needs of the people in various communities (MoHSS, 2004). However, it could be argued that health services may not yet be universal as is claimed, owing to the historical legacy of the health care services and social health problems such as poverty, ignorance, unemployment and disease surveillance which cannot be corrected within a short time (MoHSS & Macro, 2008).

Health Education

Having reviewed the background information on health care services, it is clear that the dissemination of health information in Namibia forms an integral part of the PHC approach. Health information is disseminated through the process of Health Education (HE), focusing on educating individuals and communities to promote health and gain knowledge on the topic under discussion.

Health education as defined by Simons-Morton, Greene and Gottlieb (1995, p. 91) is a “profession devoted to employ health promotion processes and to foster healthful behaviour and health itself”. Health promotion is also defined as “a set of processes that can be employed to change conditions that affect health” (Simons-Morton et al., 1995, p. 91). Generally, Health Education (HE) focuses on a target population, for example, youths in a certain setting which can be a school, work site, community or health care facility. A health education programme involves a range of objectives addressed in its campaigns that are individual, organisational, community and governmental in nature (MoHSS, 1999b).

In Namibia, the health education programme has a similar pattern to mass media campaigns in other countries in Africa, which disseminate information focusing on major health problems such as HIV/AIDS, emphasising the meaning, its modes of transmission, manifestation, and prevention and promotion measures (Simons-Morton et al., 1995). Next some background information on HIV/AIDS will be provided.

1.3 Background information about HIV/AIDS

Globally HIV/AIDS has affected many countries. The annual numbers of new HIV infections has declined from 3 million in 2001 and an estimated 4.8 million in 2003 to 2.7 million in 2007. However, 33 million people worldwide were estimated to be living with HIV in 2007, since the first case of AIDS was diagnosed in 1981 (UNAIDS, 2008, p. 23).

In many countries in Sub-Saharan Africa (SSA) in general, Southern African Development Communities (SADC) and Namibia in particular, HIV/AIDS has become a major cause of hospitalisation and death. The consequences of HIV infection affect individuals, families, communities and the country at large in all its endeavours (MoHSS, 2008b).

According to the United Nations Agency for International Development (UNAIDS) (2008, p. 32) report SSA has over 10% of the world population, but 67% of all people living with HIV infection are in Africa. Many African countries are experiencing generalised epidemics. The disease is spreading throughout the general population including higher risk groups. Young people, age 15-24 years old in SSA and Southern African countries account for half of all new HIV infections, including Namibia (UNAIDS, 2008; MoHSS & Marco, 2008).

USAIDS (2008) claimed that HIV/AIDS epidemiological situation in SSA is serious and many people are living with HIV infection. Southern Africa is presently the worst affected region on the continent. In 2007, Southern Africa had 35% of HIV infections and 38% of AIDS deaths in the continent. Countries affected most are Botswana, Zimbabwe, South Africa, Malawi, Zambia, Swaziland, Lesotho and Namibia. The HIV prevalence in SADC countries continues to rise beyond normal levels. These countries are losing skilled people vital to the delivery of services in public and private sectors because of HIV/AIDS and its related illnesses (MoHSS, 1999a).

Namibia is not an exception, being near the HIV/AIDS epicentre. Its epidemiological situation reflects a similar pattern to other SADC countries. Since the first case of HIV infection that was recorded in the country in 1986, HIV/AIDS has become the principal public health and social problem in Namibia, between 2000 and 2008 (MoHSS, 2008b, p.1). By 1996 to 2008 AIDS had become the leading cause of hospitalisation and death in Namibia (MoHSS & Marco, 2008).

According to the sero-sentinel studies of 1992 to 2007, a higher number of women (see Table 2.1 in Chapter 2) than men (because of the better monitoring for women during the sentinel surveys) were diagnosed with HIV (MoHSS, 2000; MoHSS, 2008b).

In 1999, women accounted for 54% of all reported HIV cases. While in 2001, (MoHSS, 2001, p. 4) HIV prevalence among pregnant women in different sentinel sites increased with the highest rates at 33% in Katima and 28% in Oshakati to the lowest rates of 7% in Opuwo. Since the beginning of sentinel surveys up to 2006, Oshakati and Katima recorded the highest prevalence ratio, while Opuwo recorded the lowest (MoHSS, 2007a). The 2008 National HIV Sentinel Survey measured the overall national HIV prevalence among pregnant women at 17.8% (see Table 2.1 in Chapter 2) which represents a clear decrease in comparison to other years (MoHSS, 2008b, p. 14). The cause of this reduction is not clear. Overall, in 2007, 200 000 Namibians were estimated as living with HIV infection (adults were 15.3%) aged 15 - 49 years; women of 15 years and above were estimated at 110 000. Deaths in 2007 due to AIDS were estimated at 5100 (UNAIDS, 2008, p. 35).

Globally, the most common sources of data used in all HIV/AIDS research are sentinel surveillance systems (that undertake periodic surveys among specific population groups), national population-based surveys and case reports from health facilities (UNAIDS, 2008).

Country data indicate that the number of people living with HIV infection continues to rise in all parts of the world despite the fact that preventive strategies exist. The infection rate continues to grow and millions of adults and youths fall ill and die as members of communities and all sectors of the economy stagger under the burden.

However, sometimes it is difficult to verify the accuracy of the data because the researcher does not know under which conditions the research was conducted. Each type of data has its weaknesses and strengths. The background information of all the research data related to HIV/AIDS is not always clear as to how and when the research or reports were written (Phororo, 2003).

In Namibia, HIV sentinel sero-surveillance is conducted biannually (every second year) through serologic HIV screening of Ante Natal Clinic (ANC) clients at sites around the country. The sentinel started with eight sites in 1992, fourteen sites in 1994, twenty four sites in 2004, twenty nine sites in 2006 and thirty five sites in 2008 (see Table 2.1 in Chapter 2). These sites cover both urban and rural areas representing regional and population diversity of the country. In addition, Namibia is using World Health Organisation (WHO) guidelines for HIV surveillance and generated data from the country in previous years (MoHSS, 2008b).

Given the continuing rise in infection rate, it is vital to state that HIV/AIDS is a serious public health problem in Namibia, especially among the youth. Therefore, in Namibia the pharmaceutical companies in collaboration with the MoHSS agreed to introduce Anti-retroviral drugs (ARV) for HIV infected people. However, the drugs are very expensive, and only a small number of people can afford to buy them.

According to the sero-sentinel study, in 2000 (MoHSS, 2001, p. 3) HIV prevalence all over the country varied between 34% and 6% among pregnant women, with a coverage prevalence of 19.9% in 2006 and 17.8% in 2008 (MoHSS, 2008b, p. 11).

Therefore, the MoHSS took a decision in 2002 to give ARV drugs to pregnant women and their partners. The aim of the treatment is to prevent the transmission of HIV infection from mothers to unborn babies and to prolong the lives of mothers and fathers. This programme (the prevention of mother to child transmission (PMTCT) was launched in March 2002 initially on a pilot basis at Katutura and Oshakati State Hospitals. In May 2003, the ARV treatment was extended to some hospitals, health centres and clinics (sites for sentinel surveys, see Table 2.1) in all thirteen regions in Namibia, including sites with rural and urban characteristics. The Namibian Government continues to monitor the trends of infection and measure the impact of the epidemic on population and programme evaluations in accordance with its Medium Term Plan 111 (MTP) 2004 - 2009. By 2009, ARV treatment became available at all thirty five sentinel sites in the country (MoHSS, 1999b, 2008b).

According to the MoHSS (2008b, p. 11) sero-sentinel study report the overall HIV prevalence from 1992 - 2000 was between 4.2% -15.3%; in 2002 it was at 22%; in 2004 and 2006 it was at 19.7% and 19.9% respectively and in 2008 it was at 17.8%. However, the decrease in prevalence was not observed in all geographical regions and age groups and this may have important implications for prevention, control, care and support. Despite the slight decline observed in 2004 - 2008, the survey reports demonstrated that HIV infection was still widespread throughout Namibia, had increased, and remained higher among some age groups especially the youth and young adults between the ages of 15 - 24 and 25 - 49 years, (MoHSS, 2008b, p. 17).

1.4 Statement of the problem

In this study, all reports and literature indicated that a higher number of people of both sexes and ages are affected, infected and dying because of HIV/AIDS in Namibia. The study was conducted in Oshana Region, one of the thirteen political regions in the country. This region is mainly rural with the second highest population density in the country concentrated in Oshakati, Ongwediva and Ondangwa towns. Oshana Region is a central point of education in the wider area, with three University Campuses (Oshakati, Engineering Faculty and Ongwediva), a teachers' college at Ongwediva and a vocational training centre at Ongwediva. Oshana Region also has Oshakati Intermediate Regional Hospital. Again, the HIV sero-sentinel study statistics from the northern regions, including Oshana, where Oshakati Intermediate Hospital is situated, indicate a higher HIV prevalence rate among pregnant women. These rates were 25% in 2004, 27.1% in 2006 and 22.4% in 2008 respectively (MoHSS, 2008b, p. 19).

On the same note, the 2006/7 NDHS (MoHSS, 2008b, p. 196) report also reveals that knowledge on HIV/AIDS prevention is the lowest among young respondents in various regions in the country, including Oshana Region. According to 2006/7 NDHS, knowledge of HIV /AIDS is universal in the country. This means that among both men and women, only two in three have what can be considered comprehensive adequate knowledge about the modes of HIV transmission and prevention (MoHSS, 2008b).

The statistics from the Health Ministry (MoHSS, 2001) and NPC (2003) indicate that 70 000 people were infected with HIV at the beginning of 2000. During the same year a total of 10 689 people died as a result of AIDS and related complications. According to UNAIDS report (2004) in 2003, Namibia had an estimated 210 000 people living with HIV and an estimated 16 000 AIDS deaths. But in 2007, 200 000 people were estimated as living with HIV, adults (were 15.3%) aged 15 - 49 years; women 15 years and above were estimated at 110 000 and deaths due to AIDS were estimated at 5100 (UNAIDS, 2008, p. 35).

The sentinel survey in 2006 - 2008 report demonstrates that HIV infection is still widespread throughout Namibia and increasing among some age groups especially the youth and young adults (within the age range 15 - 24) between 25 - 49 years, (MoHSS & Macro, 2008, p.17). Based on the above situations, the rates of HIV infections / cases, hospitalisations and deaths vary considerably for many reasons (Phororo, 2003). Therefore, the researcher concludes that the threat of HIV/AIDS is real and the infection rate is growing at a fast pace.

Since the first case of HIV was diagnosed in Namibia in 1986, mass media campaign organisations organises campaigns such as “Take Control Campaigns”, disseminates information on HIV/AIDS prevention to all Namibians including youths through radio, television, newspapers, posters and pamphlets (printed materials). Mass media messages used are in the form of slogans mostly used through radios such as “*Use condoms*” and “*Safe sex saves lives*”. It is also assumed that people know the disease, its modes of transmission and preventive measures.

Despite the fact that many groups of people, mass media organisations and the Namibian Broadcasting Corporation (NBC) have provided information to people in the country, there appears to be little change in lifestyles and sexual behaviours and the HIV infection has continued to grow at a high rate. It is increasingly believed that HIV/AIDS can be prevented and mass media campaigns would play a significant role in its prevention as it has done successfully in reported cases in Africa particularly in Uganda. The question is why lifestyle and sexual behaviours are not changing? What are the perceptions of the youth, In-school (ISY) and Out-of-school (OOSY) on the effects of mass media campaigns on HIV/AIDS prevention? Therefore, the perceived impact of the mass media among the youth, that is also considered to be the most vulnerable group as far as infection rate is concern, is unexplored in areas such as in Oshana Region in Namibia that provides a strong case study for this type of research.

1.5 Purpose of the study

The concept of purpose is defined by De Vos, Strydom, Fouche and Delport (2005, p. 8) as a “broader, more abstract conception of the end toward which effort or ambition is directed”. The words “aim”, “purpose” and “goal” are synonyms and will be used interchangeably in this study. The overall purpose of the study was to explore the perceived impact of mass media campaigns in communicating information on HIV/AIDS prevention to ISY and OOSY in Oshana Region, northern Namibia and to propose an integrated dialogical health communication model that could be applied to the Namibian situation. To achieve this aim, the following objectives were addressed.

1.6 Specific objectives

- 1.6.1 To explore the knowledge and views of the youth about the effects of mass media campaigns on HIV/AIDS prevention.
- 1.6.2 To determine and describe the method used in mass media campaigns in communicating information to the ISY and OOSY in Oshana Region.
- 1.6.3 To what extent the conventional method is applied in HIV/AIDS prevention in Oshana Region?
- 1.6.4 To determine whether mass media campaigns and messages influence knowledge, attitudes and behaviours of the youth towards HIV/AIDS prevention.
- 1.6.5 To describe the existing conventional model based on the study’s findings and the proposed health communication model and its application that could facilitate social behaviour change on HIV/AIDS prevention in Oshana Region.

1.7 Research questions

Research questions are queries that are asked and their answers facilitate the achievement of the study objectives (Cohen, Manion & Morrison, 2007).

- 1.7.1 To what extent do mass media campaigns on HIV/AIDS prevention have an impact on sexual behaviour changes among the youth in Oshana Region?
- 1.7.2 Which communication methods are used in mass media campaigns when disseminating information on HIV/AIDS prevention to the youth in Oshana Region?
- 1.7.3 What are the perceptions of the Oshana youth about the effects of mass media campaigns on HIV/AIDS prevention?
- 1.7.4 What is a possible model for effective health communication and mass media campaigns on HIV/AIDS prevention in Oshana Region of Namibia?

1.8 Significance of the study

This study is significant because its results direct to a better understanding of mass media campaigns as an instrumental tool to influence behaviour change and its channels of communication.

Theories and models (Social Cognitive Learning of Bandura, Rogers' Diffusion of Innovations, Health Belief Model and Participatory Model of Freire) of social behaviour change formed the base of this study. The integration and application of these models and theories explain how knowledge and understanding influence learning and behaviour change.

Study findings provide useful information on the conventional health education model as the methods used by mass media campaigns in communicating information on HIV/AIDS prevention, through radio, television and printed materials, to youths in Oshana Region and its perceived impact. Research literature shows that HIV/AIDS is a serious health and social problem among Namibians, hence the importance of the study.

The study also propose and adapt the human centred dialogical health communication model based on dialogue, participation and facilitation as advocated by Paulo Freire and its application to be used during the HIV/AIDS prevention campaigns. In addition, the proposed integrated dialogical health communication model may help all stakeholders in HIV/AIDS prevention campaigns in Oshana Region to improve media campaigns approaches, networking and possibly to reduce the number of new cases of HIV in Namibia.

1.9 Scope of the study

The study focussed on the Namibian youth covering nine secondary schools, twenty six combined schools and eight youth organisations in Oshana Region. The study was conducted in one region for the purpose of obtaining in-depth information on the youths' perceptions, knowledge and understanding of HIV/AIDS prevention. The reason for a survey research method was to generate large amounts of data in order to generalise the study findings to the whole region.

1.10 Definitions of key concepts

The definitions of concepts vary in their socio-cultural context across the world. For the sake of this study, this section explains and describes operational terms that were used in the context of the study.

Mass media

These are technologies and social institutions such as radio, television and newspapers used in the production and distribution of mass media messages to large audiences (Rogers, 1995). In this study mass media refers to technologies used to disseminate information to the public, including young people.

Campaign

A campaign is defined as a united effort or series of operations energetically pursued to accomplish a purpose or a planned set of activities that people carry out over a period of time (Fox, 1988, p. 105). In the context of this study, campaign is a communication-learning process or health education session provided by the sender to the receivers to effect change.

Youth

Hedgepeth and Helmich (1996) define youth as a stage of development from childhood to adulthood, between the ages of 15-35 years. In this study a youth or a young person, is someone aged 12-30 years old, who is an OOSY or ISY and lives in Oshana Region.

Communication

Northouse and Northouse define communication as “a way of exchanging (sharing) information, knowledge, ideas and feelings among people” or “any dynamic information - sharing process” (1985, p. 2). It includes listening, reading, writing and thinking skills. Communication has various categories such as intra-personal which means communication with oneself; interpersonal means person-to-person communication; mass communication means communication through mass media such as radio, television and printed materials (Rogers, 1995).

Health communication

Health communication is a “process for partnership and participation based on a two way dialogue” (Schiavo, 2007, p. 7). It involves the interactive interchange of information, ideas, techniques and knowledge between the sender and receivers of information on an equal footing, leading to improved understanding, shared knowledge, greater consensus and identification of possible effective action in the realm of health. Furthermore, health communication aims to influence, engage and support individuals, communities, health professionals, special groups, policy makers and the public to champion, introduce, adopt or sustain a behaviour, practice and a policy that will eventually improve health and bring changes in knowledge, attitudes, skills, behaviours, policies and social norms (Schiavo, 2007).

Learning

Learning is a way of acquiring modifications in existing knowledge, skills, habits or tendencies, attitudes or values through experience, practise and exercises (Schunk, 2002).

Information

Information refers to mass media messages on HIV/AIDS prevention given to the youth. Examples are “*Use condoms*” and “*Get tested and know your HIV status for sure*” (Maibach & Parrott, 1995, p.8).

Human Immunodeficiency Virus (HIV)

This is the name of the virus that causes the body's defence system to breakdown so that it can no longer fight off infections (Gow & Desmond, 2002, p.3).

Acquired Immunodeficiency Syndrome (AIDS)

This is the late stage of HIV infection when the person can suffer a number of infections such as skin rashes, tuberculosis, pneumonia and others (Gow & Desmond, 2002, p.4).

Impact

Impact is defined by Schiavo (2007, p. 374) as “an outcome in relation to a specific change”. This refers to what happened to the youth or target population after an intervention (the information has been given to them). In this study the word impact refers to the outcomes or perceived effects of mass media campaigns and its messages to the youth on HIV/AIDS prevention (Lévesque, 2002; Page & Czuba, 1999).

Self-efficacy

Self efficacy refers to the “belief or judgement in the ability to implement the necessary or expected behaviours” (Boulton, 2004, p. 58). In this study self efficacy describes the assertiveness abilities of the youth to understand and act responsibly.

Community Dialogue

A community refers to a group of people who resides in the same locality or group of individuals who share a common interest (De Vos et al., 2005). Community dialogue refers to a community (group) action or joint venture to solve a common problem in their communities such as the high prevalence rate of HIV/AIDS in Oshana Region. The main elements of community dialogue are collective action, social cohesion and social norms (Schiavo, 2007). Collective action refers to a joint or shared action of community members to solve new problems in the area such as HIV/AIDS in the region to ensure community development. Social cohesion refers to the extent of cooperation, participation and social networking among members of the communities. This cohesion creates the overall ability of the community to engage in effective dialogue, collective action, sense of ownership and collective participation in solving their problems. Social norms refer to collectively agreed upon or accepted standards or rules for participation in decision making. Therefore, social norms are people's beliefs about attitudes and behaviour that are normal, accepted or even expected in a particular social context to effect behaviour changes. This means that community dialogue empowers communities with relevant knowledge and skills to act responsibly (Figueroa, Kincaid, Rani & Lewis, 2002).

Empowerment

Empowerment is defined by de Beer and Swanepoel (2005, p. 23-25) as a “learning process and a collective action that release people from the poverty trap through transformation”. Empowerment in this study means to give youth the ability to have control over their own health care and to make informed decisions about their own lives. The role or key elements of youth empowerment should include access to information, ability to make choices, assertiveness and self-esteem or self-efficacy with self directed abilities among the youth (Page & Czuba, 1999). Next, the proceedings of the chapters will be provided.

1.10 Structure of chapters

The dissertation consists of the following chapters.

Chapter One introduces the study, background information on the country, a global overview of the AIDS epidemic, aim and objectives, significance and problem statement of the study. Key concepts are clarified and highlighted in this chapter.

Chapter Two presents the review of related literature on HIV/AIDS at global, regional and national levels. The chapter further highlights the response of the Namibian Government towards HIV/AIDS. It also presents various mass media campaigning organisations that are taking part in the HIV/AIDS awareness campaigns.

Chapter Three discusses theoretical perspectives of various theories and models of behavioural change used in mass media campaigns/health communication on HIV/AIDS prevention.

Chapter Four provides an overview of research methodology, which is the research design, study population and data collection technique on the perceptions of the youth on mass media campaigns towards HIV/AIDS prevention.

Chapter Five presents the data analysis and presentation of information collected in descriptions, tables and graphs. Data were collected from ISY and OOSY.

Chapter Six discusses and interprets the study results in relation to HIV/AIDS prevention, youth access to information and exposure to mass media messages. The chapter further highlights youth sexuality and vulnerability to HIV/AIDS, youth perceptions on condom use towards HIV/AIDS and the effects of mass media campaigns.

Chapter Seven describes the existing conventional health education model and its shortcomings and proposes the integrated dialogical health communication model that could be applied to HIV/ AIDS prevention in Oshana Region, Namibia.

Chapter Eight concludes the study and suggests recommendations.

1.11 Summary

The chapter gave the Namibian profile. It also presented the background information of HIV/AIDS in SSA, SADC and Namibia, the problem statement, objectives, research questions and significance of the study were also discussed. The study argues that HIV/AIDS is a serious health and social problem worldwide causing hospitalisation and death among all ages and sexes, especially among the youth. Therefore, it is important to explore the perceived impact of mass media campaigns in communicating information on HIV/AIDS prevention to ISY and OOSY in Oshana Region, northern Namibia. The chapter also covers the definitions of various key concepts used in this study. The next chapter provides the related literature review to support the study on mass media campaigns' impact and on HIV/AIDS prevention.

CHAPTER 2

REVIEW OF RELATED LITERATURE

2.1 Introduction

This chapter discusses various studies written in relation to mass media campaigns and HIV/AIDS prevention globally, in SSA, the SADC region and Namibia in particular. Research literature focuses on the youth as the focal point in the study and their relationships to HIV/AIDS. The research questions as outlined in chapter one formed the basis of the literature review. This literature review provides a basis for the empirical survey research on mass media impact on HIV/AIDS prevention campaigns.

2.2 Global and sub-Saharan African (SSA) picture of HIV/AIDS

The health sectors globally and in SSA in particular have been faced with many health problems and challenges such as HIV/AIDS, which threatens the lives of all ages and sexes, including the youth. HIV/AIDS has become an epidemic and virtually no country in the world remains unaffected (Joint United Nations Programme on HIV/AIDS) (UNAIDS, 2004).

According to the Global Report on the AIDS epidemic, the disease has continued to proliferate from 1981 since the first case was diagnosed (UNAIDS, 2008).

The report emphasises that SSA has just over 10% of the world's population, but has a large number of people (33 million) living with HIV infection. The UNAIDS (2008, p. 23) report states that the number of new HIV infections has declined from 3 million in 2001 to 2.7 million in 2007.

However two-thirds (67%) of the global total of an estimated 33 million people who were living with HIV infection in 2007 were in Africa, since the first case of AIDS was diagnosed in 1981. Again, three quarters (75%) of all AIDS deaths in 2007 occurred in Africa. Subsequently Africa as a continent is the most affected by HIV/AIDS. The UNAIDS (2008) report indicates that the epidemic in SSA is not homogeneous in all countries within the region; some countries are more affected than others.

However, in SSA, HIV/AIDS prevalence in adults is high and exceeds 15% (UNAIDS, 2008, p. 39) in some SADC countries. These countries are Botswana (23.9%), Lesotho (23.2%) and Swaziland (26.1%), whereas in Namibia, South Africa, Zambia and Zimbabwe the rates are around 15 - 20%. The prevalence is stable and very low in other countries mostly Central and East Africa (Uganda, Kenya and the United Republic of Tanzania, Cameroon (5.1%), Gabon (5.9%) and Nigeria (3.1%).

The report further indicates that the disease is spreading throughout the general population, rather than being confined to high risk groups such as sex workers, injecting drug users and homosexuals, as was perceived in the earlier days of the HIV outbreak (MoHSS, 2008b; Parker, Rau & Peppia, 2007; UNAIDS, 2004, 2008). The research reports conclude that HIV/AIDS is a global health problem.

The history of HIV/AIDS in Africa has shown how HIV prevalence has changed over time and its impact on people and countries (UNAIDS, 2008).

2.3 Youth and HIV/AIDS in sub-Saharan Africa (SSA)

Apart from HIV/AIDS being a global health problem, it is also vital to present its overview in Africa, especially in SSA. HIV/AIDS affects all ages of both sexes.

Apart from the adult population, young people are also exposed to HIV infection in different ways. One can describe the situation of HIV/AIDS among the youth as a catastrophe that needs to be prevented.

The UNAIDS (2004) informs us that today's young generation is the largest in history with nearly half of the global population being less than 25 years old. Today's young population could be considered to be the AIDS generation, because they have not known a world without AIDS (Parker et al., 2007). The UNAIDS (2002, 2004) further describes the SSA as the area with a high prevalence rate among the youth. It was estimated that 9 million young people in SSA were living with HIV infection at the end of 2003. Moreover, according to the UNAIDS (2008, p. 33) annual report young people aged 15-24 years account for an estimated 45% of all new HIV infections worldwide. By implication, globally the number of children younger than 15 years living with HIV infection increased from 1.6 million in 2001 to 2.0 million in 2007. Almost 90% of these young people live in SSA. This concluded that young people of both sexes and all ages are infected and affected by the epidemic.

Young people are assumed to be vulnerable to HIV/AIDS in SSA and elsewhere in the world. Many reasons place young people at the centre of HIV vulnerability. Some of these reasons are the lack of HIV information, lack of educational programmes with relevant youths' services and the risks that accompany adolescents' experimentation and curiosity. Therefore, youths are physically, psychologically and socially at risk of HIV/AIDS (MoHSS, 2001; UNAIDS, 2008). Parker et al. (2007) claim that the future of the epidemic maybe partly shaped by the actions of the youth, when they have knowledge and skills on how to avoid HIV infection when they became sexually active.

Experience proves this hope to combat HIV/AIDS can be successful, in countries such as Uganda. In Africa, Uganda remains an example of sustained success in decreasing the HIV infection rate. The Ugandan government, other agencies and activists in the country have promoted a comprehensive, human development centred, participatory approach with some elements of the ABC prevention strategies (UNAIDS, 2008). The **A**bstinence, **B**eing faithful and **C**ondom use (ABC) strategy was used in Uganda HIV/AIDS prevention mass media campaigns. Parker et al. (2007) elaborate that media campaigns in Uganda used a combination of risk avoidance and risk reduction approaches. However, it is not clear exactly how these strategies have contributed to behaviour change in Uganda. But the HIV prevalence rate fluctuated from 15% in 1991 down to 5% by 2001 and up to 5.4% by 2004 (Low-Beer & Stoneburner, 2004; UNAIDS, 2008).

In Ghana, the majority of the Ghanaian population are youths, aged between 10 - 24 years and prone to health risks including HIV/AIDS infection (GDHS, 2003). In 2001, more than 3% of 15 - 24 years' old people were estimated to be HIV positive. Young women were at a greater risk of HIV/AIDS. Youths were infected at a young age, 15 - 24 years (UNAIDS, 2008). According to the Ghana Demographic Health Survey (GDHS, 2003), mass media (such as the radio) and work place were the two main sources of HIV/AIDS information for adolescents, both males and females. The literatures further state that adolescents who have heard of HIV/AIDS have actually changed their behaviours by abstaining from sex, limiting their sexual partners and using condoms as a result of HIV/AIDS knowledge. In Ghana there are also policies and programmes in place to help youths to deal with the dangers of HIV/AIDS (UNAIDS, 2008).

The UNAIDS (2008) further states that positive behavioural change has been observed among youths of some countries which brings down the prevalence rates of HIV infection in these countries. This behavioural change has been matched by the understanding of the disease and the use of preventive strategies such as condoms and being faithful to one sexual partner (GDHS, 2003; UNAIDS, 2008). The experience of Ghana is similar to other countries in the SADC region such as South Africa, Namibia and Zambia.

In view of the high rate of HIV/AIDS which threatens young people worldwide, world governments adopted a Declaration of Commitment outlining specific time bound goals and targets that focus on children and young people in the fight against the HIV/AIDS pandemic (UNAIDS, 2004). It was agreed by the Joint United Nations General Assembly that governments must ensure that by 2015 at least 90% and by 2020 at least 95% of young men and women aged 15-25 years will have access to HIV/AIDS information, education and services. They should also develop life skills required to reduce their vulnerability to HIV infection. The vital goal is to reduce HIV prevalence in both sexes in young people aged 15-25 years in the most affected countries by 25% globally by 2010 (UNAIDS 2004).

Again, the Millennium Development Goals (MDG) were set to be achieved by 2015 to respond to the world's main development challenges such as poverty, inequity, unemployment and HIV/AIDS pandemic (MoHSS, 2007c; UNDP, 2000). All these plans were set for all countries worldwide, including SSA.

2.4 Youth and HIV/AIDS in the Southern Africa Development Community (SADC)

With the high prevalence rate of HIV and AIDS in Africa, the impact of the disease evidently hinders human development and the improvement of the quality of life on this continent (UNAIDS, 2008). SADC is not an exception and faces a growing human capacity crisis due to the epidemic.

The effects of the disease range from psychological trauma and suffering as a result of contracting the disease, loss of earning capacity, funeral costs and an increasing number of AIDS orphans. Southern African countries are losing skilled people vital to the delivery of services in public and private sectors because of HIV/AIDS and its related illnesses. Countries most affected are Botswana, Lesotho, Swaziland, Malawi, Zimbabwe, South Africa, Zambia and Namibia (UNAIDS, 2008).

UNAIDS (2002, p. 9) reported that 35.8% of adults in the SADC region were infected with HIV; while in South Africa 19.9% were infected. In Zimbabwe one in five adults in the population may be infected with HIV, whereas in Zambia the majority of the new HIV infections are among young people between the ages of 15 - 24 years old or younger. In Malawi it was reported that HIV/AIDS rates in young women are five to six times higher than for young men in the age range of 15 - 20 years (UNAIDS, 2008).

The UNAIDS (2004, p. 190 -191) indicates that the estimation of people living with HIV infection in the SADC region at the end of 2003, were as follows in order of frequencies, Botswana 37,3%, Swaziland 38,8%, Zimbabwe 24,6%, South Africa 21,5%, Namibia 21,3%, Zambia 16,5%, Malawi 14,2% and Angola 3,9%, with the lowest figure (UNAIDS, 2004). These data show an increase of HIV infection among adults 15 - 49 years in the SADC region, which is at odds with the Geneva General Assembly's Declaration of Commitment that advocated for 25% decrease in HIV infection by the year 2010 particularly among youths. This data demonstrate that HIV/AIDS is a real threat to the population of SADC and Africa (Jackson, 2002).

However, due to the effects of mass media campaigns in most countries in the SADC region, the HIV rates among the adult population (15- 49 years) have dropped at the end of 2007. Countries were rated as follows; Swaziland (26.1%), Botswana (23.9%), Lesotho (23.2%), South Africa (18.1%), Zimbabwe and Namibia with 15.3% each, Zambia (15.2%), Mozambique (12.5%), Malawi (11.9%) and Angola with the lowest rate of 2.1% (UNAIDS, 2008). Therefore, Jackson (2002, p. 14 -16) explains that SADC experiences varying “degrees of disparities and inequities with many associated factors”. These includes socio-economic and cultural factors; inequalities of wealth and rising poverty, especially among women; social disruption; violence and considerable population movement and gender inequality and inequity that may enhance HIV infection rates. In Southern Africa some specific contributing factors to the increase of HIV infections have been observed. Amongst others were poverty, mobility, high levels of inequality in income, alcohol abuse, and inequity in status and access to resources between urban and rural populations. It was also found that there is a high percentage of female-headed households and a high percentage of households with members living long distances away from each other (MoHSS, 2004; UNAIDS, 2008).

The UNAIDS (2008) further explained that the SADC Demographic Health Surveys indicate that the region is characterized by a youthful population structure, with around 50% of the total population falling in the reproductive age in most countries. These huge numbers of young people in sexually active age range require intensive sexual and reproductive health information and services. Youths are the window of hope and change for Africa in general and the SADC region in particular.

The literature indicates that it is a challenge to maintain the HIV negative status among the youth because they are living in societies with many contributing factors to HIV infection (Jackson, 2002). The people in the productive age of 15 - 49 years are the most sexually active and affected by HIV/AIDS. Literature shows that young people are dying and continue to die. Hence, it is vital to know what can be done to facilitate lifestyle and sexual behavioural changes, reduce the infection and death rates among the youth in Namibia in general and in Oshana Region in particular (Jackson, 2002; UNAIDS, 2008). Therefore, it is necessary to review literature on the Namibian youths.

2.5 HIV/AIDS and the Namibian youths

Since 1986 when the first case of HIV/AIDS was recorded in Namibia, HIV/AIDS has become the number one cause of hospitalisation and death in the country (MoHSS, 2007a). Many people of both sexes and all ages are affected and the most vulnerable group is the youth.

Hedgepeth and Helmich (1996) define youth as the developmental stage between childhood and adulthood. Youths are males or females between the ages of 15 and 35 years. In this study youths have been defined in Chapter One (MoHSS & Macro, 2008).

According to the 2001 Namibia Population and Housing Census (NPC, 2003) Namibia has a relatively youthful population. Forty (40%) percent of the whole population were young, aged 15 - 49 years. The report further indicates that rural areas have a relatively younger age structure than urban ones. A young population forms the base of the Namibian population, but youths are the most threatened by HIV/AIDS pandemic (UNAIDS, 2008).

Namibia is also one of the most affected countries in the world, in SSA and SADC, with the rate of HIV infection standing at 15.3% in 2007/8. HIV cases have increased, among the sexually active population (estimated at 200 000 people), the age group 15 - 49 years. This means that many adults and children of all ages were living with HIV infection in 2007/2008 in Namibia. In addition, the number of deaths among adults and children rose (estimated at 5100) and it is reported that 46% of deaths were among the 15-49 years, the reproductive age (MoHSS, 2008a; UNAIDS, 2008). These statistics confirm Otaala's (2000a) views that Namibian youths are at the greatest risk of HIV infection and its consequences. Amongst the leading contributing factors are that youths have multiple sexual partners, including sugar daddies, few young people use condoms, they also have limited information about HIV/AIDS and violence in girl-boy relationship is common and adds to the risks of HIV infection. Therefore, Otaala claims that young people in Namibia engage in risky sexual behaviour at an early stage and special efforts are vital to reach them before the future generation is completely engulfed in the AIDS crisis (UNAM, USAID & FSIS, 2004).

MoHSS (2007c) reports also identify other factors that are likely to contribute considerably to the spread of HIV infection in Namibia. These factors were the high mobility of individuals between different places in the country and cross border travel. Travelling away from home is also associated with an increase in multiple sexual partners in the country. Namibia's reliance on the mining and fishing industries, as well as seasonal agricultural production, requires regular population and family displacements (Mufune, 2003; UNAM, et al., 2004).

In the context of widespread poverty, drug and alcohol abuse, gender inequalities and limited employment opportunities, the disease will spread fast among all age groups. This implies that high levels of multiple and concurrent partnerships with inconsistent condom use, inter-generational sex and transactional sex are likely to be at the centre of this epidemic. All these factors are assumed to be common in rural and urban areas in Namibia (MoHSS, 2008a). Therefore, this study was conducted in Oshana Region with urban and rural characteristics where all these factors could be found (MoHSS & Macro, 2008).

According to the MoHSS (2001, p.4) report, the HIV prevalence among pregnant women in sentinel sites has increased in some towns (Katima Mulilo, Windhoek, Oshakati and Walvis Bay) in Namibia (see Table 2.1). Opuwo in the Kunene Region is the least affected in the country. Since the beginning of sentinel surveys, Oshakati in the north-central and Katima Mulilo in north-east recorded the highest prevalence rate, while Opuwo in north-west recorded the lowest, below 10% up to 2008 (MoHSS, 2008b).

Again, the sentinel study reveals that the HIV prevalence rate is higher in northern regions, where Oshana region is with Oshakati as its capital. The 2008 National HIV Sentinel Surveys report also identified that the highest HIV prevalence rate were found in some urban locations (Oshakati - 27.1%, Walvis Bay - 22.1% and Katutura - 21.7% in 2006) and rural areas (Katima Mulilo - 31.7%, Engela - 20.1% and Okahao - 27.4% in 2008) which were close to major transport corridors (MoHSS, 2008a).

The National HIV Sentinel Survey measured the overall national HIV prevalence rate among pregnant women at 17.8% in 2008 which represents a decrease in comparison to other years (2000 to 2006) see Table 2.1 in chapter 2 (MoHSS, 2008b, p. 14). The cause of this reduction is not clear. But the MoHSS (2008b) report assumed that the slight decline reported in the HIV sentinel surveys (table 2.1) was possibly due to the effects of improved access to ARVs and mass media campaigns in the country. However, the decrease in prevalence was observed in some areas and not in all geographical regions and age groups. This may have important implications for prevention, control, care and support. In general, the prevalence appears to be stabilising at the national levels (17.8 %), but remain the highest in the northern areas of the country (see Table 2.1), with Oshana Region being the highest (22.4%) (MoHSS, 2008a).

Despite the slight decline observed from 2004-2008 (see Table 2.1), the National Sentinel Survey report (MoHSS, 2008b) demonstrates that HIV infection was still widespread throughout Namibia and had increased among some age groups, especially youths between the age range 15 - 19 and 20 - 24 years, (MoHSS, 2007a, p. vii), between 2002 and 2008.

But it is assumed that the strong commitment by the Government of the Republic of Namibia to tackle HIV/AIDS (NPC, 2008, p. 32) and considerable increases in funding for the HIV/AIDS programmes present an important opportunity for curtailment of the epidemic (UNICEF, 2006).

Therefore, trends in HIV prevalence in various geographical locations and age groups provide valuable information, but these trends require extensive examination to identify possible contributory factors. In the light of these findings, Namibia needs to conduct behavioural surveys to better understand the behavioural and socio-demographic variables associated with HIV prevention. Therefore, the survey on the perceived impact of mass media campaigns was conducted to explore and describe the effects of HIV/AIDS prevention on the youth (MoHSS, 2007c).

The MoHSS (2008a) report further reveals that the number of deaths due to AIDS in all public hospitals increased from 86 in 1992 to 5100 in 2008 (UNAIDS, 2008, p. 35). AIDS and its related complications were identified as being responsible for 26% of all reported deaths, and for 46% of deaths of the people in the age group 15 - 49 years. According to the 2001 Namibia Population and Housing Census, the number of deaths had increased by 80% in the three preceding years (which was 1997 - 2000). Moreover, the MoHSS report shows that between 50 - 70% of hospital admissions in the country are HIV/AIDS related. This emphasises that AIDS is the main cause of hospitalisation and death in Namibia (MoHSS, 2008a; UNAIDS, 2008).

Otaala (2000a) also argues that because of the increase of the disease, school aged children and youths are kept out of school if they are needed at home to care for sick family members or help the family with other responsibilities caused by the re-assignment of roles in homes. Therefore, the full impact of HIV/AIDS on children and youths needs more in-depth research in order to identify appropriate responses in relation to issues in education sectors and all stakeholders.

Literature indicates that young people are the future and foundation of the Namibian population but they are threatened by the HIV and AIDS pandemic. Hence, this study exploring the impact of mass media campaigns on ISY and OOSY in the Oshana region. The study also reviews the Namibian Government response to HIV/AIDS prevention.

2.6 The response of the Namibian Government to HIV/AIDS

At independence in 1990 the Government of the Republic of Namibia (GRN) through the MoHSS identified the dangers of HIV/AIDS and established the National AIDS Control Programme (NACP) and Information, Education and Communication (IEC) programmes in collaboration with the then Ministry of Information and Broadcasting. NACP's aim was to campaign against HIV/AIDS and to ensure the reduction of HIV infection both for individuals and the society at large. IEC aims to inform people, educate individuals, communities and families on prevailing health problems, and suggest ways of solving them. Moreover, IEC promotes inter-sectoral approaches and the involvement of mass media in educating people about HIV and AIDS and the translation of information into local languages (MoHSS, 1992).

Table 2. 1: HIV prevalence in percentage among pregnant women at different Sentinel sites in Namibia, between 1992 and 2008

Region	Places	Years								
		1992	1994	1996	1998	2000	2002	2004	2006	2008
	Sentinel Sites									
Caprivi	Katima Mulilo	14%	25%	24%	29%	33%	43%	42%	39.4%	31.7%
Erongo	Swakopmund	3%	7%	17%	15%	22%	16%	28%	17.3%	14.2%
	Walvis Bay				29%	28%	25%	26%	22.1%	21.4%
	Omaruru									12.0%
	Usakos									17.8%
Otjozondjupa	Grootfontein		9%				30%	28%	19.3%	16.9%
	Otjiwarongo	2%	9%		16%	18%	25%	17%	18.3%	15.2%
	Okahandja								18.5%	14.9%
	Okakarara									11.4%
Oshana	Oshakati Intermediate Hospital	4%	14%	22%	34%	28%	30%	25%	27.1%	22.4%
Khomas	Katutura State Hospital	4%	7%	16%	23%	31%	27%	22%	21.7%	21.7%
	Windhoek Central Hospital							10%	9.1%	4.7%
Oshikoto	Onandjokwe		8%	17%	21%	23%	28%	22%	23.7%	21.9%
	Tsumeb						25%	16%	17%	17.1%
Kavango	Rundu		8%	8%	14%	14%	22%	21%	20.1%	18.8%
	Nankudu				13%	18%	16%	19%	13.9%	10.5%
	Andara		2%	11%	16%	15%	21%	18%	22.7%	14.2%
	Nyangana		6%	5%	10%	16%	22%	15%	10.2%	19.5%
Ohangwena	Engela		7%	18%	17%	23%	19%	19%	27%	20.1%
	Eenhana								21.4%	11.6%
	Okongo									20.7%
Omusati	Oshikuku					21%	27%	27%	22.4%	21.7%
	Outapi						23	17	20.7%	19.6%
	Okahao								22.5%	27.4%
	Tsandi									25.9%
Karas	Keetmanshoop	3%	8%		7%	17%	16%	16%	18.5%	12.7%
	Karasburg								22.7%	18.3%
	Luderitz							22%	22.5%	20.1%
Hardap	Rehoboth		3%			9%	10%	14%	13.9%	6.3%
	Mariental					10%	12%	11%	10.2%	10.8%
	Aranos									5.9%
Omaheke	Gobabis	1%			9%	9%	13%	13%	7.9%	13.1%
Kunene	Opuwo	3%	1%	4%	6%	7%	9%	9%	7.9%	7.9%
	Outjo									18.0%
	Khorixas									10.9%
Namibia (crude)		4.2%	8.4%	15.4%	17.3%	19.3%	22%	19.7%	19.9%	17.8%

Source: Data adapted from the 2008 National HIV Sentinel Survey, MoHSS, 2008b, p. 19.

Subsequently, the First Medium Term Plan (MTP I) was launched in 1992 for the period 1992 -1998 aimed at implementing awareness campaigns. In addition, the National AIDS Coordination Programme (NACOP) was established with six broad objectives. In 1999, the MoHSS realised that HIV/AIDS was not the sole responsibility of the health sector and decided to include other government departments and non-governmental organisations in the programme to tackle this national health problem. This has facilitated the establishment of the National AIDS Coordination Programme (NACOP). NACOP did not function as was expected and the National AIDS Committee (NAC) was formed to lead the national response to the epidemic (GRN, 2004; MoHSS, 1999b; MoHSS, 2008a).

The Second Medium Term Plan (MTP II) was launched for the period 1999-2004. Its aim was to reduce HIV infections among all ages, to ensure people access to information and to affordable and available services in the country. Simultaneously it aimed at empowering individuals and communities with the necessary knowledge and skills related to prevention and self protection, to avoid all discriminatory laws and practices and establish national and regional programme management structures (MoHSS, 2004, p. 6). After a review of the MTP II, a third Medium Term Plan (MTP III) was launched for the period 2004-2009. The aim was to strengthen all governmental and non-governmental activities on HIV/AIDS. All these activities were put in place after the MoHSS realised that HIV/AIDS was a serious health and social problem that needed multi-sectoral involvement and a collaborative approach as was advocated by Freire in his Empowerment Theory (MoHSS, 2004).

The National AIDS Committee is the key policy-making body on HIV and AIDS.

The multi-sectoral approach covers senior national, regional and local leaders in all thirteen political regions with the aim of focusing on policy and programme implementations. There are Regional AIDS Committees in each of the thirteen political regions chaired by the Governor with other sub-regional committees at district and constituency levels (MoHSS, 2008a). Therefore, in Namibia various individual policies and strategies are in place. Firstly, the “Constitution of the Republic of Namibia” provides a Bill of Rights (chapter 3) that addresses the issues of HIV/AIDS and human rights. This chapter guarantees every person fundamental rights and freedom of association (Constitution of Namibia) (GRN, 1990).

Secondly, the “Namibian Charter of Rights on HIV/AIDS” was launched in 2000 to provide guidelines on confidentiality and privacy for people living with HIV/AIDS. The charter also emphasised the promotion and protection of human rights that constitute an essential component in preventing the transmission of HIV infection and reducing the impact of HIV/AIDS (GRN, 2004; NPC, 2008).

Thirdly, the “National Code on HIV/AIDS and Employment” was launched and adopted to define the legal rights of people living with HIV/AIDS (Namibian Labour Act 16 of 1992). The code ensured the availability of HIV/AIDS awareness and prevention information at all work places that should be disseminated to everyone without prejudice, stigmatisation or discrimination. The code prohibits discrimination based on an individual’s HIV status (NPC, 2008).

In 2003, Namibia launched the National ARV Programme in public health facilities, to provide treatment for people living with HIV infection (GRN, 2004).

Again, the Government of the Republic of Namibia (GRN, 2004) followed these medium-term plans with a long-term national plan called *Vision 2030* for promoting socio-economic development in the country. *Vision 2030* is a shared plan developed through national dialogue. It is a tool for social dialogue and good governance. It addresses HIV/AIDS as a crosscutting issue in each sector. *Vision 2030* involved major social groups at national, regional and local levels (GRN, 2004; MoHSS & USAID, 2007). Namibian's *Vision 2030* requires commitment of leadership (political will) at all levels, a multi-sectoral approach, the promotion of policies to combat stigma and discrimination with the inclusion of HIV/AIDS in all developmental plans. This approach would ensure a greater understanding of the impact of HIV/AIDS in all sectors and enhance abilities to monitor its impact (GRN, 2004).

Literature reveals that the Namibia Government has many policies, guidelines and strategies in place (GRN, 2004). Consequently, the Namibian Government developed the National Policy on HIV/AIDS to provide an overall reference framework for all HIV/AIDS related policies. The HIV/AIDS policy aims to guide national HIV/AIDS multi-sectoral responses to HIV/AIDS in Namibia (MoHSS, 2007a). All these actions in form of policies, strategies and guidelines which have been developed and approved at national, regional and local levels, show the commitment and political will of the Namibian Government to tackle HIV infection.

However, the challenge is that HIV infection has continued to increase and many people of both sexes and ages are dying in the country. Therefore, this study focuses on youths as one of the most vulnerable groups in Namibia to explore their views and beliefs towards HIV/AIDS prevention (MoHSS, 2005).

2.7 Youth sexuality and vulnerability to HIV/AIDS

In this study, the terms “youth”, “younger adult/people” and “adolescent” are used interchangeably. In this context, a youth is defined as an ISY or OOSY aged between 12-30 years (see the definition of youth in Chapter One) (Hedgepeth & Helmich, 1996). Youths form the basis of this study as respondents and study population who have aired their views on HIV/AIDS prevention campaigns.

According to Gouws, Kruger and Burger adolescence means to “grow up” or “to grow to adulthood”. Adolescence is, therefore, defined as “a period of transition or a developmental phase in the human life cycle from childhood to adulthood” (2000, p. 2). This means that adolescence is the time when young people naturally explore and take risks in many aspects of their lives, including sexual relationships. Adolescents are individuals and complex beings who have intellectual, emotional and social qualities that develop in different ways, at different rates and at different stages in life depending on relevant social context. Adolescence is a developmental phase marked by physical, cognitive, emotional, psychological, moral, religious and social maturation. People at the ages of 12 -35 years are usually considered as adolescents or otherwise referred to as youths or young adults (Adams & Berzonsky, 2006).

Historically, in most African societies, the transition, cultural grooming or ceremonies where young people are given traditional guidance and coaching mark the period from childhood to adulthood. Young people were taught and socialised to behave as men or women in accordance with their specific cultural norms, values and practices. Socialization covers issues such as practical instructions on adult behaviour and sex education (Hedgepeth & Helmich, 1996, p. 9).

Nowadays traditional patterns of sex education, grooming and coaching have been disrupted by economic and social changes, rapid urbanisation, and rapid population growth, increased mobility in the country and neighbouring countries, education at various levels and introduction and exposure to various religions in our societies (Adams & Berzonsky, 2006).

Gouws et al. (2000) argue that traditional norms and values are disappearing fast among the youth, because young people are easily influenced by many foreign social systems, which influence their views, thereby contradicting those of their parents and cultures. Some parents feel inferior or discouraged by the way youths behave so that they are no longer guiding and grooming youths according to their cultural norms and practices. However, other parents do take their parental role of grooming their children seriously and guide youths with vigour and commitment. However, Mufune (2003) has reported a weakening of the link between community morals and sexual behaviour resulting in more liberal sexual attitudes. Therefore, Rew (2005) argues that parents need to guide youths, because guidance and training are vital parental roles to mould youths towards adulthood including sexual issues.

According to Adams and Berzonsky (2006) the period of adolescence brings changes and challenges in the lives of adolescents. All developmental stages such as physical, social, mental and emotional, occur at different and uneven rates. Young adults often become physically mature, for example, girls start menstruating, before they have fully developed the mental or social skills vital to understand or practice safe sex.

Cognitive development covers thinking skills, creativity and becoming more knowledgeable whilst social development covers changes in relations with other people and the influence of society and particular individuals on the young people (Adams & Berzonky, 2006). Youths' emotional, moral and religious developments rest on both the conative (will related) and cognitive (mind related) aspects of life.

Adolescents acquire values and norms which enable them to distinguish between correct or acceptable behaviours and those that are considered wrong or unacceptable by members of their communities, families, cultural and religious groups (Gouws et al., 2000; Rew, 2005).

Hedgepeth and Helmich (1996) suggest that the risk-taking behaviours of the youth may be linked to rebellion against adults, which is normally part of young people acquiring their own identity. The risks differ from society to society and among youths in different cultures, but in most cases include experimentation with sexual activities, alcohol and substance abuse. Risk taking behaviour among youths is strongly linked to peer pressure, which usually outweighs their relations to parents and other adults.

This shows that adolescence is a time of exploratory behaviour when fateful choices are made about eating, smoking, drinking and sexual activities with lifelong consequences. This confirms the importance of the study and the youth as respondents (Adams & Berzonsky, 2006; Mufune, 2003).

Hedgepeth and Helmich (1996, p.10) further argue that young people are more vulnerable to HIV/AIDS than older people, because young peoples' social, emotional and psychological development is complex in its nature. Therefore, youths tend to engage in risky behaviours with little or no knowledge about the dangers of their actions, such as practising unsafe sex and abusing alcohol and substances. This emphasises that risk-taking forms part of the young people's lives at the time in which they believe in themselves more than they believe in other people (Rew, 2005).

However, Schwartz (2003) notes that people's views on young people as vulnerable or at risk of HIV/AIDS differ from context to context. This perception can cloud the understanding of young people's situation. Therefore, many researchers argue that young people are vulnerable to risky behaviours because of their dependence on adults (Amon, Brown, Hogle, McNeil, Magani, Mills et al., 2000).

Brown, Sorrell and Raffaelli (2005) argue that youths are also in high risk situations for many reasons including poverty that leads to prostitution, disintegration of the family system because of migration or forced displacement or death of parents, urbanisation and inequitable gender relations. Individuals are also influenced by role models and peer groups which are in conflict with traditional norms and values.

All these reasons are applicable to youths, ISY and OOSY, from various backgrounds and social contexts (Gouws et al., 2000; Shapumba, Apollus, Wilkinson, Shifiona & Karirao, 2004).

There is a great need to furnish young people with relevant information, because the youth contain groups with different needs. Some youths are poor, almost illiterate and homeless, whereas others are working or living in violent and dangerous conditions. Some youths are often struggling to survive. As a result some of these young people are practising unsafe sex with multiple partners despite the risks involved because sex may bring them money, affection, sexual comfort, shelter or protection (Nengomasha, Toivo, Hidinua & Kabunga, 2004; Shapumba et al., 2004).

For some youths who have left or never attended school the situation might be worse. They have limited access to information, no means to prevent health problems, little or no understanding of sexual situations and no social and/or economic power to control their own lives. The list of reasons is not exhaustive and all these factors or situations make young people vulnerable to health problems and at risk of HIV infection. The situation also requires special attention with the provision of programmes specifically for young adults (Schwartz, 2003; Brown, et al., 2005; Adams & Berzonsky, 2006).

The vulnerability of young people to HIV infection is a global phenomenon. Some parents assume that the use of condoms may lead to promiscuity (LeBeau, 2004). However, Adams & Berzonsky (2006) argue that access to information and use of condoms does not encourage adolescents to start sexual activity earlier or to have more partners. It has been observed that youths need to develop life skills such as decision-making, communication and listening skills, responses to pressure for unprotected sex, negotiation and conflict resolution and skills related to condom use. Therefore, Freire (1985) argue that a young person who has life skills is empowered to make constructive decisions and have control over his/her life.

In Tanzania, a study on students' knowledge on HIV/AIDS revealed that only 26% of the male students felt that they were at high risk of HIV/AIDS, but 48% of the same group felt that their friends of both sexes were at high risk. This finding reflects a distorted sense of vulnerability to HIV/AIDS among young people. It is possible that these feelings lead many young people to ignore the risk of infection thereby taking no precautions (UNAIDS, 2004, p.70-78).

According to the UNAIDS (2004), Nigerian youths underestimated their personal risks of HIV/AIDS even though they knew about AIDS and its attendant problems. Faith organisations in Nigeria combined sex education with strict sexual ethics, encouraging young people to internalise controls from a position of knowledge and Christianity (Smith, 2004). They used peer education and other participatory strategies to open up discussions of sex and sexuality in order to give information to youths.

Therefore, it was observed that the Nigerian action of giving information to youths in faith organisations was reaching its target group because the majority of the youth took part in religious activities. Youths were actively involved in planning and implementation of the church sex education programmes. The active involvement of the youths has facilitated the success (UNAIDS, 2004; Rew, 2005). The youths' participation in planning and implementation is what Freire' (1985) has advocated in his Empowerment Theory as a user-friendly approach in learning and behaviour change.

However, in Namibia, there are two studies which reached different conclusions. Iipingie, Hofnie and Friedman (2004) found that many young people in the country had a good knowledge of HIV/AIDS and measures to prevent HIV infection, but Nengomasha et al. (2004), on the other hand, found that youths' knowledge on HIV/AIDS was low in Ohangwena Region. One social science research study in Namibia (LeBeau, 2004) revealed that this good knowledge of the Namibian youths has not been translated into practice (Iipingie, et al, 2004).

These studies indicate the need for a strong sex education programme for youths, emphasising that the schools play a significant role in relaying health messages through "Life skills" classes (Iipingie et al., 2004, p. 233) and that there is a need for youths to develop strong self-esteem (Rew, 2005, Parker & Connolly, 2007, 2008).

Moreover, according to the researcher's own experience as a Namibian with an Oshiwambo cultural background, communication between adults and youths on sexual matters, including STDs and HIV/AIDS, is nearly non-existent and where it exists it is restricted and invariably a 'top down' approach. This means that parents or adults are informing youths without any questions or discussions. In some cases, parents and grandparents play a role in sex education, but there is still a vacuum in the area of sex education and discussions.

The UNFPA and UNAM study on social and operational research in Oshana Region (Shapumba et al., 2004) reveal that young people who were able to discuss sexual and reproductive health (SRH) issues with their parents find it helpful and supportive to understand sexual development at several levels. On the other hand, those who do not have such relations with their parents reported constant conflicts on different aspects of their sexual behaviour such as condom use and girl/boyfriend relations. In the same study, those young people who were mostly in rural and remote areas found it difficult to discuss SRH issues with their parents. Young people felt that it was important to confirm that accurate information was circulated among them. The study further observed a lack of accurate information among young people who did not attend schools and those in remote rural areas (Mufune, 2003).

A similar study conducted in the Ohangwena Region revealed that the level of knowledge on SRH among adolescents and youths, both males and females, was low (Nengomasha et al., 2004). For example, their familiarity with knowledge about condoms was limited and shrouded in negative myths.

The study also explains that adolescents have difficulties in differentiating between HIV and AIDS; with most believing in myths that if a person looks healthy, he/she cannot be HIV positive. Apart from this low level of knowledge among some youths, the same study also discusses misconceptions and negative rumours among the youth. These misconceptions have serious implications on the utilisation of sexual and reproductive health facilities in the fight to combat the spread of HIV, STDs and other health problems (Ipinge et al., 2004).

Otaala (2000b) in a study conducted at the University of Namibia, where most of the respondents were adolescents, reveals that students indicated that though they have knowledge of the causes of HIV/AIDS, more information is needed. Most students revealed that they had two or more sexual partners and they were reluctant to practice safe sex because using condoms is time-consuming and disturbed the sexual desire. It was also observed that an open-talk between parents and children on sexual matters was still considered a taboo. The 'taboo' element refers to a situation where sex cannot be discussed openly between adults and children according to African culture and different religions. This revealed that even adolescents at institutions of higher learning have misconceptions and inaccurate information about sexual issues, HIV/AIDS and condom use (Mufune, 2003).

Therefore, Otaala (2000b, p.17) recommends that young people need to be taught and guided on decision-making and communication skills which can enable them to protect themselves and view HIV/AIDS as a challenge to themselves, the country and tertiary institutions.

Mufune (2003) also argues that there is some notable cultural continuity in northern Namibia where sex is regarded as a taboo and may not be discussed among people of different ages. The latter makes it difficult for parents to teach their children about sex and HIV/AIDS. Mufune (2003) further explains that the lack of discussion between parents and young people implicates the youths' access to information.

A baseline study on communication for the Adolescent HIV Prevention Programme of United Nations Children's Fund (UNICEF) in Namibia (2001) showed that the majority (80 - 90%) of the Namibian youths has basic knowledge about transmission and prevention. The same study, however, also indicates that Namibian youths have limited understanding of the underlying processes regarding HIV/AIDS prevention.

This is a real concern, because if one does not understand or has limited knowledge one will not be able to make constructive decisions vital to life. The literature concludes that youths are in danger of HIV/AIDS, therefore, the solution to the problem needs to be investigated (Iiping et al., 2004; UNICEF, 2006). Otherwise, if youths do not perceive their vulnerability to HIV/AIDS, the success in the fight against HIV/AIDS might be relatively slow.

Firstly, youths need to have knowledge and understanding that they are in dangers of HIV infection and perceive their vulnerability to this disease. Secondly, youths should have the desire to solve problems and to act collectively as a group, hand in hand with other stakeholders, to find solutions to their problems (Rew, 2005; Ross, Dick & Ferguson, 2006).

According to Freire (1985) youths need to be empowered with knowledge and skills to be able to understand, perceive the danger of the disease and make informed decisions. This means that the active participation of all youths in their education is necessary to enable them to solve their problems and promote behavioural change. The focus on the youth for change is vital because the age group 15 - 49 years, the productive age, is the most affected group with the highest new cases of HIV infections (MoHSS, 2008b) globally, SSA and in Namibia.

Therefore, the WHO points out that:

“During early adolescence, HIV rates are the lowest of any period during the life cycle. The challenge is to keep them this way. Focusing on young people are likely to be the most effective approach to confronting the epidemic, particularly in high prevalence countries” (UNAIDS, 2004, p. 93)

According to a socio-cultural study among adolescents and youths in Oshana Region in northern Namibia (Shapumba et al., 2004), 37% of 12 -14 years old and 50% of 15 - 18 years of age group were already sexually active. The study further noted that early sexual activity is associated with high risks of contracting HIV infection and STDs/ STIs. Pisani (2003) echoes the same sentiment and stated that in South Africa, 20% of sexually active girls between the ages of 16 -18 years were infected with HIV.

But the NDHS in 2006/7 (MoHSS & Macro, 2008) indicates that women aged 15 -19 years, who had had sex before age 15 years decreased between 2000 - 2006 from 9% to 7% respectively.

The decrease was also observed among men, aged 15-19 years down from 27 % to 17%. Whatever the reasons, the UN Secretary-General's Task Force on Women, Girls and HIV/AIDS in Southern Africa, found that both transactional sex and intergenerational sex have become the norm in many countries in Africa. In Zimbabwe, for example, it was reported that nearly 25% of women in their 20s were in relations with men at least 10 years older (UNAIDS, 2004). These types of relationships (transactional and intergenerational sex) have been identified as the major factor in feminisation of AIDS in Africa (UNAIDS, 2008).

Pisani (2003) also indicates that HIV infection is spreading fastest and furthest in conditions of poverty and powerlessness as well as a lack of information which is a situation in which many young people in SSA live, including those in Namibia. As indicated in many of the research studies in this chapter, youths are sexually active and vulnerable to HIV/AIDS. Literature reveals that youth whether in Namibia or elsewhere in the world are described as risk takers who believe in themselves. Youths are also at high risk of HIV/AIDS due to the socio-economic environment (poverty, unemployment) in which they live. In addition, youths are influenced by role models and peers in their surroundings and live in societies with strong traditional norms and values. Literature also indicates that because of youths' sexuality and vulnerability to HIV/AIDS, they need to have access to HIV/AIDS information with emphasis on life skills development. Lack of life skills information impinges youths to develop strong self-esteem and overcome barriers (peer pressure) in their daily lives. Therefore, this study explores whether youths have access to information on HIV/AIDS prevention.

2.8 Youth and access to HIV/AIDS information

Literature reveals that young people are sexually active and vulnerable to HIV infection, but at the same time interested in experimentation. Therefore, it is pivotal for them to have access to information on HIV/AIDS prevention, because information is power.

According to UNAIDS (2004) the United Nations Declaration of Commitment on HIV/AIDS of 2001 has stipulated that young people should have access to information, education and services on HIV/AIDS. This is also applicable to young people in Namibia in general and Oshana region in particular.

In Africa, for example, in Ethiopia, researchers have identified that many communities lack sufficient basic information on HIV/AIDS, especially in rural areas. These studies also explained that most youths in this country are ill informed about sexual and reproductive health rights/issues and have limited access to relevant services (Jackson, 2002).

This is in contrast to other countries in SSA especially Southern Africa where the radio often gives information to people about HIV/AIDS and related issues. Jackson (2002) argues that the giving of information should be combined with active involvement of the youth and problem-solving approaches that will empower youths to find solution to their own situations (Best, 2003).

In Uganda, it was reported that information was given to the youth through sex education and life skills development before they become sexually active, at an early stage. Through this information young people were encouraged to wait before having their first sexual encounter or returning to abstinence if they were not virgins. All sexually active adults were encouraged to practice “zero grazing” which meant staying with a regular partner and not having casual sex (Jackson, 2002, p.13; Ndyabangi, Kipp & Diesfield, 2004).

According to the UNAIDS (2008) in some countries in SSA, people do have limited access to mass media. For example, some youths listen to the radio, watch television and read newspapers at least once a week. It is further elaborated that adolescents have regular access to only one or two types of media, and in many countries many young people have no weekly exposure to any mass media. This finding emphasised that young people on the continent have limited access to radio, television and newspapers and other possible sources of information on HIV/AIDS (Hutchinson, Mahlalela & Yukich, 2007). Furthermore, youths deal with traditional social values that prescribe strict gender roles for males and females, and that condone male sexual promiscuity while placing a high value on female fidelity (Iipinget al., 2004).

The socio-cultural study conducted by UNFPA and UNAM (Shapumba et al., 2004, p. 131) in Oshana Region of Namibia reveals that “the main source of sex education information for young people was the programme 'My Future is My Choice'(MFMC). The latter was organised by the Ministry of Education (MoE) to facilitate peer education among the youth.

However, some youths state that the programme does not reach remote rural areas and for those in urban areas it does not help youths to overcome the prejudice of adults. Young people also complain that most parents, teachers and community leaders in rural areas do not discuss SRH issues with them (Shapumba et al., 2004).

In a similar socio-cultural study conducted in Ohangwena Region, Nengomasha et al. (2004) found that young people need information on HIV/AIDS and SRH issues. The information will empower them to make informed decisions about their lives.

At a national level the provision of important information on HIV/AIDS is stated in the Namibian Constitution and also in the Governments' *Vision 2030* document under the chapter of Population, Health and Development (GRN, 2004).

As the Namibian Governments' leadership response, dissemination of information was rolled out nationwide in 2004 through the MoE, in MFMC and Windows of Hope. The coverage of these two voluntary life skills programmes was 79% of junior and senior secondary schools. It focuses on teachers and learners to equip them with information on HIV/AIDS issues (MoHSS, 2007b).

Literature indicates that youths' access to information on HIV/AIDS prevention in SSA is limited. Literature also reveals that in Africa there are strong traditional social norms and values that prescribed strict gender roles for males and females, with male domination on decision making processes.

Literature further explain that some youths in SADC countries including Namibia received information through the radio, television and printed materials, on a weekly basis. The lack of knowledge and information puts youths at risks of contracting HIV/AIDS, sometimes at early age of their lives. This means that if youths lack information they do not have power to make decisions and take part in designing and planning of media messages. Uganda' good example of giving information to the people through a two-way participatory approach during mass media campaigns could be emulated by other African countries including Namibia and Oshana Region in particular. Therefore, it is pivotal for this study to explore the perceptions of the Oshana youths about the effects of mass media campaigns on HIV/AIDS prevention as one of the main research questions (Iipingwe et al., 2004; Shapumba et al., 2004; Parker & Connolly, 2007).

2.9 Media campaigns in HIV/AIDS prevention and control

Mass media in this study is defined as “technologies and institutions such as radio, television, posters, pamphlets and newspapers used in production and distribution of mass health messages to large audiences” (Gow & Desmond, 2002, p. 34). In this situation, the message is communicated from the sender (source of information) to the receivers (audience - youth) through a channel that could be a radio or television or posters or newspapers (Northhouse & Northhouse, 1985).

Mass media campaigns are explain as the ‘process of exchanging information between the sender and the receivers’ (Rogers, 1995, p. 8). Freimuth (1995) also describes mass media campaigns as traditional communication approaches intended to produce a specific outcome within a specific period of time, directed at a large number of people through an organized set of communication activities (Amon et al., 2000).

Schiavo (2007, p. 7) also defines a health communication campaign as “the study and method used to inform and influence individuals and communities of decisions that enhance health”.

Freimuth (1995) notes that from the health point of view, communication methods, interpersonal and mass communications are used to create and increase public awareness about the disease, its causes, prevention, and treatment. They educate the public and communities about the disease, promoting public attitudes towards the disease, changing individuals’ and communities’ behaviour to prevent and control diseases, advocate for policy changes in favour of disease prevention and control and promotes healthy living. For example, in the case of HIV/AIDS' character of changing from a health problem to a socio-economic developmental factor is crucial and needs media intervention and multi-sectoral approaches (Northouse & Northouse, 1985; Hutchinson et al., 2007; Parker& Connolly, 2008).

Allegrante and Sleet (2004) concurred with Freimuth (1995) that in the absence of cure and vaccine for HIV and AIDS, the only alternative is to help people to take precautions to protect themselves against the HIV infection. This means that the core message in HIV/AIDS communication is disease prevention through preventive measures and advocacy of behaviour change.

At the crossroads of HIV/AIDS and information sharing, there is the science of health communication. The latter is described as disease prevention through behavioural change. This emphasises health communication by noting that in the absence of a medical treatment and vaccine, the provision of information to people through the mass media campaigns is vital to educate people to take control over their lives (Allegrante & Sleet, 2004; Schiavo, 2007).

Levy and Friend (2000) claim that mass media have the power to reach and influence millions of people at one time, if they operate on a large scale. Mass media campaigns are described as cost effective ways to communicate to individuals and communities and to promote behaviour change. Levy and Friend further elaborate that mass media can influence both personal and social behaviour that will provide the support needed to promote individual behaviour change.

Again, according to Freimuth (1995) an effective communicative strategy is a crucial component of the global efforts in HIV/AIDS prevention and education.

However, Valente and Saba (1998) explain that many scholars have argued that mass media are effective in disseminating information to the public, but interpersonal communication is still necessary for behavioural change. Meanwhile, Freimuth (1995) noted that different types of media affect audiences differently, for example business and advertising media stimulate interest in commercial goods and influence how and where people should go to shop. This is also the same situation in HIV/AIDS education and mass communication that enables people to understand and personalise the prevention message if an effective communication strategy has been used (Ross et al., 2006; Parker & Connolly, 2008)).

However, Schooler, Chaffee, Flora and Roser (1998) argue that health communication campaigns which influence people's behaviour are those that are communicated over a period of time, giving different ideas about an issue through multiple channels rather than using a single channel. Literature further shows that mass media messages are strongly affected by choices of channels that are affordable, feasible and sustainable over a period of time.

But Schooler et al. (1998) also explain that people will only be able to change their behaviours if they have knowledge about behaviours and conditions that place them at risks and about ways in which these risk factors can be reduced. Therefore, behaviour change does not follow directly from mere exposure to persuasive messages from radio or television. It is necessary for people to internalise that message and act on it before there will be any change in their behaviour.

Therefore, it is pivotal for people to have knowledge and understanding of situations before any informed decision is taken. Rogers (1995) carried out a study of radio campaigns for 200 families who were persuaded to use boiled water. The study revealed that the campaign was unsuccessful because people strongly believed in their traditional norms and boiling water was against their culture (Amon et al., 2000). This means that strong traditional norms and values are determinants of change.

Ewles and Simnett (1995) state that mass media messages should be carefully designed so that the right messages reach the target audience in a form appropriate to their needs and lifestyle. However, many governments in various countries around the world use mass media campaigns in HIV prevention aimed at creating awareness among people (UNAIDS, 2008).

For example, in Jamaica, a mass media campaign was used to encourage delays in sexual initiation and a targeted age based approach focused on the youth encouraging them either to abstain from sex or create self-awareness or to use condoms for protection purposes. While in South Africa it was observed that they are using innovative media approaches and messages of love life to promote HIV prevention and breakdown social taboos regarding adolescent sexuality and raise awareness among people in the country (Jackson, 2002).

In Namibia, government and non-governmental organisations have policies and guidelines in place on HIV/AIDS prevention (MoHSS, 2004). Mass media campaigns with media messages through radio or television were used to disseminate information to people (Shapumba et al., 2004). According to Schwarz (2003) mass media's reach in Namibia, as in most African countries, is limited mainly to more affluent and urban audiences. Radio has been identified as the most egalitarian medium with rising significance of television (TV) and print media (Parker & Connolly, 2007, 2008).

Literature reveals that mass media campaigns is an instrumental tool that gives information to the public (individuals and communities) with the aim to influence people's behaviours and promote change (Chanda et al. 2008). Literature indicates that mass media messages can reach millions of people at a time; therefore it is regarded as an effective communication strategy where the receivers of information suppose to have knowledge and understand issues surrounding their daily lives (Valente & Saba, 1998).

Literature further reveals that mass media campaigns have a significant influence on young people, but the question is how frequently they (youths) are reached by HIV/AIDS related messages and its effects on youths' needs, lifestyle and sexual behaviours. On this notion, literature shows that no research was conducted on mass media campaigns in the Oshana region. Therefore, it is important for this study to review literature on the ABC strategy as a HIV prevention campaigns communicated through mass media communication in the country.

2.10 Youth and the ABC strategy of HIV prevention campaigns

Prevention is the basis of the response to HIV/AIDS; therefore, many countries worldwide have adopted the “**ABC**” prevention measures in their communication campaigns. The “**ABC**” combination strategy means **A**bstinence from sex, **B**e faithful to a single sexual partner and **C**ondom use. The strategy is known as the “**ABC**” approach (Dailard, 2003; UNAIDS, 2004, p. 73). Chanda, Mchombu and Nengomasha (2008) argue that the ABC approach to HIV/AIDS education places great importance on disseminating information on health risks and awareness. They further state that awareness influences receivers of information to possibly change their behaviours. In section 2.10.1 to 2.10.3 are the brief explanations of the three elements in this campaign strategy.

2.10.1 Youth and Abstinence

Abstinence refers to ‘no engagement in sexual intercourse or delaying of sexual initiation’ (UNAIDS, 2008). The meaning of abstinence or abstaining from sex differs from person to person, from area to area and from country to country, although it has been observed that to abstain from sex reduces the risks of infection.

In Uganda, it was claimed that abstinence has been used as a prevention strategy through radio and school sex education programmes. It was also observed that abstinence caused a slight change in the attitudes of youths in Uganda with the reduction in HIV infection rates (Okware, Kinsman, Onyango, Opio & Kaggwa, 2005).

The UNAIDS (2008) report argues that in the SADC region both male and female youths in some countries, such as South Africa, are aware of abstinence as a way of preventing HIV infection, but the practice in real life situations is questionable.

In Namibia, abstinence has different meanings to youths and individuals in various communities. For example, Talavera (2002, p. 17) claims that “abstinence does not exist among the Ovahimba and Ovaherero youths” because they grew up in the environment where animals mate all year round. He argues that youth easily imitate their social environment and abstinence is a myth to them. Therefore, youths in these communities play sex games at an early age of development. For one to enhance change among the youth in this environment requires a lot of commitment and early commencement.

According to MoHSS & Macro (2008) Opuwo has the lowest HIV/AIDS prevalence rate (less than 10%) in Namibia’ NDHS 2006/7. Opuwo is a rural town in the Kunene Region, where mainly the Ovahimbas live. Talavera (2002) argues that Ovahimba people have sexual encounters at an early age. It is assumed that people in the Kunene Region may have one sexual partner or are faithful to their sexual partners. The latter practice is an HIV prevention strategy, controlling the spread of infection. Therefore, it is assumed that the disease prevalence rate is low in Opuwo (7.9%) as reported in the 2008 sentinel survey due to their cultural and traditional practises.

A study by UNICEF HIV Prevention Programme by Schwarz (2003) also found that even youths who are studying at the University of Namibia, an institution of higher learning, were reluctant to practice abstinence and needed more information on HIV/AIDS prevention strategies. Again, the 2001 Namibia Population and Housing Census (NPC, 2003) indicate that respondents aged 15-19 years old from Opuwo and Rundu lack knowledge about abstinence. This is an indication that though abstaining from sex is vital to youths, they might not have the necessary information to equip them to act accordingly. According to the NDHS in 2006/7 (MoHSS & Macro, 2008) although Opuwo youths lack knowledge on abstinence and have sexual intercourse at an early age, they have the lowest HIV prevalence rates in the country. This data need further investigation. Literature reveals that to practice abstinence is a challenge in some communities in Namibia.

2.10.2 Youth and being faithful to one sexual partner

In the HIV prevention, being safe means being faithful to one not infected sexual partner. In Uganda (Okware et al., 2005) the issue of faithfulness and fidelity was identified as playing a key role in AIDS prevention. The study reveals that there was a large reduction in incidence of having multiple sexual partners from 86% to 29% among men and from 75% to 7% among women. This practice was probably the single most important behavioural change that resulted in prevalence decline. It was also identified that Ugandans have adopted the “zero grazing” approach as was described earlier in the chapter (see section 2.8) (UNAIDS, 2004).

In Namibia, faithfulness means different things to youths in different communities. Therefore, Talavera claims that the notion of faithfulness does not mean one exclusive partner in some societies (2002). For some people faithfulness means one exclusive sexual partner and to others means two or three faithful partners. Talavera (2002) also argues that fidelity and faithfulness are theoretical concepts in some communities.

According to Parker and Connolly (2008) multiple and concurrent partnerships, rapid turnover of partners and inconsistent condom use have been identified as important contributing factors to high levels of HIV infection in the Namibian context. Young adults, between ages 15 and 29, show the highest levels of multiple partners. This causes of the HIV and Sexually Transmitted Infections (STIs) to increase within that generation. This is an indication that youths are in dangers of HIV/AIDS since the practice of faithfulness and fidelity might not be meaningful to them. Therefore, it is vital to equip youths with information that enables them to understand the dangers of multiple sexual partners and the risk of contracting HIV infection (MoHSS & Marco, 2008).

2.10.3 Youth and condom use

In the context of this study, condom use means the use of condoms correctly and consistently every time a person has sexual intercourse. It aims to reduce the risks of HIV transmission for sexually active young people engaging in sexual activities. Condom use in this study does not refer to the number of new condoms taken without correct and consistent usage (MoHSS & Marco, 2008).

The use of condoms as the HIV/AIDS prevention measure is universal in many African countries, because condom use is identified as a key means of preventing HIV infection (Okware et al., 2005). Therefore, many programmes in the world, including Africa, focus on increasing the population's knowledge and access to condoms (UNAIDS, 2008). However, condom use among younger people in SSA varies widely from country to country and among men and women of the reproductive ages, namely 15 - 49 years (Bouare, 2009; Schwarz, 2003). Therefore, most countries in Africa have adopted policies and programmes promoting condom use in their HIV prevention priorities (UNAIDS, 2008).

It is claimed (UNAIDS, 2004) that Cote d' Ivoire, promoted one of the more specific policies in Africa with regard to condom promotion among the youth. It is also observed that Nigeria articulated 100% condom use in "all casual sex" in relationship with culture and Christianity (Smith, 2004). But according to a survey in SSA, the percentage of unmarried sexually active young people aged 15- 49 years who reported using condoms at their previous sexual encounters ranged from only 25% to 18%. This situation occurs in many African nations, where condoms are sometimes viewed negatively as sliding off or causing HIV infection. Therefore, some young people in SSA do not believe that condoms can offer reliable protection against unwanted pregnancies and/or HIV infection (Ndyabangi et al., 2004; UNAIDS, 2008).

In the SADC region, some countries with higher HIV prevalence rates like Botswana have a policy on condoms, but ironically youths in the same country have negative misconceptions about condoms. Therefore, condom use in Botswana is low among youths who are vulnerable and sexually active (UNAIDS, 2008).

However, in South Africa the situation is different; with the level of current condom use among young married couples is somewhat higher, 20% higher than other countries (UNAIDS, 2008).

In Namibia, there is no policy on condom use, but there are policies and guidelines in place related to HIV/AIDS prevention (GRN, 2004). The general observation is that mass media campaigns give information on HIV/AIDS prevention to people including youths. Therefore, it is assumed that people have information about the use of condoms (Ipinge et al., 2004; Parker & Connolly, 2008).

According to Talavera (2002), the extent of the use of condoms in Namibia is not clear because youths are afraid or unwilling to discuss condoms with their sexual partners (Mufune, 2003; UNICEF, 2006). These uncertainties make the situation difficult among youths with the result that they end up using condoms improperly or inconsistently. The non-use of condoms is exacerbated by the fact that condoms are not always accessible in some remote areas. Moreover, some cultures do not encourage the use of condoms, for example, the Ovahimba people, in Opuwo where the HIV prevalence rate is the lowest in the country among the reproductive age, 15 - 49 years (MoHSS, 2008b).

However, the respondents in NDHS 2001 (NPC, 2003) in Caprivi, Kavango and Omusati Regions have the lowest knowledge levels of condom use in the country.

Schwarz (2003), in his study, concludes that on average, young people are still reluctant to use condoms, particularly those who are in the Kavango, Omusati and Omaheke Regions.

According to the NDHS 2006/7 (MoHSS & Macro, 2008) educating youths about condom use is controversial with some people saying that it might promote early sexual experimentation. The NDHS 2006/7 also states that overall 41% of women and 57% of men reported condom use at their last sexual encounters. Reasons stated for the reluctance to use condoms included peer pressure, misconceptions about condom safety, self-efficacy and the implications of unfaithfulness. This means that youths need more education on condom use and HIV prevention strategies.

The uses of condoms also differ from country to country. In Namibia literature reveals that youth in general have low knowledge on condom use and this limited knowledge impinges some youth to discuss condoms use with their sexual partners in their relationships (Ipinge et al., 2004). Literature further indicates that condoms are not accessible to all youth especially in rural remote areas.

In conclusion, literature shows that Namibian youth are sexually active and vulnerable to HIV/AIDS and have limited access to information on HIV/AIDS prevention.

Literature further indicates that youth do not understand issues in their surrounding environment and lack necessary life skills (such as communication, listening, negotiation and decision making) towards HIV/AIDS prevention such as condom use for them to be able to act responsibly as self-directed individuals.

It is further explained that the strong African traditional norms and values of males and females implicate some youth to be reluctant to discuss issues such as condom use in their sexual relationships or to overcome barriers (such as peer pressure) in their daily lives.

Literature has identified mass media campaigns as an instrumental tool used to give information on HIV/AIDS prevention, but it lacks participatory approach between media campaigners and receivers of information in the communication-learning environment in Oshana Region. However, youths in Oshana Region like in other African countries have strong cultural and traditional norms and influencing their daily lives.

2.11 Summary

This chapter has discussed the overview of HIV/AIDS in SSA, SADC and Namibia. The chapter further outlined the Namibian Government response to HIV/AIDS prevention, the youth sexuality and vulnerability to HIV/AIDS, access to information, exposure to media messages and the ABC strategy. Most of the reviewed literature revealed that HIV/AIDS is a serious health and social problem worldwide. Globally, the majority of people living with HIV infections are in SSA and the most affected population are women and young people. Research literature shows that the overall level of awareness about the ABC strategy for HIV/AIDS prevention among the youth in SSA is low, with the exception of Uganda.

The literature reviewed also revealed that many studies have been conducted on mass media campaigns and HIV/AIDS prevention globally and in Africa. However, only few studies were conducted in Namibia on mass communication and HIV/AIDS prevention. All reviewed studies applied a theoretical framework based on the traditional theories of learning and behaviour change. This study utilises two theories and two models of social behaviour change. The study found that there are challenges with the conventional health communication model used in HIV/AIDS prevention. The specific weaknesses include its application and relevance to African cultures, a non-interactive approach, teacher-centred, hierarchical and lack of dialogue and participation by key stakeholders. The literature reviewed emphasises the relevance of the conventional health communication model to Western cultures.

This study will attempt to come up with the relevant health communication model to African cultures, including Namibia, because culture is the main building block for social and behaviour change.

In Namibia, literature reviewed also revealed that the HIV prevention awareness programmes are available in the country and provide information to people still some people are lacking HIV/AIDS prevention information in some rural communities. The literature also reveals that many of those who have adequate information implement only few changes in their sexual behaviours partly due to strong traditional norms and values. The chapter concludes that youth need knowledge on HIV/AIDS prevention and understanding of issues (youth self-efficacy) in their surroundings coupled with life skills to be able to take responsible actions. The next chapter presents and discusses the theories and models of social behaviour change.

CHAPTER 3

THEORIES AND MODELS FOR HEALTH COMMUNICATION IN HIV/AIDS PREVENTION

3.1 Introduction

This chapter presents the theoretical perspectives of various theorists and educational thinkers used in mass media campaigns on HIV/AIDS prevention. A combination of various communication theories and models of social behaviours change from varied perspectives form the theoretical base of this study. The chapter further discusses the Social Cognitive Learning Theory of Bandura (1977), Diffusion of Innovation Theory of Rogers (1995), the Health Belief, Model (BHM) and the Empowerment/Participatory Theory of Freire (1985). In general, the theories focus on individuals' psychological processes such as attitudes, beliefs, social relationships and structural factors in explaining human behaviour. The theories and models also discuss and explain the nature of learning and how knowledge and understanding influence the learning process of young people.

According to Schunk (2000, p. 2-3), theories and models are explained as:

“a set of interrelated concepts, definitions and propositions that present a systematic view of events or situations by specifying relations among variables.....to explain/predict the events/situations/cause-effect relationships. Concepts are “building blocks” and “primary elements”. Models are “generalized, hypothetical descriptions, often based on an analogy and used to analyse or explain things”.

Theories and models are used to shape the pursuit of answers to research questions as to why, what and how things are happening (Reihl-Sisca, 1989; Fawcett, Paine-Andrews, Francisco, Schultz, Richter, Lewis, et al., 1995). In this study, theories were used to guide the search for theories and models of social behavioural change and explain the prevention strategies towards HIV/AIDS awareness campaigns.

3.2 General views of learning and learning theories

Various learning theories and models are discussed in relation to relevant approaches/strategies used to enhance effective learning and promote social change. The study discusses various perspectives and the significance of their contributions to learning and social behaviour change. It provides background information about the theoretical framework that aims to support the argument that some theories and models are more relevant to mass media campaigns that could facilitate social and behaviour changes among the target audience.

Educational theorists, such as Albert Bandura, Everett Rogers, and Paulo Freire have theorised about learning and behaviour change as the basis of addressing real life problems and situations. Therefore, learning has been defined as “an enduring change in behaviour or in capacity to behave in a given fashion/situation, which results from practice or other forms of experience” (Schunk, 2000, p. 2).

Educational theorists have elaborated that critical issues in the study of learning are how learning occurs and which factors influence and promote learning (such as motivation, willingness to learn and good environment). Furthermore, it is vital to determine for the purpose of this study how learning takes place in HIV/AIDS awareness prevention campaigns (Freimuth, 1995; Simons-Morton et al., 1995).

Other researchers have also defined and explained on learning theories (Freire, 1985, p. 123) as “the study of the creation of knowledge” from various perspectives such as humanistic, cognitive, behavioural, social and constructivist (Illeris, 2003). The theories advocate that the acquisition of knowledge and skills, as well as change in attitudes, practices and behaviours, occur in different ways depending on the theoretical perspectives involved (Fawcett et al., 1995). Critical thinking and transformation are explained as the important dimensions to learning, especially among adult learners (Riehl-Sisca, 1989). As the learning environment is multi-dimensional in nature, youths need to be empowered with knowledge and skills and transformed to solve the problems facing them in their daily lives (Zimmerman & Warschausky, 1998). In their diverse perspectives, researchers maintain that the aim of learning is to empower learners/youths and transform individuals into self-directed beings. Self-directed youths are capable of changing social, political and cultural conditions and forces (such as peer pressure) that prevent them from living and controlling their normal lives and pose difficulties in their societies (Freire, 1972, 1985; Freimuth, 1995; Illeris, 2003; Rogers, 1995).

The Social Cognitive Learning Theory (Bandura), Communication/Diffusion of Innovation Theory (Rogers'), the Health Belief Model (HBM) and the Participatory/Empowerment Model (Freire) are the theories and models that are mostly used in this study.

3.3 Social Cognitive Learning Theory

Albert Bandura's Social Cognitive or Social Learning Theory is the first theory under discussion (Bandura, 1977). This theory views learning as "an information processing activity in which information about the structure of behaviour and environmental events is transformed into symbolic representations that serve as guides for action" (Schunk, 2000, p. 81). It states the relationship between the person and the surrounding environment.

Bandura (1977) believes that human behaviour is conditional; dogged both by the situation and one's interpretation of that situation. He describes people as critical thinkers or thinking beings, interpreting situations, learning and interacting within their diverse situations. Bandura (1977) also states that learning occurs through actual performance and by observing models such as a live television programme showing how women in a community should behave in a culturally acceptable ways (being obedient and performing their multiple roles of caring for family members such as fetching water, collecting firewood and preparing food), by listening to instructions (a radio programme discussing how to use condoms and enhance safe sex) and by reading printed materials (Illeris, 2003; Rogers, 1995).

Bandura, like Paulo Freire, believes that learning and performance are influenced by various factors. The latter are readiness to learn from the learner's side, conducive environment (free from physical and psychological disturbances) and availability of study materials (Freimuth, 1995). Rogers (1995) also explains human behaviour in terms of connection between environment and observable responses. This means that youths should be free individuals able to discuss and interact with friends/partners about their sexual relationships (Bigge, 1982).

According to Bandura's theory observing a model does not guarantee learning or the ability to perform certain behaviours (Schunk, 2000, p. 3). It elaborates that new behaviours are learned either by modelling the behaviour of others or by direct experience. Modelling serves informational and motivational functions: providing information about the probable consequences of experiences and actions, can influence how the observer acts. This means that one needs to have knowledge (be well informed) and motivated (to perceive the dangers of HIV/AIDS in the society) to adopt change (Fawcett et al., 1995).

In Social Cognitive Learning Theory, human functioning is viewed as a series of reciprocal interactions between personal factors, behaviours and environmental events (Riehl-Sisca, 1989). Therefore, Lévesque (2002, p. 225) argues that youths need to be given opportunities to "experience democracy" (active interactions with others) in classrooms, schools and communities to be able to learn. Youths who are passive listeners may not be critical thinkers in the teaching-learning environment.

Therefore, youths need to be active participants and critical thinkers equipped with knowledge and skills (life skills) which enable them to identify their problems and find solutions as a collective team (Elder, Shults, Sleets, Nichols, Thompson & Rajab, 2004).

Bandura's Learning Theory emphasises the role of social norms in influencing individual behaviour and learning. It further explains that maintaining healthy behaviours (for example avoiding unprotected sex and using condoms) is influenced by many surrounding factors. These are knowledge, motivation, outcome expectancy and self-efficacy. Therefore, youths should be knowledgeable and self-directed to be able to negotiate safe sex. If youths lack the above factors no learning and behaviour change (no negotiation of safe sex) will take place (Schunk, 2000).

Bandura (Schunk, 2000, p. 82) also states that Social Learning Theory focuses on vicarious, symbolic and self-regulatory processes. It also looks at human behaviour as a continuous reciprocal interaction between cognitive, behavioural and environmental determinants. In this theory for a person to learn, a reciprocal interaction between critical thinking, attitudes, beliefs and the surrounding environment is necessary. Therefore, Bandura suggests that in real life situation youths and media campaigners should interact, plan, implement and evaluate media messages and processes during the HIV/AIDS prevention campaigns. Bandura further elaborates that youths as target audience need to do the actual performance (active recipients) to facilitate learning, because information alone will not ensure proper learning (Amon et al., 2000).

The Social Cognitive Learning Theory further emphasises the use of modelling or observational learning, as learning by observing behaviours of the others or by direct reinforcing experience. According to Bandura (Freimuth, 1995) modelling is an effective learning principle in observing and imitating the action of the others to ensure significant learning. This means that youths may learn good or bad behaviours from their parents and role models or leaders in their communities through imitation (Hedgpeith & Helmich, 1996; Steinberg, 1999).

Bandura's theory further explained that change in behaviour is facilitated by an awareness of consequences. Awareness (Bigge, 1982, p. 157) is explained as a "powerful facilitative factor" and not "a sufficient condition for behavioural change". Therefore, Bandura's theory reveals that young people need to be aware that through their actions they can contract HIV infection if they practise unsafe sex or have multiple sexual relationships. This means that media messages should mould youths to understand their situations and think critical for them to be able to give reasons for their actions.

The Social Learning Theory summarises that learning is an "information process" influenced by many factors such as motivation, peer pressure, personal beliefs and practices, knowledge and understanding of events and situations (Illeris, 2003). Bandura's theory also explains that learning involves goal setting, attainment and concerns of how people can deliberately shape their environment. Generally, Social Cognitive Learning Theory intends to affect, enhance and change people's behaviours.

The theory concludes that learning takes place when learners have integrated information with attitudinal change through motivation and reinforcement of modelling and self-efficacy (Schunk, 2000). Bandura's theory also explains human behaviour as a continuous reciprocal interaction. This means that for one to learn it is conditional to his/her attitudes, understanding and interpretation of the surroundings.

Even though, the literature in chapter two (Iiping et al., 2004; Parker & Connolly, 2007, 2008) reveals that Namibian youths have adequate knowledge on HIV/AIDS prevention which needs to be translated into actions. Literature further states that media campaign officers, as facilitators of the learning process, should act as influential role models to promote behavioural change. If this is not done no learning will take place.

The key concepts in the Social Cognitive Learning Theory are discussed in the next part of this chapter. Concepts in the Social Cognitive Learning Theory explained and discussed in this study are knowledge, motivation, outcome and self-efficacy. These concepts, in relation to HIV/AIDS awareness/ information campaigns, are discussed and adapted in this study (Hedgepeth & Helmich, 1996, p. 71) as follows:

Knowledge refers to an understanding of what is to be done. Understanding means to think critically and implement HIV/AIDS prevention strategies. Currently, mass media campaigns are using conventional, persuasive health education approaches which promote passive listening of learners and memorising of information provided to them (Freire, 1985).

Motivation refers to a person's belief that one will benefit from one's action, for example, unprotected sex with multiple partners is a risk to a person's health that needs to be avoided. Youths need to understand that their actions will either protect or destroy them. Therefore, youths should have the motivation to implement the HIV/AIDS prevention strategies and protect themselves.

Outcome expectancy refers to the outcome results. For example, certain skills or methods of protection (using condoms consistently and correctly) will prevent and protect a person against HIV infection. Youths need to understand the outcomes or results of their actions that multiple sexual relationships and inconsistent condom use will endanger their lives. Therefore, they need to comply with the learning process.

Self-efficacy is the belief/judgement in their abilities which youths need to implement the necessary/expected behaviours. Self-directed actions are assertiveness implying that youths have to make informed decisions about their lives. An example is a youth convincing a partner to delay sexual encounter, abstain from sex or insist on condom use (Simons-Morton et al., 1995). According to research studies (Illeris, 2003; Elder et al., 2004) mass media campaign messages focus mostly on knowledge acquisition and persuading individuals to adopt ideas and to change behaviours. Literature reveals that awareness messages alone do not mould youths to become self-directed individuals and critical thinkers. Freire (1985) argues that youth are expected to imitate role models and adopt assertiveness abilities for them to learn. Hence the importance of this study to suggest active learning approaches that enhances change.

In summary, Bandura's Social Cognitive Learning Theory defines learning as an information-sharing process, which takes place in a continuous reciprocal interaction in a communication-learning environment (Bandura, 1977). The theory views receivers (youths) of information as critical thinkers who need to be knowledgeable to understand issues in their daily lives, to be motivated to learn and be self-directed to make informed decisions about their lives. The theory emphasises that youths learn and change their behaviours through modelling, direct observation and imitation of others. The theory has the limitation that a mere modelling or imitation does not guarantee learning nor social behaviour change. Therefore, Bandura (1977) argues that receivers of information (youths) need to have knowledge and understanding to be able to take responsible actions. Bandura further elaborates that media campaign officers (providers) and youths (receivers) should interact in a reciprocal way to ensure the desired end results (knowledge, understanding and taking responsible actions). Failure to this neither learning nor behaviour change will take place.

Bandura's Social Cognitive Learning Theory (1977) implies that an individual behaviour is the result of the interaction among cognition, behaviour, environment and psycho-social beings. Its primary domains of learning are modelling (imitation behaviour of a role model) and self-efficacy (ones' perceived ability to adopt a recommended behaviour) (Bandura, 1977). It is believed that this theory is useful in the HIV/AIDS communication campaigns in Western cultures, but there is a question about its relevance in African cultures where the individual decisions are the result of group norms. However, this theory advocates the need to focus on collective efficacy as recommended in this study (Illeris, 2003; Simons-Morton et al., 1995; Tubbs & Moss, 1994; Waisbord, 2001).

3.4 Communication of Innovation Theory

Everett Rogers' Communication of Innovation Theory is the second theory explored, also known as a Diffusion of Innovation (information) Theory. Everett Rogers (1995, p. 5) defines Diffusion of Innovation Theory as "a process of how an idea is disseminated throughout a community". Other writers, such as Simons-Morton et al. (1995, p. 15) define diffusion as the "way by which new ideas or practices spread to members of communities". Rogers' Theory also explains innovations as "new ideas or practices" (Rogers, 1995, p. 5) that may not always be recognised or perceived as being necessary, important or useful in the communities.

In the context of this study, the Innovation Theory aimed to examine how mass media (through communication technologies such as radios, television and printed materials) disseminate information to youths through the process of Diffusion of Information. Rogers (1995) explains that when innovation is introduced only a few innovators and adopters learn about it. Murray (2009, p. 110) defines an innovation as "an idea, practice or object that is perceived as new by an individual or other unit of adoption". Examples of innovations are mass media messages ("use of condoms" and "safe sex saves lives"). The Innovation Theory also emphasises that new practices occur at various societal levels such as working places, churches and schools through mass media influence.

Researchers of Diffusion of Innovation Theory suggest that the extent and distribution of adoption of an innovation depends on the characteristics of the target population, innovation itself and stages of adoption (Harting, Rutten, Rutten & Kremers, 2009; Murray, 2009; Simons-Morton et al., 1995; Tubbs & Moss, 1994).

According to Rogers (1995) Diffusion of Information consists of three individual stages, namely newsbreak (time vital for reporters to transmit essential information to communities/receivers), dissemination stage (period when news spreads through certain members of audience and communities and pass information to others) and thirdly, saturation occurs when most (90%) of the population has heard the information. This means that innovations diffuse over time according to the Diffusion of Information stages (Tubbs & Moss, 1994).

Moreover, Rogers (1995, p. 5) describes diffusion as “a process” by which innovations (mass media messages with new ideas) spread to members of a social system. Individuals may know new ideas (how to practise safe sex to prevent HIV/AIDS) but may not develop a favourable/unfavourable attitude towards it or do not adopt/reject it (Harting et al., 2009). Therefore, Barker (2004, p. 132) states that “trusted opinion leaders can gain entry” (this means that opinion leaders are accepted in their communities as the trusted and preferred source of information) for new ideas and these ideas will be adopted favourably in their communities.

Diffusion of Information in the Innovation Theory (Rogers, 1995, p. 10) consists of five essential elements namely the inventors, innovation, channels, receivers (members of communities) and effects (consequences). The innovation is communicated through media channels (radio, television and newspapers), over time, among members of a social system or community. The exposure of youths to new ideas which takes place within a social network or through the mass media determines how fast or slow an innovation will be adopted by adopters.

In contrast, the communication process also has its elements namely source, message, channels, receivers and effects matching with those of the Diffusion of Innovations. Both processes are cyclical in nature and effects or results are vital to observe change, either in knowledge acquisition or behaviour change (Rogers, 1995).

Simons-Morton et al. (1995) state that innovation is likely to be adopted by people from diverse educational, societal, cultural, religious and political backgrounds in different ways. People's perceptions are vital for behavioural change in health. Thus, the Innovation Theory speculates that people are likely to adopt new behaviours based on favourable evaluations of ideas communicated to them by respected or experienced members of their communities as their models or leaders. Bandura (Rogers, 1995) also states that new behaviours are learned through modelling and direct observation of an experienced person or opinion leader. If youths are persuaded by media campaign officers (strangers) to learn and change behaviours, then learning will not take place. Rogers like Bandura emphasises that youths are learning by imitating what their role models or opinion leaders are doing.

Simons-Morton et al. (1995, p. 353), like Rogers (1995), describes human beings according to their characteristics and qualities as “innovators, early adopters, late majority and laggards” in relation to Diffusion of Innovations. Innovators are independent change-oriented and risk-taking individuals and early adopters are known and respected community members called opinion leaders. Rogers (1995) proposes early adopters as models to emulate their role models and generate a climate of acceptance and the appetite for change. Late majority people are sceptical of change and tend to wait until an innovation is established as a norm. They are greatly influenced by their peers through peer education. Laggards are traditional, conservative, less educated people with lower socio-economic status and restricted communication networks in their environments. People’s learning is influenced by their characteristics (Barker, 2004; Murray, 2009).

Barker (2004) further elaborates that information flows from media sources to opinion leaders, and to followers with the influence to inject change. The process is called transfer of information technology. Therefore, Waisbord (2001) states that mass media is vital in increasing awareness although interpersonal communication and personal sources are crucial in making decisions to adopt innovations.

Rogers’s Theory states that a variety of communication behaviours including Diffusion of Innovations provides useful understanding of the flow of mass communication (Rogers, 1995). Communication Theory, according to Rogers (1995), covers the process by which an idea is transferred from a source to a receiver in order to reach a mutual understanding and intended change in behaviours.

Usually the sender intends to alter the receiver's knowledge, create or change attitudes towards the new ideas for example persuade youths to use condoms or abstain from sex, as part of their regular behaviour.

Rogers' (1995) Diffusion Theory confirms that the best way to disperse messages within a community is through opinion leaders/peers who are role models to change community norms. Learning in this theory is facilitated through (Rogers, 1995, p. 286) "knowledge on innovation, persuasion, decision to adopt/reject the message, to implement and confirm the decision". Media channels are "knowledge-creators", whereas interpersonal networks are more important in "persuading individuals" to adopt/reject change.

Currently, the issue of HIV/AIDS prevention in the Diffusion Theory is difficult to practise, because some adults are key persons in the spread of the disease. For example, some adults have multiple relationships; have negative attitudes and practice of "I will not die alone" and use money to buy sex irrespective of their HIV status. Hence these adults are contributing factors to the spread of the infection instead of being good role models striving to combat HIV infection (MoHSS, 2008b).

However, Barker (2004) emphasises that Diffusion of Innovation Theory enhances learning through easily available, trusted sources of information (opinion leaders) and behaviour modelling (peer educators) as agents of change. Barker also elaborates that new communication channels such as the use of peer educators is a useful approach to bridge the gap.

But in contrast, Agha and Van Rossem (2002) explain that peer educators and information providers have limited coverage with stronger impacts than the mass media messages on individuals' intentions to implement behaviour change. Peer educators, as individuals, can react to a small number of people at a time with a strong message through face-to-face talking rather than using technology (radio/ television). Agha and Van Rossem (2002) also maintain that mass media campaigns have an impact at population levels because of their considerably greater access to various communities.

Rogers' Innovation Theory and Bandura' Social Cognitive Learning Theory have much in common in relation to learning. Both theories emphasise learning through modelling and reciprocal interactions between the senders and receivers. These actions are imitated and learned by inexperienced persons and young people. Therefore, literature also cites that social norms, relationships and power create meaning and determinants of behaviours and social behavioural change (Barker, 2004; Murray, 2009; Rogers, 1995; Simons-Morton et al., 1995).

Rogers' Diffusion of Innovations Theory like Bandura's Social Cognitive Learning Theory, argues that learning is a cyclical process that takes place through modelling. In both theories the process of learning is very slow. According to the Diffusion of Innovation Theory youths are placed in social settings among opinion leaders/peers with desired opinions, attitudes, skills, experiences and behaviours to learn through observation, modelling and discussions.

Both theories stress information exchange as essential to behaviour change and view network links as the main explanation of how individuals alter their behaviours. They conclude that a portion of people's general hypothetical knowledge is imitated from others, but that social modelling frequently occurs through diffusion or communication networks. Social theories and models also confirm that individuals' behaviours are rooted in their social and cultural contexts (Brown, 2005).

Rogers (1995) in his Diffusion of Innovation Theory defines learning as a cyclical process. Roger believes that youths should perceive their vulnerability to HIV/AIDS, because they are active adopters of innovations. He also maintains that opinion leaders and peer educators (need to be used as an approach to bridge the gap between senders and receivers of information and create an interaction) should be used as good role models to disseminate information to the active recipients (youths) and to promote a networking approach. Rogers also elaborates that adopters should have access to information and be aware of the innovations in their surroundings. In this theory receivers of information should perceive their need to learn.

The diffusion theory implies that communication is a process by which the new idea or an innovation becomes known to the audience or the youth in Oshana Region. The Diffusion of Innovation theory has two guiding principles when used in HIV/AIDS prevention campaigns. These principles are the creation of awareness of the disease and the use of opinion leaders/peers to influence youth's beliefs, actions, attitudes, beliefs and behaviours (Rogers 1995). The theory has the limitation for widening the gap between the 'providers' and 'adopters' in the society (Freimuth, 1998).

Despite its limitation, the use of opinion leaders in helping to shape culturally appropriate strategies is a part of this theory that offers possibilities in HIV/AIDS communication. This means that this theory focuses on communities' interpretation of their own problems, group discussions in families to share information and to use local languages during their community meetings. In this study the diffusion of innovation theory create a web of networking including all key stakeholders such as media campaigners, youths, community leaders, peer educators and community HIV/AIDS committee members at different levels to be able effect change and fill the gap between providers and adopters.

3.5 Health Belief Model (HBM)

The Health Belief Model (HBM) is the third model to be discussed. This model provides a different perspective. It was originally introduced in the 1950s by psychologists (Hochbaum, Rosenstock, Leventhal and Kegeles) working in the U.S. Public Health Service (Simons-Morton et al., 1995). HBM was developed as a way of understanding preventive health behaviours, specifically to identify high priority factors that might affect a patient's decision to comply with the medical regimes or mass media messages. HBM derives from value expectancy theory that refers to a view of rational decision-making in situations of uncertainty (Simons-Morton et al., 1995).

Thomas (2001) claims that HBM was one of the first models that adapted theory from the behavioural sciences to health problems. It remains one of the most widely recognised conceptual frameworks of health behaviours. The HBM aims at explaining and predicting preventive health behaviour. It focuses on the relationship of health behaviours, practices and the utilisation of health services. HBM emphasises the importance of perceptions in decision-making.

In general, perceptions are influenced by a variety of factors such as individual perceptions, contexts within which stimuli are perceived, previous experiences, personality, cultural factors, socio-economic status and many more. The HBM holds that health behaviour is “a function of individuals’ socio-demographic characteristics, knowledge and attitudes” (Thomas, 2001, p.301). Therefore, in this model perception is what one believes to be true. Perception is also described as a guiding principle of learning in this model (Neuwenhuijsen, Zemper, Miner & Epstein, 2006).

According to this model (Simons-Morton et al., 1995, p. 268 - 269), a person must hold the following seven beliefs in order to be able to change behaviours:

Perceived susceptibility is explained as the extent to which individuals believe they are vulnerable or at risk of contracting HIV/AIDS. The person must feel susceptible to the HIV infection without exception (Freimuth, 1995).

Perceived seriousness refers to the severity of the health problem and its consequences. This covers the effects of a health problem on one's state of health affairs and the difficulties that disease would create. For example, how serious is HIV infection and AIDS as a health problem and how negatively will it affect people's lives (Neuwenhuijsen et al., 2006). This means that youths should view HIV/AIDS as a serious problem in anybody's life which can affect everybody without discrimination.

Perceived belief refers to the persons' beliefs in the effectiveness of the new behaviour (condoms are effective measures against HIV prevention). A person must believe that the benefits of taking the recommended action (use of condoms) outweigh the perceived barriers (cost of condoms, attitudes and myths against condoms). A perceived benefit of preventive action is a benefit or an advantage of using condoms and avoiding contracting HIV infection (Thomas, 2001).

Perceived barriers refer to things which impede action even if an individual may believe that the benefits to take action are effective. These barriers are inconveniences experienced by condom users when using them, expensive condoms (costs), cultural norms (young girls/boys cannot use condoms since it will encourage promiscuity), religious norms, peer pressure and negative attitudes (condoms interfere with sexual pleasure) towards condom use. A barrier could also be a dominant male partner who convinces the female partner not to use condoms, even if she wanted to do so (Neuwenhuijsen et al., 2006).

Cues to action are strategies used to activate readiness and stimulate overt behaviour. A health belief recognised that the number of events (life experience of witnessing a death of a close friend or relative dying because of AIDS) can serve as cues to action (Thomas, 2001). Thus the HBM helps to better fit challenges of changing habitual unhealthy behaviours, such as failing to use condoms in the case of HIV/AIDS prevention (Waisbord, 2001).

Self-efficacy in this model describes the self-confidence and understanding of people to act responsibly and take control over their own lives. This refers to the self-esteem the person has to adopt change even in the face of barriers and circumstances that make change difficult to implement (Thomas, 2001).

Simons-Morton et al. (1995, p. 270) further emphasise that the HBM is used as a framework for conducting needs assessments in preventive health behaviour and compliance studies. Therefore, the HBM is using cues to action that can be of benefit to people during media campaigns using radio and television broadcasts as well as newspapers and posters. Strategies provide the force for people to understand HIV/AIDS and act responsibly. Self-efficacy which includes self-confidence and understanding about HIV infection empowers young people to make informed decisions, take control over their lives and how to overcome barriers (Freimuth, 1995).

In both Social Cognitive Learning Theory and the HBM, self efficacy describes assertiveness as qualities that individuals (youths in this study) should have to be able to learn, understand, think critical and prevent HIV infections. A person without the self-directed abilities or perceived beliefs will learn and understand with difficulty (Di Clemente & Peterson, 1995, p. 617).

According to the HBM, perception is very important in life. The HBM further emphasises that change in a person's behaviour occurs if that person (the youth) perceives risks and believes that he/she can contract HIV infection, but also can prevent it when resisting peer pressure (barriers) from friends and partners. Therefore, HBM implies that it addresses health prevention from an individual and rational perspective. It is also assumed that the HBM is inadequate for communicating HIV/AIDS prevention and care messages in Africa because it is relevant to western societies (Niewenhuijsen et al., 2006). Therefore, this theory is focusing on individualistic rather than collective approach which is Freire' dialogical process. In this study mass media messages should build on recipients' (youths) abilities to perceive, understand and behave critically towards implementing HIV/AIDS prevention strategies.

The HBM promotes actions such as the use of a youth (peers) who is HIV positive as an example during media campaigns, as an innovative approach that facilitate change in an individual's personal beliefs, perceptions in decision-making and develops high levels of self-efficacy (Niewenhuijsen et al., 2006).

The HBM is designed to address health prevention from an individual and rational perspective. It is assumed that HBM is inadequate for communicating HIV/AIDS prevention in Africa because in Africa like in Oshana Region, people believe in collective actions and not individualism. Therefore, this model has been used to guide communication strategies for HIV/AIDS, but its effectiveness is questionable in some communities with strong cultural believe in collectivism (Thomas, 2001; Niewenhuijsen et al., 2006; Freimuth, 1995; Andersen et al., 2001).

In conclusion, the HBM focuses on reciprocal interactions coupled with personal experience, self-esteem and esteem of others and knowledge of how to change. Youths as individuals should act, as critical thinkers with self-efficacy or self-directed characteristics that will enable them to perceive their susceptibility (risk) to HIV infection and believe that they can prevent it. Young people need to interact with their social environment to be able to perceive their susceptibility and change. The HBM can be applied to HIV/AIDS prevention if youths are empowered and actively involved in the communication-learning process as partners and not individuals in the awareness campaigns. Again, youths need to have the understanding to be able to make informed decisions and to overcome barriers (as discussed in this chapter under section 3.10) in their lives. If youths are critical thinkers in their actions, they will design user friendly strategies to overcome barriers in their daily lives.

3.6 Participatory/ Empowerment Model

The fourth model is Paulo Freire's Participatory/Empowerment Model. Paulo Freire (1972, 1985), a Brazilian adult educator, conceived communication as dialogue and participatory in nature, which can be used to offer liberation education.

According to Freire (1985, p. 85) the aim of communication and education is “conscientization”, explained as “free dialogue that prioritised cultural identity, commitment, trust, ownership and empowerment”. Freire's approach to education is called “Dialogical Pedagogy”. This approach describes equity in distribution of power and active grassroots participation as the central guiding principles of learning. Freire's (1972, 1985, p. 85-86) “Dialogical Pedagogy” education is a sharing of information and not a transmission of information from those “who have it” to those “who have not” or from the powerful to the powerless. According to Freire (1985) conscientization means “raising awareness, reflecting and creating discovery of the world”. He further explains that consciousness/conscientization promotes creativity and reasoning as a way for participants in the learning environment to uncover the nature of their problems and their root causes in the society, such as the socio-economic, political, cultural and historical context of their personal lives (Freire & Shor, 1987). Therefore, according to Freire's Dialogical Pedagogical approach, what is needed is an understanding of communication known as “conscientization”. Paulo Freire (1985, p. 86) also elaborates that conscientization is limited in some awareness mass media campaigns (Figueroa et al., 2002).

Freire (1985) believes that in liberation education people should solve their own problems and situations. Someone like a media officer should not guide communities on what to do to prevent HIV/AIDS without internalising the root cause of the health problem.

The Participatory (Empowerment) Model proposes a human centred approach that values the importance of interpersonal communication in decision-making processes at both individual and community levels. The sender and receiver in the communication process start from the situation (causes) in the community using active learning methods (group work dialogue/ discussion) to determine collectively its own needs and priorities (Fawcett et al., 1995; Freire, 1985; Page & Czuba, 1999).

The Participatory (Empowerment) Model proposes that youths should diagnose their own needs and identify solutions as a team in collaboration, with media campaign officers. Andersen, Ostergaard, Moller and Olesen (2001, p 417) argue that the “persuasive approach, by telling or instructing communities what to do” (abstaining from sex to prevent HIV infection) does not facilitate significant learning. Andersen et al. (2001) are of the view that learning does not take place when one is forced or persuaded to learn. This confirms what Agha and Van Rossem (2002, p. 152) state that “information alone” cannot enhance change.

Paulo Freire’s ideas of conscientization (Freire, 1985) can be contrasted against the fundamental principles in the Diffusion of Innovation Theory (Everett Rogers) which have sender focus, are externally driven and behaviour bias inherited in the persuasion models.

The persuasive model (the existing conventional model used in health education) diagnoses youths as being in need of information that will enable them to change their behaviours (Fullan, 2001). In addition, Freire (1985, p. 88) maintained that people learn when they think critically, understand messages and analyse the situation and adopt it without coercion.

Freire believes, like Bandura, that human beings are critical thinkers. They should use their assertive abilities and act accordingly. Lévesque (2002, p. 225) in theories of adolescent development also states that learners/youths need information and experience to become critical thinkers and responsible decision makers (Low-Beer & Stoneburner, 2004).

Freire's human-centred approach favours the use of interpersonal methods of communication, where providers of information act as facilitators of dialogue. He envisages that media technologies (radio, television and printed materials) should be used as supplementary teaching methods.

Freire calls for community based forms of communication namely group media (songs, community radio, theatre, and storytelling) and other traditional activities (drama) that need to be promoted and used as teaching aids in the dialogical teaching-learning environment (Fawcett et al., 1995; Figueroa et al., 2002).

For example, in HIV/AIDS awareness campaigns in Oshana Region, cultural group activities (such as group discussions and community meetings) should be used to share information among the audience instead of a television advert instructing youths to use condoms or to abstain from sex. Freire 's human-centred/learner-centred approach suggest the use of media messages that provide opportunities for youths to identify common problems and solutions, reflect upon personal and community issues and mobilises resources (Fullan, 2001).

The human centred approach further explained that youths in collaboration with media technologists need to be in charge of decision and production processes. Information should be disseminated in a dialogical process focussing on exchanging views, involving community members, empowering them and reinforcing ownership of solutions and problems (Freire, 1985; Perkins & Zimmerman, 2006; Schiavo, 2007). The interactive approach is lacking in the media awareness campaigns.

However, Lévesque (2002, p. 226), like Freire, recognises the reciprocal nature of socialization and democracy (active involvement of learners) in the teaching-learning environment.

Freire's Participatory (Empowering) Model is against the conventional, didactic, persuasive health education approach that is the current practice of mass media campaigns, in Oshana region in Namibia. Paulo Freire believes that the passion for critical knowledge is the source for social change (Freire, 1985; Freire & Shor, 1987; Zimmerman & Warschausky, 1998).

Critical activists, like Paulo Freire, believe that power and ability to change situations can come through the acquisition of knowledge and experience. Freire's empowering model recognises people as critical thinkers and promotes consciousness (Freire & Shor, 1987). Therefore, Freire's human centred approach reaffirms facilitation, discussions and dialogue as the best methods of teaching and learning. It highlights the significance of messages for learners' needs and situations (Freire, 1985; Low-Beer & Stoneburner, 2004; Schiavo, 2007).

In conclusion, the Empowerment/Participatory Theory defines learning as a dialogical process of conscientization. In this process youths need to be liberated through education to participate and discuss HIV/AIDS prevention/awareness campaigns. It is anticipated that when youths understand, think critically and perceive their vulnerability and susceptibility to the disease and its severity, they will learn and behavioural change will take place. Therefore, Freire's (1985) human-centred approach of conscientization needs to be implemented in the mass media campaigns for HIV/AIDS awareness to promote dialogue and facilitation. The latter approaches empower youths to understand social, personal, cultural, economic and political forces that are problematic in their lives. Freire's model advocates dialogue, participation, self-reflexivity and self-consciousness vital to improve current situation.

3.7 Overview of existing Conventional Health Education Model

For the purpose of this study, it is necessary to give an overview of the existing conventional persuasive educational model as currently practised in many African countries, including Namibia. This model is a persuasive, one-way, top-down, authoritarian, hierarchical and individualistic information process (Low-Beer & Stoneburner, 2004). The concern is that the elements of this model and its application could create a situation where youths distance themselves from health communication. Its conventional approach is teacher-centred as elaborated by Freire (1985).

In the existing conventional model, the sender is regarded as a resource (an expert) person, who has the tendency to blame communities (audiences) for their traditional beliefs and practices (victim-blaming) and focuses on lifestyles and not on root causes of the problem (Freire, 1985). Allegrante and Sleet (2004) argue that if the community is blamed for its traditional beliefs and practices, it may interpret the message wrongly or will not collaborate to do what they are expected to do. This means that if the sender blames communities for their resistance to change behaviours, to use condoms, the outcome may be a subconscious negative reaction by the community towards media messages. However, Stein (2001) also concludes that mass media campaigns in some African countries were blaming communities for their actions. He also cited the examples from Uganda where media campaigns had played a role in HIV/AIDS awareness without victim-blaming. Therefore, the media campaigns in Uganda impacted on individual and social change in communities.

The literature reveals that the sender in the existing model decides, formulates and prepares persuasive media messages including media spots without dialogue and active participation of the targeted population. This means that the sender is diagnosing the needs of the individuals and communities and decides on the needed programme in isolation. This is an example of top-down communication which is currently taking place in Oshana Region (Freire, 1972).

According to Maibach and Parrot (1995) the existing conventional model's messages are persuasive in nature with various barriers. These barriers are the unfamiliar languages and technical words used in the communication process as cited by Rogers (1995) in his Diffusion of Innovation Theory. The latter theory's dominant ideology of individualism is marred by three fundamental flaws: it ignores health as a social product, it wrongly assumes the existence of free choice and it is ineffective in preventing ill-health. Maibach and Parrott (1995) also argue that this model leads to little or no change in behaviour modifications, because of the nature of its structure and approach.

This study reveals that disseminated information on HIV/AIDS awareness prevention was received from radios, television and printed materials as pre-determined information from the campaigners. The youth did not participate in any message formulation, but they were given the information and expected to act according to it. Youths were also expected to use condoms, change their lifestyles, and follow the media campaigners' instructions.

Freire (1985) portray in the Empowerment Theory that receivers of information in any communication process should not be passive listeners; otherwise neither learning nor behaviour change will take place.

Mass media campaigns in Oshana Region are the examples of conventional model, matching the features of this model in Table 7.1. This implies that the existing model's channels of communication are non-interactive and operate on the basis of indoctrination through the process of telling people what to do and how to do it (Schiavo, 2007). For example in the existing model, the health communicators (senders) tell young people to use condoms and how to use them, to practise safe sex, to prevent HIV/AIDS and change sexual behaviours. But Bandura (1977) argues that information alone will not facilitate learning neither effect change. However, this communication process lacks needs assessment (analysis) of the targeted population, sender-receiver interaction on action taken, dialogue and active involvement of all stakeholders (Freire, 1985, p. 17; Schiavo, 2007) in the HIV/AIDS prevention. The study results also revealed that media campaign organisations in Oshana Region were operating in isolation; My Future My Choice (MFMC) does not collaborate with Catholic AIDS action.

In the existing conventional model the sender (media officers) uses conventional, teacher-centred approaches without dialogue and democracy in decision-making. Chanda et al. (2008) also found out that mass media campaigns are adult-controlled with no youth's involvement in construction and delivery of messages.

Traditionally, mass media campaigns rely on mass communication (such as public service announcements on billboards, radio and television) and educational messages in printed materials (such as pamphlets and posters) to deliver messages. The existing model's underlying assumption is that the information given will influence people to change their attitudes and behaviour. But Rogers (1995) argues in his Diffusion of Information Theory that people only learn when they perceive the dangers of HIV/AIDS and their vulnerability to it.

Receivers (youths) in this study according to the existing model are seen as passive listeners, who receive information and are expected to change their sexual behaviour. Freire (1985) argues in his Empowerment Theory that no learning take place when one is forced to learn. He further narrates that young people learn when there is democracy and dialogue in their communication-learning environment. The study findings revealed that youths do have adequate knowledge on HIV/AIDS prevention from mass media campaigns, but with little perception on HIV risky behaviour and how to facilitate social behavioural change (Iipinge et al., 2004).

In the existing model owing to its non-interactive approaches, has no feedback or dialogue between the sender and the receiver. This is a challenge to the existing model that needs to be modified to the proposed model which promotes dialogue and interaction among stakeholders (Schiavo, 2007).

3.8 Summary

The chapter discusses four theoretical frameworks in relation to mass communication campaigns and their application to learning and behaviour change. Two theories and two models provide the base of this study. Social Cognitive Learning, Communication/Diffusion of Innovations, Participatory /Empowering and Health Belief Model have their own theoretical perspectives that describe what learning is and how it takes place with the aim to effect individual and social change.

The Social Cognitive Learning Theory (Bandura, 1977) concludes that learning is a continuous information-sharing process. It takes place when youths integrate (not by mere modelling or imitating others) information with attitudinal change through its guiding principles of modelling/imitation and self-efficacy. A reciprocal interactive process is vital between the receiver (youths) and provider of information (campaign officers). The theory maintains that youths learn and change behaviour when they have knowledge and understand issues affecting their own lives. Therefore, this theory states that human behaviour is conditional. This means that youths do not learn through persuasion or mere provision of information. The theory emphasises that youths need to be critical thinkers and self-directed individuals interacting with providers of information in the communication-learning environment to be able to learn, change and prevent HIV infection (Burns & Grove, 2001).

Diffusion of Innovation Theory (Rogers, 1995) also concludes that learning is a cyclical process where youths are learning through modelling and reciprocal interactions. It further states that youths' learning is influenced by their social, environmental and cultural determinants. Youths as adopters are influenced (positively or negatively) by opinion leaders and peer educators in their communities. This means that youths learn from their role models (peer educators and opinion leaders) in an interactive manner through the networking approach to bridge the existing gap between the senders as experts and passive receivers of information during awareness media campaigns. If there is no reciprocal interaction, between media campaign officers and communities in the Oshana Region, then no desired outcomes (prevention of HIV/AIDS and the reduction of HIV/AIDS prevalence rate) will be achieved.

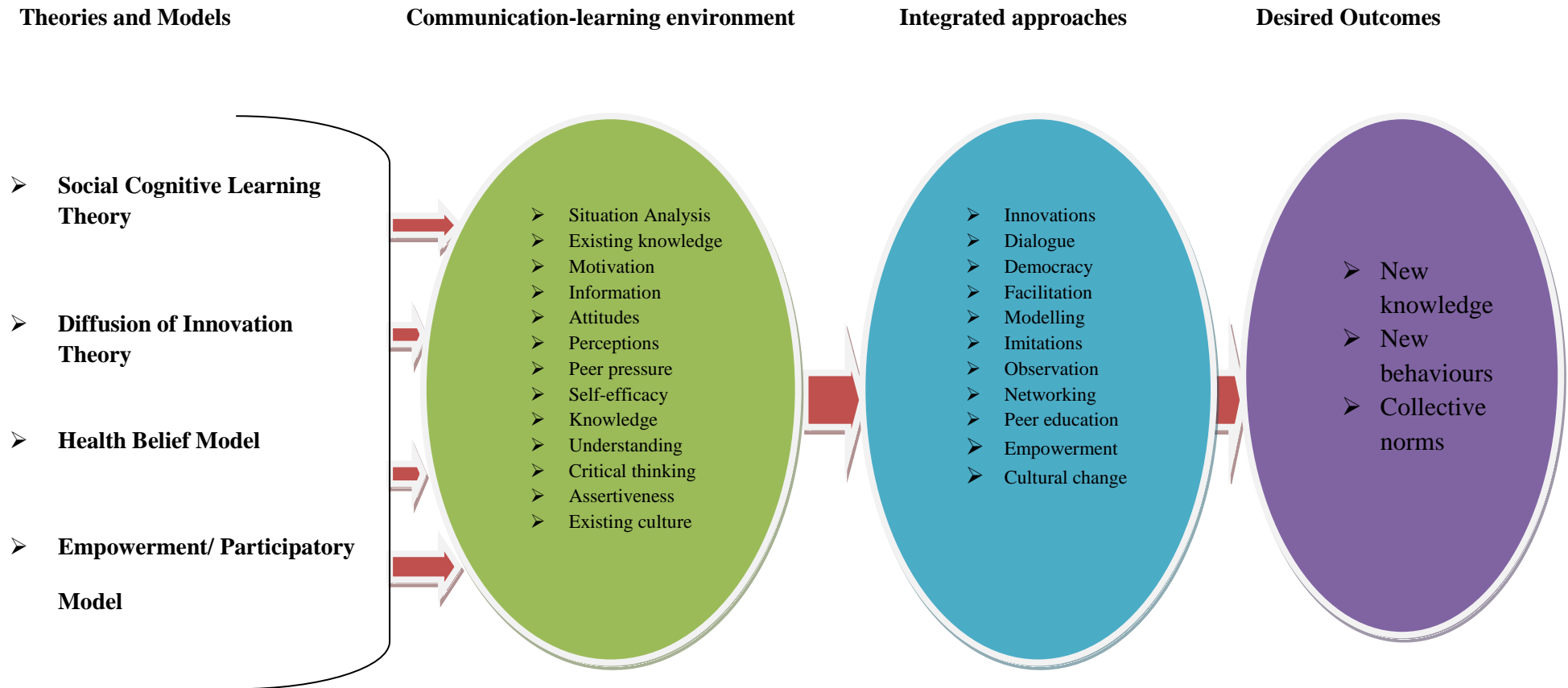
Further, the HBM emphasises the promotion of actions to change in lifestyle and sexual behaviours and the importance of individual personal beliefs and practices. In this model, perception (means to believe in oneself) is an important domain of learning. Therefore, youths need to perceive their vulnerability to HIV infection and the severity of HIV/AIDS in their communities. They should also have a strong personal belief in the HIV/AIDS prevention strategies for example that condoms are protective against infections. The HBM implies that youths should be aware of barriers (their attitudes towards condom use, myths, cultural and religious norms, peer pressure) that can impinge on preventive actions. Therefore, youths need to implement strategies such as peer educators (use examples of youths who are HIV positive as real life examples) in their education campaigns for learning and behaviour change to take place.

The theory also emphasises individualistic approach against collective actions as the guiding principle in many African cultures. Therefore, this study focuses on the significance of participation and collective actions in Oshana Region during HIV/AIDS awareness campaigns. It is further elaborated that the youth need to have self-confidence, be self-directed, have self-esteem, think critically, understand and behave with enthusiasm towards practising HIV/AIDS prevention strategies. If this is not done, no preventive behaviour will take place. But if youths have self-efficacy coupled with knowledge and understanding, they will comply with the health beliefs and they will learn and change behaviours (Andersen et al., 2001; Best, 2003).

Freire's empowerment/Participatory Model (Freire, 1985) also concludes that learning is a dialogical process of conscientization (self-awareness). In this process community analysis is necessary to identify root causes and set priorities. Currently mass media campaigns officers are instructing and telling youths (audience) what their problems are and what they should do. But according to Freire's theory youths should identify their own problems, needs and find solutions in collaboration with media campaign officers as a team.

The Empowerment model emphasises that youths need to be liberated to participate actively as critical thinkers and practise a reciprocal dialogue coupled with understanding, democracy, assertiveness and facilitation. If there is no interaction in the dialogical process, then neither learning nor behavioural change will take place in that community.

Figure 3. 1: The Theoretical framework shows its pathways to desired outcomes



Therefore, all theories and models discussed in this chapter envisage that information (message) needs to be disseminated in a dialogical process through media channels (radio, television and printed materials), to a large number of individuals or audience, within a specific period of time and with an organised set of communication activities in a good environment through a reciprocal interactive approach.

The conventional model currently used in Oshana Region is not appropriate for learning and behaviour change, because of its non-interactive approach. The model lack dialogue and participation among its stakeholders. Therefore, the conventional model does not influence youths to perceive the dangers of HIV/AIDS. Literatures also conclude that youths in this communication-learning environment lack proper knowledge, understanding and empowerment skills to be able to make informed decisions over their lives.

The research questionnaire in this study was formulated in a way that questions in section two, three and four addresses specific aspects of youths' knowledge, understanding, self-efficacy, perceptions, exposure to mass media messages and how it influencing their lifestyle and sexual behaviours. These aspects influence youths as receivers of information in the information-sharing communication-learning environment in which youths' learning is rooted in their cultural, social and environmental determinants. All these aspects are illustrated in Figure 3.1 that highlighted the integration and application of theories and models of social behaviour change in the information-sharing awareness campaigns.

The theoretical perspectives confirmed that theories and models used in this study were designed to guide the implementation and evaluation of media campaigns with the aim to yield the expected outcomes. The aspects of life in Figure 3.1 is applicable to the situation of Oshana Region where people' existing knowledge, culture and holistic environment is being ignored during information awareness campaigns. This theoretical pathway is crucial for one to develop new collective norms and behaviours.

The chapter concludes that theories and models of social behaviour change are relevant to guide the implementation and evaluation of the HIV/AIDS prevention media campaigns in Oshana Region, northern Namibia. It is believed that implementers should act and follow the self-expressed theoretical pathways as illustrated in Figure 3.1 to achieve the desired outcomes.

CHAPTER 4

RESEARCH DESIGN AND METHODOLOGY

4.1 Introduction

This chapter presents the research design and data collection techniques used in this study on the perception of the youth on the impact of mass media campaigns in communicating information on HIV/AIDS prevention in Oshana Region.

4.2 Research design

According to Mouton (2001, p. 55) a research design may be defined as “a set of guidelines and instructions on how to reach the goal that a researcher set for the study or a detailed plan to be followed in addressing the research problem”. It is like a route planner or an overall plan for addressing a research question during data collection and analysis (Cohen, Manion, & Morrison, 2007).

The research design for this study is quantitative, descriptive, explorative and analytical in nature. A quantitative study assigns numerical values to the data collected. A descriptive study gives a detailed account of an event. Descriptive research is aimed at describing the characteristics of a population without generalising or testing statistical hypotheses (Suter, 2006, p. 310). Descriptive designs mostly use the survey method. An analytical study analyses or answers all queries related to the condition under study (Babbie & Mouton, 2009).

An exploratory study explores and reveals unknown issues related to the conditions under study. The selection of the research design depends on the type of the research problem, questions to be addressed, overall objectives of the study and the type of the data/information needed. This study aims to get information and give a detailed account of the perceived impact of mass media campaigns in communicating information on HIV/AIDS prevention to the ISY and OOSY in Oshana Region (Cohen et al., 2007, p. 506 – 512; Polit & Hungler, 1999).

4.3 Research method

A research method is defined as “a strategy for gathering and analysing data in a research investigation”, whereas the methodology “is the underlying theory and analysis of how research should proceed” (Polit & Hungler, 1999, p. 707). A survey research is the selected method for this study. A survey was conducted using questionnaires as a data collection method to gather information about the study. The survey was conducted among the youth (ISY and OOSY) to gather their knowledge, views, behaviours, attitudes and preferences and youths’ perceptions on mass media campaigns and their perceived impact when disseminating information on HIV/AIDS prevention in Oshana Region (Graziano & Raulin, 2004).

A survey is “non-experimental research that focuses on obtaining information regarding the status quo of some situation, often via direct questioning of a sample of respondents” (Babbie & Mouton, 2009, p. 232).

The aim of the survey approach in this study was also to give a detailed description of the activities of the media campaigns. The researcher was interested in understanding why HIV/AIDS was increasing at a high rate, and why people, including youths, find it difficult to change their sexual behaviours. The survey research provides a quantitative or numeric description of trends, attitudes or opinions of a population by studying a sample of the population (Creswell, 2008).

Case (2002) notes that survey research can make use of variety of question types and techniques such as dichotomous and close-ended to demonstrate the opinions and perceptions of the respondents. The perceived impact of information disseminated to youths through mass media was also assessed as part of this study (Cohen et al., 2007; De Vos et al., 2005; Groves, Fowler, Couper, Lepkowski, Singer & Tourangeau, 2004; Mouton, 2001).

The survey method has many advantages such as being useful for the discovery of new insights, it is cheap to conduct and can be applied to many people. Survey research, on the other hand also has disadvantages such as being very difficult to probe insights relating to the causes of the problem and designing questions that will be at least minimally appropriate to all respondents and a researcher may miss questions most appropriate to many respondents. It is also not possible for survey to allow respondents to express themselves and the questionnaires cannot easily capture the complexity of information needed (Babbie & Mouton, 2009).

4.4 Study population

Population is a term that sets boundaries to the unit under study. It is defined as an ‘entire set of individuals in the universe who possess specific/common characteristics’ (De Vos et al., 2005, p. 193). Babbie and Mouton (2009) cite that a population is any group that shares a set of common traits. The study population for this study includes ISY and OOSY in Oshana Region and this is the group the researcher selected as the representative sample. According to MoHSS & Macro (2008) the NDHS did not indicate the precise number of youths as ISY and OOSY and this is a challenge in the literature review. Youths in this study were ISY and OOSY. ISY aged 12 - 30 years, doing grade 10 or 11 or 12 and studying at Combined or Secondary Schools in Oshana Region. A total of 7498 learners were in grade 10/11/12 in the Oshana region in all four circuits during the data collection period in 2006 (Groves et al., 2004; Polit & Hungler, 1999; Babbie & Mouton, 2009)).

OOSY were of the same age and in the same geographical area as ISY. OOSY who have completed grade 10/11/ 12 answered the questions. These youths (OOSY) were members of the Youth Organisations in Oshana Region in 2006. Youth organisations identified were Namibia Youth Enterprises Fighting Against Unemployment (NYEFU) recently renamed as Speed Bike; My Future is My Choice (MFMC); Oshana Youth League; Oshana Youth Forum; People’ Health Project; Youth 2000, Youth Against Crime and Tulongeni Projects. OOSY in any other youth organisations, religious and/or educational in nature, available in the region during the study period were also included in the study population.

OOSY who did not belong to any youth groups were presumably excluded from the sample and this could have introduced systematic bias in the study.

The precise number of OOSY could not be recorded since that youth organisations could not give specific number of their members. Cohen et al (2007, p. 110) state that the main challenge with the random sampling is that a complete list of the population is needed and this is not always readily available and sampling error may occur. All these young people were selected because they have attributes that represent the young population in Namibia. Babbie and Mouton (2009) further state that survey is generally economical in time, money and efforts to get the desired information (data) from only the sample rather than the whole population.

4.5 Selection of the study sample

4.5.1 Sampling method

The sample in this study was selected using probability sampling (each unit has an equal chance of being selected as the study sample), simple random and stratified sampling methods. Sampling is “a process of selecting a portion of the population to represent the entire population” (Polit & Hungler, 1999, p. 279). A sample, according to Polit and Hungler (1999, p. 279), is “a subset or portion of a population selected to be studied in a research study”. A sample is composed of elements containing the most representative or typical attributes/characteristics of the population (Babbie & Mouton, 2009). A study sample was selected because of limited time and resources to cover the whole study population (Cohen et. al., 2007, p. 110).

Simple random sampling means that each member of the population under study has an equal chance to be selected as part of a sample. It involves the selection of a sample from the list of the population, namely the sampling frame (Groves et al., 2004; Cohen et al., 2007). In this survey research, simple random sampling is the most basic form of probability sampling that was used to select ISY and OOSY from the sample frame. A random sample provides assurance against misleading results through their ability to specify that the sample findings do not differ by more than a certain amount from true population values (Johnson & Christensen, 2008).

Stratified sampling is formed by identifying subgroups with certain characteristics in the population. It involves a sample selected from the homogeneous subsets of that group. The stratification is organising the population into homogeneous subsets by gender (males and females), by seniority (senior and junior secondary and combined schools) and by geographical location per circuits (rural or urban areas). This is how schools and youths were selected (Gall, Gall & Borg, 2007; Babbie & Mouton, 2009).

Combined schools are schools with learners as from grade one to ten whereas secondary schools have learners as from grade eight to twelve, according to the Namibian education system. Simple random and stratified samplings both ensure a degree of representative-decreasing probable sampling errors. Again, homogeneous population used in this study produces samples with smaller sampling errors than does a heterogeneous population. Stratified is used when measuring the degree of agreement or disagreement in research questions (De Vos et al., 2005).

A probability sample also provides a guarantee that enough youths were selected from each youth group to provide an estimate for the stratum (Babbie & Mouton, 2009). Therefore, Johnson and Christensen (2008, p. 241) state that the more homogenous the population, the smaller the sample size can be. Random sampling is also useful in randomisation, categorisation, analytical and inferential statistics (Cohen et al., 2007; Robson, 2002).

4.5.2 Composition of the sample

A sample of eight hundred and twenty five (825) ISY and ninety five (95) OOSY answered the questionnaires. The ISY were selected from combined and secondary schools, whilst OOSY were selected from youth organisations in Oshana Region. Again OOSY were few in number in comparison with ISY since some OOSY had migrated to other towns/areas in the country looking for employment. Respondents were randomly selected. Every learner in the school in Oshana Region had an equal chance of being selected and taking part in the study. Similarly youths in the youth organisations in the same region were also randomly selected and used as a study sample (De Vos et al., 2005; Graziano & Raulin, 2004).

The study sample includes respondents (youths) who met the following selection criteria.

- A youth or scholar aged between 12 - 30 years old.
- An ISY schooling in Oshana Region
- An OOSY who is member of a youth organisation in Oshana Region

The researcher did not know the total number of all secondary and combined schools in the region; therefore, the list of all these schools was requested and obtained from the Regional office of the Ministry of Education in Oshana Region. There are four school circuits in Oshana Region, namely Eheke, Oluno, Onamutai and Oshakati. Schools were stratified (grouped and selected) as discussed earlier in this chapter under section 4.5.1 according to whether they were combined or junior or senior secondary schools. All schools were selected from these four school circuits.

Five secondary schools in Oshakati, Ongwediva and Ondangwa towns (the tripartite cities in Oshana Region) within the specified circuits in Oshana Region, namely Gabriel Taapopi, Mweshipandeka, Andimba Toivo ya Toivo, Oshakati and Iipumbu, were included in the study sample. All senior secondary schools were grouped and selected by seniority. These schools are the only senior secondary schools with grade twelve (12) in the region; therefore this is a probability sampling bias (Cohen et al., 2007).

Combined and junior secondary schools were also stratified, grouped and selected randomly as junior or combined schools. Combined and junior secondary schools were selected first from circuits and secondly according to their geographical location (circuit) and site, namely rural or urban (Robson, 2002). Two boxes were used and marked, one rural and the other urban. The names of schools were written on papers, folded and put into boxes, mixed and two names were taken at random per box.

A sample of four junior secondary schools, namely Ntuli, Uunona, Olukolo and Nangolo, was randomly selected per circuit in each box. Therefore, two junior secondary schools (Olukolo and Nangolo) were selected representing urban area schools and Ntuli and Uunona, representing schools in rural areas. Twenty-six combined schools were randomly selected as a sample. The following combined schools were selected from each circuit, in Oluno (Ambili, Etambo, Okashandja, Olulongo and Uukwiyushona), Onamutai (Elago, Eloolo, Indangungu, Ohakwenyanga, Oikango, Omashekediva, Omupanda, Omusheshe and Onamutai), Oshakati (Amutanga, Iiviyongo, Nakele, Ondjondjo, Ongwediva and Uukwiyoongwe) and Eheke (Kapembe, Kapolo, Onakamwandi, Ondjora, Ondiamande and Oshipumbu) circuits. Almost all circuits cover more than one constituency. More combined schools were selected in some circuits than the others because of the proportion of schools available in some circuits (Oshakati and Onamutai). Combined schools were also stratified (rural and urban) and randomly selected.

A total sample of twenty youths/learners per grade was randomly selected in each school. The sample consists of boys and girls who were stratified (by gender) and randomly selected from each grade, ten to twelve, in all secondary schools. For example, ten boys from grade ten and ten girls from the same grade were selected at random. In total in this study, twenty youths were selected per school and youth organisation, respectively. At Uukwiyoongwe combined school the researcher found eleven learners only in grade ten.

At each school learners' names were written by the researcher on piece of paper which were folded and placed into two boxes. These boxes were mixed and then names of learners/youths selected at random. One box had the names of boys and the other box had the names of girls. A learner from grade eight or seven, who was not part of the selected grades, helped the researcher to pick ten names from each box at random.

The researcher was assisted by school principals of the selected schools and the youth supervisor at Oshakati Multipurpose Youth Centre to organise youths to answer questionnaires. OOSY were also randomly selected. The same procedure of simple random and stratified sampling selection was implemented.

In summary, the study sample included the following subgroups:

- Respondents (ISY) who were Grades 10, 11 and 12 learners at combined and secondary schools in Oshana Region.
- Respondents (OOSY) who were members of the youth organisations in Oshana Region.

4.6 Research instruments

A self-administered questionnaire was used as a data collection instrument to collect information on mass media usage from the receivers' point of view. De Vos et al. (2005, p. 169) define questionnaires as "a set of questions on a paper which is completed by the respondents or self report data in respect of a research study".

Babbie and Mouton (2008), on the other hand, describe a questionnaire as a document containing questions designed to solicit information appropriate for analysis.

According to Cohen et al. (2007) questionnaires are required to be short, simple, clear and quick to complete. However, questionnaires have challenges where questions can be too simple to obtain the required information (answer research questions) or require extensive knowledge of the issues under investigation (research objectives). It is further elaborated that questionnaires are data collection instruments that reflects strength of attitudes, views, perceptions and opinions (Robson, 2002).

In this study, data were collected through a structured questionnaires made up of scaled, open/closed-ended and “yes” or “no” questions (dichotomous questions). Both open-ended and close-ended questions were used. Close and dichotomous questions were used to obtain straightforward answers (Johnson & Christensen, 2008).

Closed-ended questions are easy to use and they give the respondents a chance of choosing from two or more limited number of responses. The main disadvantage of open-ended questions is that they create forced choices and rule out the possibility of unexpected responses by respondents (Oppenheim, 2008).

The Likert scale is the most scale which was used in this study to measure attitudes, opinions, views and belief of youths towards HIV/AIDS prevention. The most common scale is 1 to 5. The Likert scaling approach was widely used in the design of questionnaires.

Youths were asked to indicate that they agreed, disagreed, or not sure or had no opinion towards HIV/AIDS prevention statements. Some of the questions asked in this study were mainly aiming for individuals to show their levels of agreement and disagreement (Oppenheim, 2008).

Rating scales normally are used in research in order to determine frequencies and correlation relationships and other form of qualitative research. Rating scales also allow degrees /intense of response. HIV/AIDS is an intense emotional subject (Cohen et al., 2007) as explained in the literature review (Chapter Two). In this study a four point scale was widely used in the questionnaires (Creswell, 2008; Oppenheim, 2008).

Open-ended questions are usually employed in exploratory research. They provide a frame for respondents to answer without any restrictions or limited preset of categories. Open-ended questions are appropriate for respondents to air their views, perceptions and beliefs. For instance, in case of seeking information towards HIV/AIDS prevention campaigns (Babbie & Mouton, 2009).

In general, a questionnaire was chosen to provide more information about mass media campaign messages and how they influence the sexual behaviours of the youth (see Appendix 7). Literature (as described in Chapter Two) in collaboration with theories and models (in Chapter Three) for social behaviour change indicate that knowledge and understanding is vital to ensure learning/change and collective actions.

Therefore, in this study a questionnaire was used with various types of questions to respond to research questions. A questionnaire was selected because it covers a large group of the population, with less time and offers the possibility of complete anonymity (Graziano & Raulin, 2004; Groves et al., 2004; Oppenheim, 2008).

Questions were divided into four sections.

Section One covers respondents' background information with the aim of collecting biographical data on respondents such as age, gender, levels of education, home language, residential location and reading ability.

Section Two seeks data on HIV/AIDS background knowledge, attitudes, perceptions and beliefs of both ISY and OOSY. It aims to determine the level of knowledge and understanding of respondents towards HIV/AIDS prevention.

Section Three covers data on youths' sexuality and self-efficacy. It aims to explore youth sexuality and their levels of self-efficacy.

Section Four covers mass media campaigns and youths exposure to mass media messages. It aims to explore the perceived impact of mass media campaigns on youths and how it influences and empowers young people on HIV/AIDS prevention (De Vos et al., 2005).

4.7 Validity and reliability in the survey research

A self-administered questionnaire was used in this study to gather research data from ISY and OOSY. The quality of the questionnaires was evaluated according to two standard measurement criteria for assessing the appropriateness of any measurement instrument namely validity and reliability.

According to Pilot and Hungler (1999, p. 419) validity is defined as “the degree to which the instrument measures what it is intended to measure”, whereas De Vos et al. (2005, p. 162) explained reliability as “the accuracy or precision of an instrument”. The research instrument test reliability when it produces the same results after a test or a researcher set an observation using the same instruments frequently and obtains the same data repeatedly (today and tomorrow). The research instrument should test the reliability and validity at the same time.

Validity in survey research refers to appropriateness of the interpretations, inferences and actions made from the study data (Johnson & Christensen, 2008). This means that the instrument is measuring what it intends to measure and not something else. Validity in the survey design consists of various types of validity that are content, construct, criterion and face validity (Gall et al., 2007). Content validity refers to the evaluation of consistency of the subject under study and how adequately questions sampled it.

The pretesting of research instrument was done to test the content validity. In this study instruments were pretested before the final survey was undertaken and all comments and corrections from the questionnaires were incorporated into the final research instruments. The same questionnaire was used in the main study to answer research questions and achieve the research objectives (Cohen et al., 2007).

Construct validity is based on the logical relationships among variables (Babbie & Mouton, 2009). This refers to theoretical expectations about the way the variables relate to each other. Construct validity ensured the use of concepts in theories and models of social behaviour change and the Centre for Disease Control Protocol and Prevention (as per WHO guidelines). To ensure content and construct validity the same questionnaire was used and answered by all study samples (Gall et al., 2007).

Validity and reliability of data was also ensured through the use of quantitative and explorative techniques in the data collection process, therefore, the questionnaires was used (Polit & Hungler, 1999; Graziano & Raulin, 2004). Research questions were designed in a way that they covered respondents' biographical information, issues on mass media campaigns and attitudinal items towards HIV/AIDS prevention. The issue of consistency, stability and accuracy of the research instruments were covered during its design. The content of the questionnaire was developed and validated during review of relevant literature where similar information had been solicited were closely consulted (Groves et al., 2004; De Vos et al., 2005; Johnson & Christensen, 2008; Babbie & Mouton, 2009).

4.8 Pilot study

In order to ensure validity and reliability, pretesting of research instruments was conducted prior to the final survey research commenced. Polit and Hungler (1999) elucidated that pretesting or pilot study (pilot study and pretesting were used interchangeably) as a trial run is done in preparation for the real study. The aim of pretesting is to assess if the questions are clear and can yield the required data. The trial run ensures the elimination of errors and ambiguities that ascertain the suitability of the research instruments. This means that the pretesting like pilot study is intended to help the researcher to refine the data collection plans with respect to both the content of the data and the procedure to be followed (Mouton, 2001; Robson, 2002; Graziano & Raulin, 2004).

The pretesting of the instrument was a very important step in the study in order to measure the content validity of the questionnaires. The sample of the pilot study was drawn from the OOSY in Omusati Region at the Youth Centre in Okahao. Twelve young people were interviewed, six males and six females. The researcher conducted each interview and wrote the answers on the questionnaires. The pretesting established that youths were not comfortable to respond to personal questions though interview. After the interviews, a group discussion was held with all youths as a group to seek their views on the instruments used and to determine whether the questions were clear and sought the relevant information (Cohen et al., 2007).

Several suggestions for improvements of the instrument were incorporated; for example, that young people should fill in the questionnaires themselves because respondents would be more open than when interviewed. Another challenge was the time allocated to complete questionnaires. The time allocation varied between 45 to 60 minutes. Youths were comfortable with English in the questionnaires (Cohen et al., 2007; De Vos et al., 2005).

4.9 Data collection process

Permission to do research in schools was requested and obtained from the office of the Permanent Secretary, Ministry of Education. The researcher wrote a letter to the Permanent Secretary, Ministry of Education, explaining the aims of the study and sought permission to conduct research in schools in Oshana Region (Appendix 2). A copy of the research proposal was sent to this office to provide more information about the study. After written permission had been obtained from the Permanent Secretary (Appendix 3), the researcher wrote another letter to the Regional Director of Education in Oshana Region to inform that office about the study and seek permission regionally (Appendix 4). The Regional office gave written permission and provided the researcher with a list of all schools in the region. After that, the researcher selected schools and provided the regional office with the list of selected schools for research (Appendix 5).

The Oshana Regional Director of Education, through the office of School Inspectors in all four circuits, informed school principals of all the selected schools about the study and data collection process. During the data collection process, the researcher at each school personally and orally asked for permission to conduct research at the school. School principals at each school gave verbal permission for research to be conducted at their respective schools and also on behalf of learners' parents. The researcher also wrote letters to the Managers of Youth Organisations in Oshana Region, seeking permission to conduct research in their organisations (Appendix 6).

Lastly, individual permission was requested and obtained from each individual youth, after the researcher had introduced herself to each respondent; explaining the purpose and significance of the study (Appendices 1 & 8).

After all the permissions had been obtained, data were collected through self-administered structured questionnaires.

Each questionnaire had a covering letter describing the research project and motivating the respondents to participate in the survey. The researcher read through all questions before the respondents answered questions and answered all queries related to the questions. Respondents were grouped in one classroom or hall to answer questionnaires as individuals, after the selection process was completed. The researcher was present at all schools and youth organisations waiting for respondents to complete the questionnaires.

Every day after data collection, the researcher went through all answered questionnaires, to check whether all the questions had been answered and required data had been entered. In case of any questionnaire that was not answered, the researcher went back to the school for a complete questionnaire.

4.10 Analysis and interpretation of data

In this study, data were gathered using questionnaires. All data in closed-ended questions were coded by giving each answer an alphanumeric value and entering it into the database (Chambers & Skinner, 2004). After the data had been entered into a database, it was then imported into the Statistical Package for Social Sciences (SPSS) Programme and analysed using that programme.

A lecturer in the Statistics Department, at the University of Namibia did the data processing. Descriptive and inferential statistics were used. Descriptive statistics were used to describe and synthesize data obtained from the survey. Inferential statistics were also used also to make inferences and draw conclusions about the population (Polit & Hungler, 1999).

Open-ended data were analysed using quasi-statistical approaches. Robin (2002, p. 458) states that qualitative data are analysed through various approaches such as quasi-statistical, template editing and immersion. The quasi-statistical approaches rely on the conversion of qualitative data into a quantitative format and covered under the heading of content analysis.

Content analysis is the process of summarising and reporting written data - content of data and their messages. It involves counting concepts, words or occurrences in documents and reporting them in tabular form. In this study open-ended questions were content analysed. The merging and recurring themes or topics were constructed into meaningful statements/responses (Cohen et al., 2007; Chambers & Skinner, 2004; Cohen et al., 2007).

4.11 Ethical measures

Ethical considerations were respected. Permissions/consents were obtained from all relevant stakeholders, for example, from the MoE and Youth Organisations to conduct research in their institutions. Individual respondents were requested to give their personal consent voluntarily (Appendix 1) (Graziano & Raulin, 2004). This means that respondents and site of research were respected according to the research ethics (Babbie & Mouton, 2009). The purpose of the study was also explained to individual respondents prior to the data collection. Respondents were free from physical and psychological pressure during the data collection process and were treated as individual beings. Respondents were free to stop the study if they felt uncomfortable or wished to withdraw without coercion or pressure. The information gathered was treated as confidential. Individuals remained anonymous since they were not expected to write their names or any information which could identify them on questionnaires (Robson, 2002; Graziano & Raulin, 2004; Groves et al., 2004; DeVos et al., 2005; Johnson & Christensen, 2008; Babbie & Mouton, 2009).

4.12 Summary

The research design for this study was quantitative, descriptive, explorative and analytical in nature. The study population were the ISY (grade 10, 11 and 12 learners from combined and secondary schools) and OOSY (youth who were members of youth organisations) in Oshana Region. Research by survey was conducted to gather data based on probability sampling approach, using simple random and stratified sampling methods. Permissions (written and oral) to conduct research in schools and youth organisations were requested and granted. Ethical aspects of research were adhered to during the data collection process. Data were collected using self-administered questionnaires. Respondents completed questionnaires as individuals to give their views and express their feelings on the impact of mass media campaigns and its messages on HIV/AIDS prevention in an environment free from physical and psychological pressure. The next chapter presents the analysis of the research data.

CHAPTER 5

DATA ANALYSIS AND PRESENTATION

5.1 Introduction

This chapter gives a presentation of results from the analysis of the data collected from ISY and OOSY in Oshana Region. A total of 920 respondents answered the questionnaires. A survey was conducted among the youth that aimed at exploring knowledge, views and perceptions about the impact of mass communication on HIV/AIDS prevention. The study also aimed to determine whether mass media campaigns and its health messages influence youths' knowledge, attitudes and behaviours towards HIV/AIDS prevention.

The chapter consists of two sections; section one presents ISY and OOSY data which give demographic information; youths' background knowledge and information on HIV/AIDS; youths' sexual activities and self-efficacy; media campaigns and youths' exposure to mass media messages. Section two presents data from both youth groups in response to open-ended questions.

5.2 Data from in-school (ISY) and out-of-school youth (OOSY)

5.2.1 Demographic information

A total of 825 ISY from schools and 95 OOSY from various youth organisations in Oshana Region participated in the study.

Youths were asked to indicate their age group, gender and places of residence. ISY, 54.2%, were in the age group 17-21years, followed by 43.6% in the age group 12-16 years, those between 22-25 years were 1.7%, and the smallest group was 26 years and older (0.5%). Fifty three percent of the ISY were females and 46.9% were males. ISY, 71.8%, lived in rural areas, while 23.1% lived in towns and 4.9% lived in peri-urban areas.

Data from OOSY indicated that 33.7% were in the age group 17 - 21 years; 32.6% were in the age group 22-25 years and 26.3% were 26 years and older. Females were 58.9% and 41.1% were males. OOSY, 45.7% lived in towns, 43.6% lived in rural and only 8.5% lived in peri-urban areas

Respondents were asked to indicate their mother tongue/language and the highest grade or qualification they had completed. The majority, 97.2% of the ISY and 82.1% of the OOSY, spoke Oshiwambo. Only 2.8% of the ISY spoke other languages. But OOSY spoke other languages such as Silozi (4.2%); Rukwangali (4.2%); English (2.1%); Herero (1.1% and languages not listed on the questionnaire. Portuguese was spoken by 6.3% youths in the region. These findings differ from ISY, because some OOSY lived in towns and spoke various local languages. The ISY' highest grade completed was grade 9 (63.7%), 22.8% had grade 10 and only 12.3% had grade 11. Table 5.1 indicates the grades completed and qualifications obtained by OOSY.

Table 5. 1: Highest grade/qualification completed by OOSY (N = 95)

Highest Grade / qualifications	Frequency	Percent %
Grade 9	13	13.7
Grade 10	27	28.4
Grade 12	35	36.8
Certificate	8	8.4
Diploma	8	8.4
No grade or qualifications	4	4.2
Total	95	99.9

Data in Table 5.1 indicates that some OOSY had obtained tertiary certificates and diplomas, with 28.3% had completed Grade Ten and 36.8% had Grade Twelve. In this study ISY had only received primary and secondary education.

Youths were also asked to state whether they could read and understand easily or with difficulty information related to HIV/AIDS prevention in newspapers, magazine, posters and other printed materials. The data indicated that the majority 86.5% of the ISY and 74.2% OOSY said they could easily read and understand information related to HIV/AIDS prevention. Only 10.9% of the ISY and 17.2% OOSY said they could read and understand information with difficulty, whereas 2.6% (ISY) and 8.6% (OOSY) could not read nor understand any information at all. This summarises that both youth groups are literate, they had basic reading and writing skills, but a small number had reading difficulty (they did not understand written information clearly).

5.2.2 Respondents' HIV/AIDS background knowledge and information

Respondents were asked whether they had heard about HIV/AIDS. The results revealed that of the youth, ISY (98.2%) and OOSY (88.4%) had heard of HIV/AIDS. Only 0.7% ISY and 11.6% OOSY respectively, had not heard of HIV/AIDS. Youth who had heard about HIV/AIDS were asked to state where they heard about HIV/AIDS for the first time.

Table 5. 2: Places where ISY and OOSY heard about HIV/AIDS for the first time

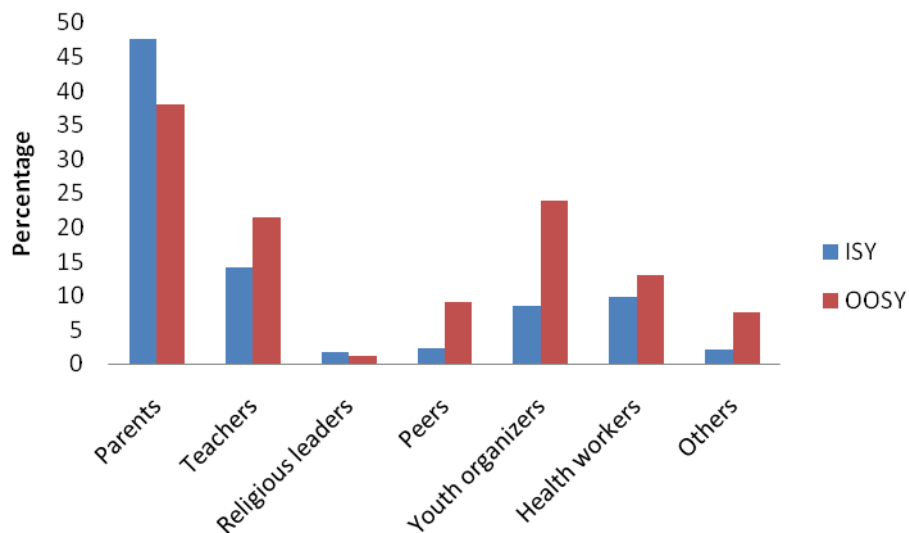
	ISY%	OOSY %
Home	24.2	19.1
School	23.8	22.3
Church	2.4	6.4
Media (radio, television, newspapers and other printed materials)	43.6	30.9
Youth organization	2.6	7.4
Health workers / facilities	2.2	3.2
Others	1.0	3.2
No response	0.1	7.4
Total	99.9	99.9

ISY (43.6%) and OOSY (30.9%) stated that they heard about HIV/AIDS for the first time from media sources, that is either radios or television or printed materials. ISY mentioned other sources where they obtained information about HIV/AIDS as home (24.2%), school, and church and health facilities.

OOSY also mentioned other sources such as home, school, youth organisation and church. OOSY (7.4%) (n = 7) did not respond to the question. This may have different meanings such as that OOSY did not have any information on HIV/AIDS prevention, therefore they could not respond to the question.

On the question as to who were the main sources of information for ISY and OOSY, both youth groups responded as indicated in Figure 5.1.

Figure 5. 1: ISY and OOSY pattern of hearing about HV/AIDS for the first time



Data in Figure 5.1 indicates that the most common source of information on HIV/AIDS mentioned by all (ISY- 47.6% and OOSY- 38%) youths were parents. The second most common source of information for ISY was teachers (21.4%), whereas the second source for OOSY was youth organisers (23.9%). Other sources mentioned by both youth were health workers (OOSY - 13%) and peers (ISY- 9%).

Thus both youth groups had heard about HIV/AIDS. But ISY (43.6%) and OOSY (30.9%) had heard about HIV/AIDS for the first time from parents and media (which are either radio or television or printed materials). This is an indication that both youth groups (ISY & OOSY) have access to information. In contrast, both youth groups heard about HIV/AIDS from their parents and according to literature in this study, sex is a taboo subject and some parents do not discuss sex issues with their children.

Respondents were also asked to measure their level of knowledge on the meaning of HIV and AIDS. Almost a half (49%) of the ISY perceived their level of knowledge on HIV/AIDS as being good, while 24.7% regarded their knowledge as excellent, 15.3% as average, 2.7% as poor, 1.6% as very poor and 2.3% did not know (could not rate themselves). OOSY (44.1%) perceived their level of knowledge on HIV/AIDS as good, only 21.5% regarded their knowledge as excellent, 8.6% as average, 3.2% as poor and very poor as 2.2%. But a total of 6.4% (OOSY) and 6.6% (ISY) indicated that they had inadequate knowledge and information on HIV/AIDS. This information echoed the data in Table 5.2; some youth did not respond maybe because they did not know or did not have any information on HIV/AIDS prevention.

Respondents were given a series of statements describing causes/mode of transmission and preventive measures of HIV/AIDS to indicate whether they agreed or disagreed.

Table 5. 3: OOSY responses to mode of transmission/causes of HIV/AIDS

	Agreed %	Disagreed %	Do not know %
Blood transfusion	62.7	14.5	22.9
Unprotected sex	77.1	6.0	16.9
Kissing each other	13.7	56.2	30.1
Direct contact with human discharges	43.4	18.4	38.2
Self-injection as drug users	52.7	14.9	32.4
Abstain from sex	83.0	3.4	13.6
Have faithful partner	74.1	11.1	14.8
Use condom	69.8	11.6	18.6
Make informed decision	61.0	12.2	26.8

Table 5. 4: ISY responses to mode of transmission/causes of HIV/AIDS

	Agreed %	Disagreed %	Do not know %
Blood transfusion	51.7	30.2	18.1
Unprotected sex	91.4	5.8	2.8
Kissing each other	12.4	73.8	13.7
Direct contact with human discharges	37.8	31.8	30.2
Self-injection as drug users	67.9	14.4	17.6
Abstain from sex	86.8	9.8	3.5
Have faithful partner	70.7	20.5	8.8
Use condom	80.5	15.8	3.5
Make informed decision	57.1	23.0	19.8

Tables 5.3 and 5.4 indicate that both youth groups, OOSY and ISY, know the causes, mode of transmission and preventive measures against HIV/AIDS, but some still lack adequate knowledge (no responses) on HIV/AIDS preventive measures.

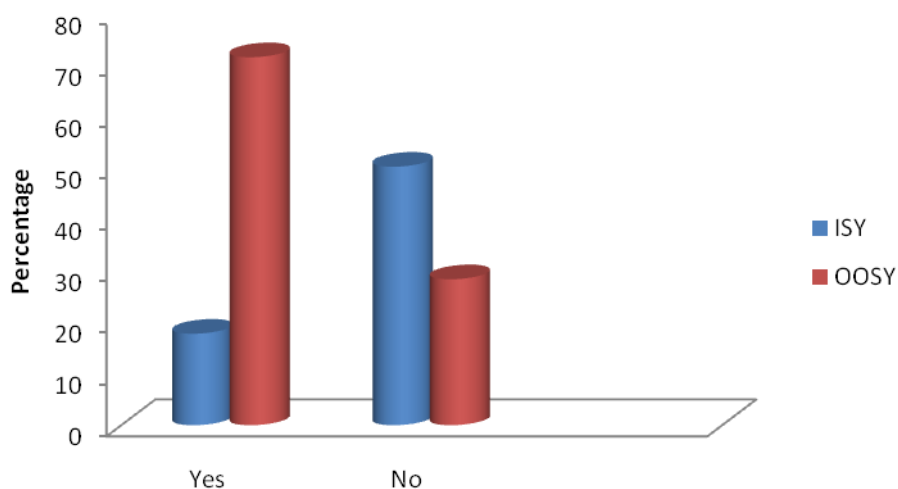
The data further revealed that many ISY and OOSY did not know that to make informed decisions (make constructive decisions) in life could prevent HIV/AIDS. But in terms of actual knowledge, almost all youth groups know at least three correct modes of transmission and at least three correct preventive measures for HIV/AIDS.

5.2.3 Sexual activity and self-efficacy of the youth

This section examines issues related to youths' sexuality such as sexual history, including the type of sexual partners, onset of sexuality, decision-making and self-efficacy/assertiveness skills.

Respondents were asked if they had sexual partners. Nearly two thirds (73.3%) of the ISY stated that they did not have sexual partners. In contrast more than a half, 71.6% of the OOSY and only 26.3% of the ISY confirmed that they had sexual partners. But, only 28.4% of OOSY did not have sexual partners during the surveyed period. However, 0.7% ISY did not respond to this question.

Figure 5. 2: ISY and OOSY with sexual partners



This data indicates that more OOSY had sexual partners than ISY.

A follow-up question was asked whether youths who had sexual partners had penetrative sex with their boyfriends/girl friends/partners. This question was asked because the fact that youths did not have sexual partners at the time of the survey did not mean that they had not had penetrative sex in their life.

Out of 215, 23.6% ISY who had sexual partners, 67.4% (n=145) had had penetrative sex with their partners and only 32.6% (n=70) had not had penetrative sex. Sixty eight OOSY who had sexual partners, 58.1% (n=54) had penetrative sex with their partners, and only 29% (n=27) had not had penetrative sex in their life. Those youths who had penetrative sex, were asked to state how old they were during their first penetrative sexual encounter.

Both youth groups, ISY (67.4%) and OOSY (79.4%) who had first penetrative sexual intercourse had it in the age group of 16 - 20 years.

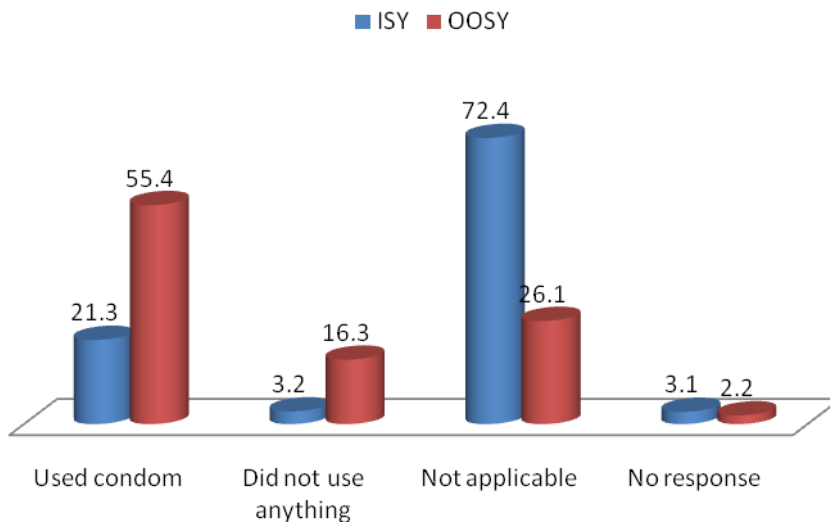
Youths were asked when last they had had penetrative sexual intercourse. Of the respondents (ISY) who had sexual penetrative intercourse during the surveyed period, 7.3% could not remember when last they had sexual encounters, whereas 7.1% had it years ago, 6.9% had it months ago, 3% had it weeks ago and the balance had it some days ago (2%). While the percentage of OOSY stated that those who had sexual penetrative encounters during the surveyed period had it years ago was 23.3%, some days ago these was 12.8%, months ago these was 11.6%, and weeks ago was 3.5%. But 20.9% (OOSY) could not remember when last they had sex.

Respondents who had sex were asked to state whether they had sex with their regular partners or another person (another person here refers to multiple partners). Of the ISY who had penetrative sex, 15.7% had it with their regular partners and only 4.8% had sex with other persons. Whereas, OOSY (56.5%) who had penetrative sex had it with their regular partners and only 13% had sex encounters with other persons.

However, youths who were sexually active and had sex with regular partners or other persons could contract STI's such as HIV infection and other venereal diseases.

Youths were asked to state whether they had used condoms during their last sexual encounters.

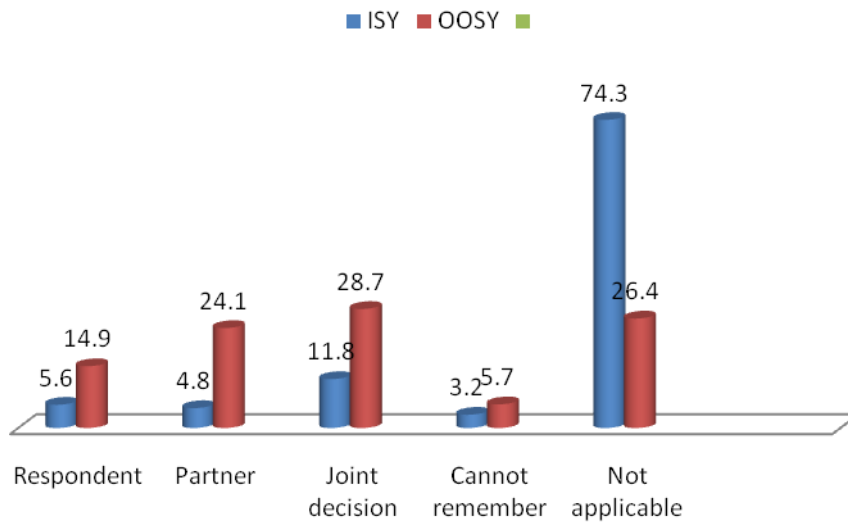
Figure 5.3: ISY and OOSY who used condoms during their previous sexual encounters



Data in Figure 5.3 indicates that more OOSY had used condoms than ISY. Youths, who had sex without using condoms, were prone to infection, including HIV infection and STI's. The youth who did not respond to this question (2.2% - OOSY and 3.1% - ISY), are also in dangers of the disease, because is vital to know why they did not respond. Both youth groups (ISY and OOSY) who had not had any sexual encounters stated that this question was not applicable to them.

Youth were asked several questions: if they had sexual partners, had penetrative sexual encounter, used condoms during their last sexual intercourse and who took the decision on condom use.

Figure 5. 4: ISY and OOSY who took decisions on condom use



Data in Figure 5.4 indicates both youth groups (ISY - 11.8% and OOSY – 28.7%) who took joint decisions on condom use during their previous sex encounters.

Table 5. 5: Gender cross tabulation of ISY, males and females who took decisions on condom use during their last sexual encounter (N= 226)

	Gender %		Percentage
	Females - 103	Males - 123	Total %
In-school youth (ISY)			
Respondents	8.4	11.5	19.9
Partner	9.3	7.8	17.1
Joint decision	18.5	23.4	41.9
Cannot remember	5.7	6.1	11.8
No response	3.9	5.3	9.2
Total	45.8	54.1	99.9

Table 5.5 indicates that males and females (ISY) took decisions on condom use during their previous sex encounters; male respondents (11.5%) and female partners (9.3%) were males. It can be seen from this figure that males were the most youth groups in decision making about condom use. In contrast, Table 5. 5 further indicate that females as respondents (8.4%) and partners of male youths (7.8%) were the only female youth groups who took decisions in their relationships. This means that females either hesitated to take decisions or were subordinated in their sexual relationships or dominated by their male partners.

Table 5. 6: Gender tabulation of OOSY (males and females) who took decisions on condom use during their last sexual encounter (N = 72)

Out-of-school youth (OOSY)	Gender %		Total %
	Females – 41	Males - 31	
Respondent	6.9	11.1	18.0
Partner	19.4	9.7	29.1
Joint decision	20.8	13.8	34.6
Cannot remember	5.5	1.3	6.8
No response	4.1	6.9	11.0
Total	56.7	42.8	99.5

Table 5.6 indicates that OOSY (male respondents -11.1% and their female partners - 19.4%) were all males (30.5%). Only 16.6% (female respondents - 6.9% and their male partners - 9.7%) were females who took decisions on condom use in their sexual relationships. This means that males were slightly dominating (30.5%) their female counterparts in making decisions on condom use.

Data in Figures 5.5 and 5.6 indicate ISY and OOSY who used condoms during their last sexual encounters.

Figure 5. 5: ISY who used condoms during their last sexual encounters

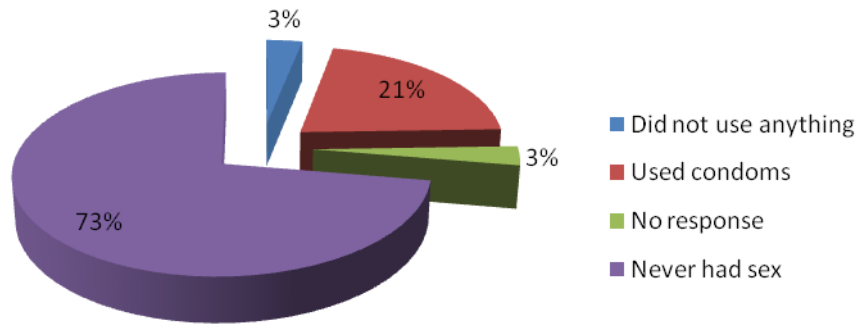
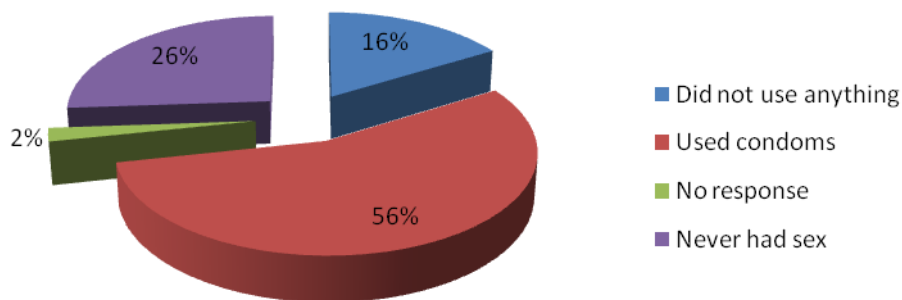


Figure 5. 6: OOSY who used condoms during their last sexual encounters



OOSY who had sexual encounter (54%) had used condoms that could prevent diseases such as HIV infection and STIs. Table 5.6 indicates that more OOSY (54%) used condoms than ISY (21%) in Table 5.4.

In contrast, slightly more OOSY (16%) than ISY (3%) had sexual encounter without using a condom. Again slightly more than a half (54%) of the OOSY and less than a quarter of (21%) of the ISY had used condoms during their last sexual encounter.

Youth were also asked to state the reasons why they did not use condoms. The reasons stated by ISY respondents who had not used condoms at the last sexual encounters was that no condom was available (4.9%), no agreement was made on condom use (4.4%) or it was difficult to negotiate condom use with the sexual partners (3.6%). It is worth noting that some respondents (5.6%) could not remember the reasons why they had not used condoms during their last sexual encounter, whereas 3.5% did not respond to the question.

Figure 5.7: ISY and OOSY reasons for not using condoms during their last sexual encounter

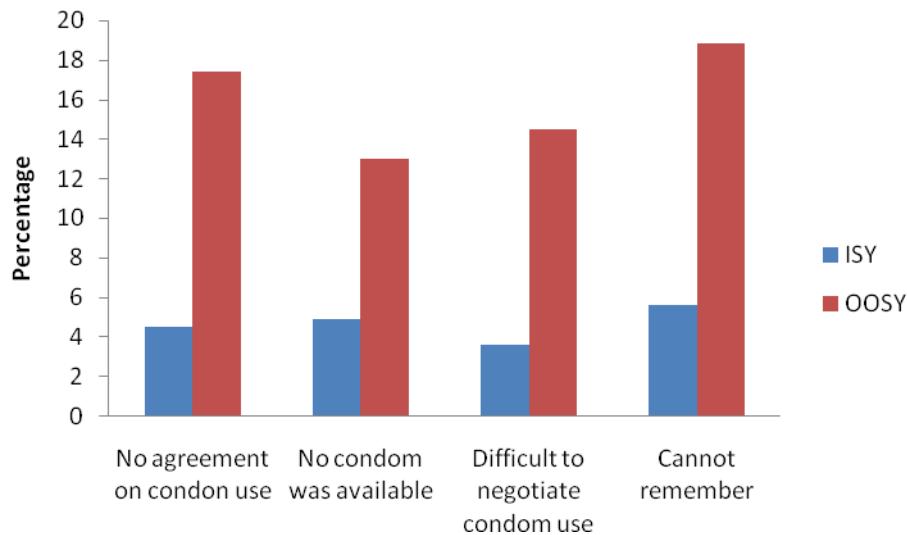


Figure 5.7 depicts various reasons why youths had not used condoms during their previous sex encounters.

All youth who had not used condoms during their last sexual encounter, stated three main reasons as indicated in Figure 5.7 (no condom was available, there was no agreement on condom use and it was difficult to negotiate condom use). Difficult to negotiate condom use refers to the process of initiating negotiations. No agreement on condom use refers to the end result of the negotiation process.

Respondents were also asked to state the most important reason why condoms should be used during sexual intercourse.

More than two thirds (76.5%) of the ISY said that condoms should be used during sexual intercourse to prevent diseases such as HIV infection and STI's, whereas the majority (80.6%) of the OOSY said that condoms should be used during sexual intercourse to prevent diseases such as HIV infection and STIs.

However, only 12.4% - ISY and 6.5% - OOSY, said that condom use could prevent unwanted pregnancies. ISY (2.8%) and OOSY (11.8%) said also that they did not know reasons why condoms should be used during sexual encounters. Some youths did not respond to this question probably because they did not know any answer to this question or were too embarrassed to answer.

Youth as respondents were also asked to state if they knew a place where condoms could be collected free of charge or where they could buy them.

The majority (82%) of the ISY knew where a person could get condoms in their respective areas and only 16.8% said they did not know and 6% did not respond to the question. More than a half (61.5%) of the respondents (ISY) stated that condoms could be collected free of charge from clinics, health facilities, public rest rooms, cuca shops and bars, but some ISY (37.9% and 81.3%) said that condoms were not available at clinics/health facilities, public restrooms /bars/ cuca shops. Again, the majority of ISY (92.1%) also said that condoms were not available free of charge at pharmacies.

The majority (86.7%) of the OOSY knew where a person could get condoms in their areas and only 13.3% did not know. More than a half (62.1%) of the OOSY stated that condoms could be collected free of charge from clinics and health facilities, 28.4% from public restrooms, bars and cuca shops and 18.9% from workplaces/offices.

Some OOSY (5.3%) did not respond to the question on the availability of condoms in their areas. Data further revealed that both youth groups knew where condoms could be collected free of charge (health facilities) or bought (pharmacies) in their areas.

On the question as to whether it was easy or difficult to get condoms in their areas, the majority (75.5%) of the OOSY and more than a half (68.1%) of the ISY said that it was easy to get condoms in their areas.

Only 18.6 % (ISY) and 14.9% (OOSY) of the respondents stated that it was difficult to get condoms in their areas and 12.7% - ISY and 9.6% - OOSY said that they did not know youths who knew where condoms could be collected indicated that they had knowledge on condom availability and accessibility in their areas. This knowledge is linked to HIV/AIDS prevention strategies.

Respondents were given a series of statements, on condom use and who should use them. They were also asked to indicate if they agreed or disagreed or had no opinion on those statements.

Youth expressed their perceptions or views on condom use as pointed out in Table 5.7. Table 5.7 indicates that ISY (74.1%) believe that condoms are the best protective measures against HIV/AIDS. ISY further indicated that they disagreed that women did not have the right to ask their partners to use condoms (77.7%), that only loose women/prostitutes ask their partners to use condoms (64.5%), women ask their boyfriends /fiancées to wear condom when they do not trust them (46.9%) and men should only use condom when they had sex with prostitutes or sex workers (68.2%). ISY disagreed or had no opinions on other statements as shown in Table 5.7.

Data revealed that ISY believe that condoms are the best protective measures against HIV infections. It is also indicated that ISY beliefs about sex and condoms varied as depicted in Table 5.7. Some ISY also indicated no response or had no opinion on this question.

Table 5. 7: Perceptions of the ISY on condom usage (N = 825)

	Agree %	Disagree %	No opinion %	No response
Condoms are the best protective measure against HIV/AIDS and other diseases	74.1	19.2	5.7	1.1
A woman does not have the right to ask her partner to use a condom	8.1	77.7	9.9	4.1
Only loose women or prostitutes ask their partner to use condoms	7.3	64.5	23.5	4.4
A woman asks a boyfriend/fiancée to wear a condom when she does not trust him	29.2	46.9	19.4	4.2
A man should only use condoms when he is having sex with a prostitute or sex worker	9.3	68.2	18.1	4.0

Table 5.8 gives the perceptions of OOSY on condom use. OOSY were also asked to state whether they agreed or disagreed or had no opinion on the given statements.

OOSY (65.3%), like ISY, believed that condoms are the best protective measures against HIV/AIDS. OOSY also disagreed that women did not have the right to ask their partners to use condoms (73.7%), only loose women or prostitutes ask their partners to use condoms (62.1%) and men should only use condoms during sexual encounter with a prostitute or sex worker (53.7%).

Table 5. 8: Perceptions of the OOSY on condom usage (N= 95)

Statements	Agree %	Disagree %	No opinion %	No response %
Condoms are the best protective measure against HIV/AIDS and other diseases	65.3	21.1	11.6	2.1
A woman does not have the right to ask her partner to use a condom	4.2	73.7	9.5	12.6
Only loose women or prostitutes ask their partner to use condoms	7.4	62.1	18.9	11.6
A woman asks a boyfriend/fiancée to wear a condom when she does not trust him	28.4	38.9	18.9	13.7
A man should only use condoms when he is having sex with a prostitute or sex worker	8.4	53.7	21.1	15.8

OOSY (38.9%) also disagreed that women ask boyfriends or fiancées to wear a condom when they do not trust them. OOSY also revealed that they did not have any opinion or were not sure with some given statements. This seems to be a sign of uncertainty on condom use among the OOSY (see Table 5.8). Both youth groups disagreed that if one trusts a partner then condoms should not be used.

Table 5. 9: Perceptions of OOSY males and females on condom use (N = 95)

Statements	OOSY %							
	Females (56)				Males (39)			
	Agree	Disagree	No opinion	No response	Agree	Disagree	No opinion	No response
Condoms are the best protective measure against HIV/AIDS and other diseases	41.1	10.8	4.5	1.0	23.5	10.7	7.3	1.0
A woman does not have the right to ask her partner to use a condom	2.9	36.7	5.6	7.6	1.9	35.0	5.2	5.0
Only loose women or prostitutes ask their partner to use condoms	5.3	26.1	12.6	5.0	3.0	33.0	8.8	6.6
A woman asks a boyfriend/fiancée to wear a condom when she does not trust him	16.0	18.0	12.0	4.0	11.0	20.4	10.0	7.7
A man should only use condoms when he is having sex with a prostitute or sex worker	4.5	33.3	12.6	9.0	5.5	24.6	12.3	6.9

A gender cross tabulation on OOSY perceptions on condom use indicates that both males and females youths agreed that condoms were the best protective measures against HIV/AIDS. Almost all OOSY males (36.7%) and females (35%) disagreed with the statement that women did not have the right to ask their male counterparts to use condoms.

In general youth of both sexes dismissed the idea that only loose women can ask partners to use condoms and women can ask partners to use condoms when they do not trust them. Again both sexes disagreed that men should only use condoms when they had sex with prostitutes or sex workers.

ISY were asked also to air their perceptions on condom use according to gender. ISY of both sexes also agreed that condoms are the best protective measures against HIV infection. ISY females (41.5%) and males (35.4%) disagreed with the statement that women do not have the right to ask their partners to use condoms.

In summary, both sexes of OOSY have information on condom use although some youths revealed their beliefs and opinions and uncertainty on condom use as it illustrated Tables 5.7, 5.8, 5.9 and 5.10. ISY, females and males, also indicated their disagreement with other statements. This data confirmed that most youth groups of both sexes have information on condom use and believe that condoms can protect and prevent HIV infection and STIs. ISY also indicated their uncertainty or no opinion or no response answers to some statements given.

Table 5. 10: Gender cross tabulation on perceptions of males and females ISY on condom use (N= 825)

Statements	Females % = 438				Males% = 387			
	Agree	Dis agree	No opinion	No response	Agree	Dis agree	No opinion	No response
Condoms are the best protective measure against HIV/AIDS and other diseases	43.2	9.6	4.6	0.0	30.7	9.8	1.2	1.0
A woman does not have the right to ask her partner to use a condom	3.7	41.5	4.3	2.1	4.8	35.4	6.1	2.0
Only loose women or prostitutes ask their partner to use condoms	2.6	37.2	11.7	2.3	5.0	25.8	13.3	2.1
A woman asks a boyfriend/fiancée to wear a condom when she does not trust him	12.6	25.6	11.5	2.2	17.4	19.2	8.8	2.0
A man should only use condoms when he is having sex with a prostitute or sex worker	2.7	36.6	10.9	0.0	6.9	30.5	7.9	1.0

Participants were given statements measuring their attitudes and self-efficacy skills as individuals in relation to condom use. For ease of understanding and interpretation of the significance of the results, the responses for “probably could” and “definitely could” are considered as “agreed” and “definitely could not” are considered as “disagreed” and the results of “not sure” and “no response” is considered as “do not know”. Results are shown in Table 5.11.

Table 5. 11: Attitudinal statements assessing self-efficacy skills of the ISY (n = 825)

Statements	Definitely could not %	Probably could %	Definitely could %	Not sure %	No response %
Could you force your partner to use a condom every time you have sexual intercourse even if she /he does not want to use it?	12.7	20.5	51.0	13.0	2.1
Could you refuse to have sexual intercourse with your partner if she /he does not want to use a condom but you wanted him or her to do so?	20.7	15.8	47.8	13.1	2.3
Could you refuse to have sexual intercourse with a person who wants to have sex with you without a condom but you do not want to do so?	30.2	14.5	41.0	10.9	2.9
Could you refuse to discuss with your partner the use of a condom every time you have sexual intercourse, even if she /he wants to use one?	42.9	17.0	23.3	13.8	2.8

Respondents indicated that 71.5% agreed (‘probably’ and ‘definitely could’) that they could force their partners to use condoms every time they would like to have sex.

Again, ISY (63.6%) indicated that they ‘could definitely refuse’ (agreed) to have sex if their partners (55.5% - agreed) did not want to use condoms. Only 42.9% of the respondents ‘could definitely not refuse’ (agreed) to discuss with their partners condom usage, whereas 40.3% of the youths agreed that they ‘could probably’ and ‘definitely refuse’ to discuss condom use with their partners every time they had sexual encounters.

ISY (51%) also agreed that they ‘could definitely’ force partners (means to pressurise a partner to agree on condom use) to use condoms every time they had sexual encounters. Only 23.3% could ‘definitely refuse’ to discuss issues related to condom use with partners. All these information suggests that ISY have high level of self-efficacy beliefs towards condom use. On the other hand data also indicated that some ISY did not either respond to questions or had no opinions on statements given. This seems to be that some ISY are uncertain on the issues under exploration.

OOSY were also given statements to assess their level of self-efficacy as shown in Table 5.12. OOSY were assessed whether they had self-efficacy beliefs toward condom use. For the sake of easy understanding and interpretation, the assessment was conducted as shown in Table 5.12. The ‘not sure’ and ‘no response’ answers were interpreted as “uncertainty” on condom use.

OOSY, like ISY, agreed ‘probably and definitely could’ that they could force their partners to use condoms (64.2%); they agreed that they could refuse to have unprotected sex (61%) and less than a half (37.9%) agreed that they could ‘probably and definitely could’ refuse to discuss condom use with their sexual partners. Only 33.7% OOSY said that they could not refuse ‘definitely could not’ discuss condom use with their partners.

Table 5.12 further revealed that 40% of the OOSY stated that they could “definitely” force their partners to use condoms every time they had sexual encounters.

Table 5. 12: Attitudinal statements assessing self-efficacy activities of the OOSY (N = 95)

Statements	Definitely could not %	Probably could %	Definitely could %	Not sure %	No response %
Could you force your partner to use condom every time you have sexual intercourse even if she /he does not want to use it?	13.7	24.2	40.0	17.9	4.2
Could you refuse to have sexual intercourse with your partner if she /he does not want to use a condom but you wanted him or her to use one?	14.7	20.0	41.1	17.9	6.3
Could you refuse to have sexual intercourse with a person who wants to have sex with you without a condom but you do not want to do so?	22.1	12.6	38.9	16.8	9.5
Could you refuse to discuss with your partner to use a condom, every time you have sexual intercourse, even if she /he wants to use one?	33.7	20.0	17.9	18.9	9.5

Some OOSY did not respond to the statements. It appears that some youths were uncertain on condom use and the given statements. Information in Tables 5.11 and 5.12 revealed that both youth groups (ISY & OOSY) had high levels of self-efficacy beliefs towards condoms use in relation to HIV/AIDS preventive behaviours.

Both youth groups were given statements to measure their way of solving problems and conflicts facing them on a daily basis. For ease of understanding and interpretation of the significance of the results, the responses for “somewhat true” and “exactly true” are considered as “agreed” and “not true at all” are considered as “disagreed” and the results of “do not know” and “no response” are considered as “no opinion or do not know”. Results are illustrated in Table 5.13.

Table 5. 13: ISY problem-solving and conflict resolution approaches (N = 825).

	Not true at all %	Somewhat true %	Exactly true %	Do not know %	No response
Can always manage to solve problems if I try to do it	14.7	22.5	52.0	8.1	2.4
Can always deal with unexpected situations / problems on my own	26.7	25.1	33.6	11.4	3.0
Can usually find solutions to problems through negotiation when I need to do it	8.1	17.8	60.0	10.9	2.8
Cannot solve problems or unexpected situations on my own	39.9	22.2	22.2	11.5	4.0
Cannot negotiate issues related to sex such as condom use with my partner / boyfriend / girlfriend	50.8	10.8	16.7	17.3	3.3
Can always discuss and understand issues related to my life such as condom use as a preventive measures against HIV/ AIDS	5.5	8.8	77.0	5.9	2.3

Data indicated that respondents (ISY) agreed ‘somewhat true’ and ‘exactly true’ that (22.5% + 52.0%) 74.5% could always manage to solve problems if they try; (25.1% + 33.6%) 58.7% could always deal with unexpected situations/problems on their own, (17.8% + 60.0%) 77.8% could find solutions to problems through negotiations and (8.8% + 77.0%) 85.8% could always discuss with partners and understand issues such as condom use as a preventive measure against HIV/AIDS. ISY (50.8%) agreed that they could negotiate issues ‘not true at all - disagreed’ that they could not negotiate issues related to sex and condom use. Other ISY who answered ‘no response’ and ‘do not know’ indicated that they did not have knowledge of problem-solving and conflict resolution approaches.

Table 5.13 illustrated also that 52% of ISY believe that it is “exactly true” that they could solve their own problems, 60% believe that they could find solutions to problems through negotiations and 77% could always discuss and understand issues affecting their lives such as condom use in their sexual relationships. A number of ISY could not solve problems on their own, because they either were not sure or did not know. This data revealed that ISY also had moderately high self-efficacy beliefs; therefore they could solve their problems through discussions and negotiations in their sexual relationships.

Table 5.14 indicates how OOSY could solve their problems and conflicts on a daily basis. OOSY were given the same statements as ISY to answer. The analysis and interpretation of data in Table 5.14 was conducted as with the information in Table 5.13.

Table 5. 14: OOSY ways of solving problems and conflict resolution (N = 95).

	Not true at all %	Somewhat true %	Exactly true %	Do not know %	No response %
Can always manage to solve problems if I try to do so	14.7	42.0	27.4	10.5	5.3
Can always deal with unexpected situations / problems on my own	18.9	27.4	29.5	12.6	11.6
Can usually find solutions to problems through negotiation when I need to do so	9.5	20.0	45.3	12.6	12.6
Cannot solve problems or unexpected situations on my own	22.1	23.2	27.4	15.8	11.6
Cannot negotiate issues related to sex such as condom use with my partner / boyfriend / girlfriend	38.9	11.6	24.2	16.8	8.4
Can always discuss and understand issues related to my life such as condom use as a preventive measures against HIV/ AIDS	5.3	6.3	58.9	22.1	7.4

More than two thirds of the OOSY (42.0% + 27.4% = 69.4%) said that they could solve problems; (27.4% + 29.4%) 56.9% could deal with unexpected situations whilst (20.0% + 45.3%) 65.3% could find solutions to problems through negotiations and (6.3% + 58.9%) 65.2% could always discuss and understand issues related to sex such as condom use with their sexual partners.

Only 38.9% of OOSY agreed that they could not negotiate issues ‘not true at all’ that ‘they could not negotiate issues’ related to sex with their partners.

A number of OOSY who answered ‘no response’ and ‘do not know’ indicated their uncertainty on problem-solving and conflict resolution approaches. Data revealed that some OOSY could solve their problems and unexpected situations through discussions and negotiations. This means that OOSY like ISY have moderately high levels of perceived self-efficacy beliefs towards condom use.

5.2.4. Media campaigns and youths’ exposure to mass media messages

This section describes issues on mass media campaigns, types of mass media, how often youths were listening to the radio, watching television and reading newspapers and other printed materials, received mass media spots/messages and their perceived impact of information on their sexual behaviours.

Youth were asked whether they had heard of a person who died of HIV/AIDS. Almost all (95.6%) ISY and the majority of the OOSY (83.7%) indicated that they had heard of a person who had died of HV/AIDS. Only 16.3% - OOSY and 3.8% - ISY had not heard of anybody who died of HIV/AIDS. Only 0.6% of ISY did not give any response to this question.

On the question of whether there were HIV/AIDS media campaign programmes /organisations in their areas, the majority of (79.6%) the ISY agreed that there were HIV/AIDS media campaigns in their areas, and only 19.8% said that they were not aware of any media campaigns programmes/organisations in their areas. While two thirds (70.7%) of OOSY agreed that there were HIV/AIDS media campaign organisations in their areas. Only 28.3% said that they were not aware of any media campaigns in their areas.

Radio listening

Respondents were asked if they listened to the radio. Most of the ISY and OOSY who were surveyed, responded that they had been listening to the radio (74.6% -ISY and 69.9% - OOSY) for the past three months.

Both youth groups were asked if they could remember receiving information from mass media campaigns through the radio on HIV/AIDS prevention over the last three months. Nearly three quarters (74.6%) of the ISY said that they remembered receiving information through the radio on HIV/AIDS prevention over the previous three months, while only 24.3% (ISY) said that they could not remember receiving any information through the radio. This means that most youths were listening to the radio and paying some attention to media campaigns messages. Over two thirds (69.9%) of the OOSY said that they remembering receiving information through the radio on HIV/AIDS prevention over the past three months, only 28.9% (OOSY) said they could not remember receiving any information from the radio. Some youths (OOSY - 1.2% and 1% - ISY) did not respond to the question.

Watching television

On the question of whether youth normally watched television, nearly two thirds (61.5%) of the ISY responded that they normally watched television, only 37.3% said they did not watch television.

Respondents were also asked if they could remember receiving information through NBC television on HIV/AIDS prevention campaigns over the past three months.

Slightly less than a half of the ISY (43.2%), who watched television, remembered receiving information through NBC television on HIV/AIDS prevention campaigns over the previous three months. However, less than a half (45.6% - ISY) said that they could not remember seeing any information on NBC television about HIV/AIDS prevention.

Sixty seven percent of the OOSY responded that they did not normally watch NBC television, and only 32.1% said they did not watch NBC television. OOSY were asked to state if they could remember receiving information through NBC television on HIV/AIDS prevention campaigns over the past three months. Over a half (61.3%) of the respondents (OOSY) who watched NBC television could remember receiving information through NBC television on HIV/AIDS prevention over the previous three months, and only 38.8% said that they could not remember seeing any information on NBC television.

Reading newspapers/magazine/posters and other printed materials

On the question of whether ISY normally read newspapers and other printed materials, youths agreed that they read newspapers, magazines and other printed materials with information on HIV/AIDS prevention. Further respondents were asked whether they could remember reading information in newspapers/magazine/posters and other printed materials on HIV/AIDS prevention campaigns over the past three months.

Two-thirds (64.5%) of the respondents (ISY) agreed that they could remember reading information in the newspapers and other printed materials on HIV/AIDS prevention over the previous three months, but 32.8% said that they could not.

OOSY were also asked to state whether they normally read newspapers, magazines and other printed materials. They agreed that they did read newspapers, magazines and other printed materials. In addition, OOSY were asked whether they could remember reading information in newspapers /magazines/posters and other printed materials on HIV/ AIDS prevention campaigns over the past three months. Over three quarters (80.7%) of the OOSY agreed that they could remember reading information in the newspapers and other printed materials on HIV/AIDS prevention over the previous three months, but 19.3% said they did not read any information on HIV/AIDS prevention.

Table 5.15 summarises both youth groups (ISY and OOSY) who were exposed to mass media messages through mass communication.

Table 5. 15: Youths who were listening to the radio, watching television and reading printed materials

		Radio %	Television %	Printed materials %
ISY	Yes	74.6	61.5	92.9
	No	24.3	37.3	6.5
OOSY	Yes	69.9	67.9	80.7
	No	28.9	32.1	19.3

Data indicated that youth of both groups (ISY and OOSY) received health information through the radio, NBC television and printed materials.

Education through mass media campaigns

Both youth groups were asked to air their views on whether mass media campaigns were succeeding in educating people (general public including the youth groups) in the region on HIV/AIDS prevention. The majority of the ISY (83.6%) and 74.7% of OOSY agreed that mass media campaigns were optimistically succeeding in educating people about HIV/AIDS, especially through giving information on the radio, NBC television, newspapers, posters, magazines and other printed materials. This is a mere statement from the youth and it needs further research to be validated.

Language use during mass media campaigns

Respondents were also asked to state the most common language used during mass media campaigns. ISY (59.1%) and 49.4% of the OOSY stated that English was the most common language used by many mass media campaigns to educate the public about HIV/AIDS prevention. Only 31.3% of the ISY and 47% of the OOSY identify use of the vernacular/local languages in the mass media campaigns programmes/health education programmes on HIV/AIDS prevention campaigns in their areas.

Radio spots/messages on HIV/AIDS prevention

Respondents were asked if they had heard any radio spots (short messages given through radios) or messages with regard to HIV/AIDS prevention in the previous three months and how often. Figure 5.8 indicates both youth groups who have heard radio spots/messages with regard to HIV/AIDS prevention in the last three months.

Figure 5. 8: ISY and OOSY who had heard radio spots/messages with regards to HIV/AIDS prevention in previous three months.

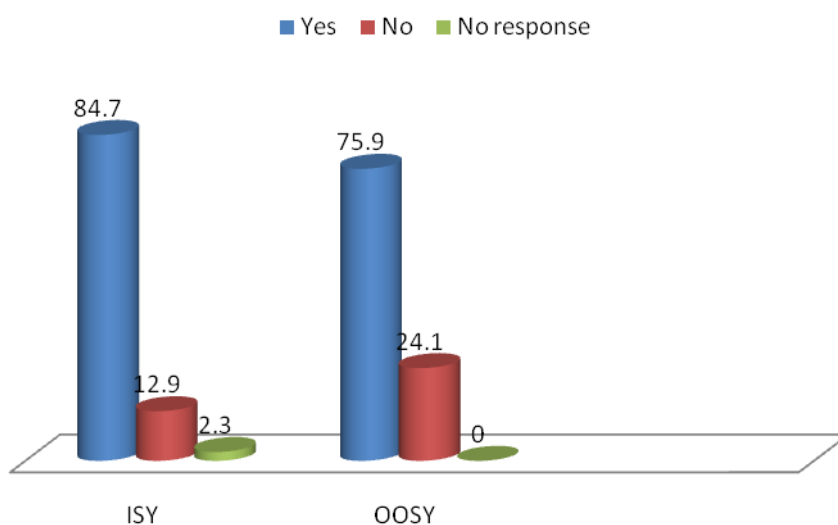


Table 5.16 indicates the responses of how often ISY and OOSY had heard HIV/AIDS prevention radio messages.

Table 5. 16: How many times ISY (N= 825) and OOSY (N = 95) heard radio spots/ messages during the last three months?

	OOSY %	ISY%
Every day	58.5	43.5
Once a week	24.4	35.5
Once a month	9.8	8.8
Never listen to radio	6.1	5.5
No response	1.2	6.4
Total	100%	99.7%

Data in Table 5.14 depicts that more OOSY (58.5%) listened to the radio daily than ISY (43.5%). However, slightly more ISY (35.5%) listened to the radio weekly than OOSY (24.4%). This data confirmed that youth of both groups had heard radio spots/messages with regards to HIV/AIDS in the previous three months.

Both youth groups were asked to state how often (how many hours a day) they listened to the radio. Less than a half (43.5%) of the respondents (ISY) said that they usually listened to the radio everyday an hour or more.

Table 5. 17: Time of the day ISY and OOSY usually listening to the radio

	ISY %		OOSY %	
	Yes	No	Yes	No
Mornings	11.4	88.6	43.2	56.8
Afternoon	42.1	57.9	17.9	82.1
Evenings	40.7	59.2	29.5	70.5
Cannot remember	7.2	92.7	10.5	89.5

OOSY (59.8%) said that they usually listened to NBC radio everyday for an hour or more. Data in Table 5.17 indicates that both youth groups listened to the radio both daily and weekly.

Youth were further asked to state which radio stations they usually listened to.

Data indicates that the public broadcaster (NBC) radio, Oshivambo service was identified as the most common (65.3% - ISY and 62.1% - OOSY) radio station listened to by youth of both groups. Other NBC radio local language services (3.2% - ISY and 10.5% - OOSY)) that were listened to were NBC national radio, radio Silozi and radio Rukwangali.

Table 5. 18: The radio stations listened by ISY and OOSY

	ISY %		OOSY %	
	Yes	No	Yes	No
NBC Oshiwambo radio	65.3	34.5	62.1	37.9
Omulunga radio	23.9	76.1	20.0	80.0
Radio energy	25.7	74.3	30.5	69.5
Other radio stations	3.2	96.8	10.5	89.5

Figure 5. 9: Radio stations listened mostly by ISY and OOSY in Oshana Region

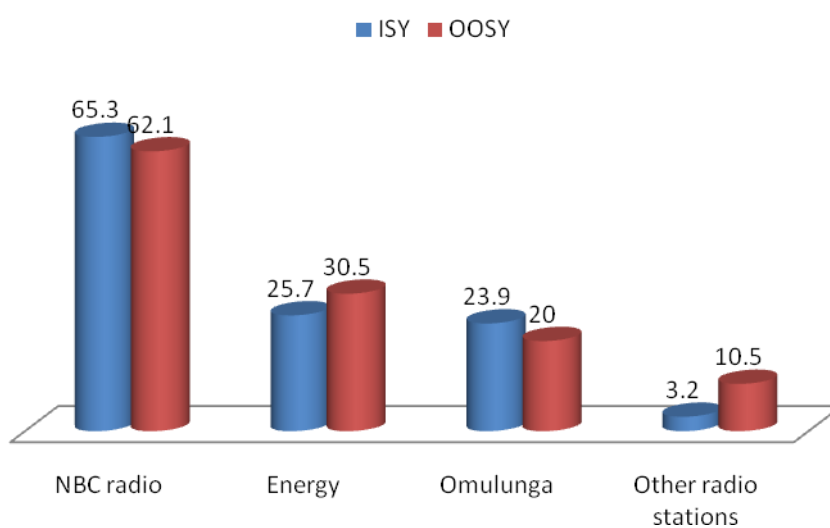


Figure 5.9 indicates that both youth groups identified NBC radio service as the most common radio station listened to among the youth in Oshana Region.

Television spots/messages on HIV/AIDS prevention

Both youth groups were asked to state whether they had seen NBC television spots/messages with regard to HIV/AIDS prevention in the past three months and how often they saw the messages. ISY (61.5%) and OOSY (67.9%) who watched television during the surveyed period said that they had seen NBC television spots/messages on HIV/AIDS prevention campaigns.

Figure 5.10 indicates that both youth groups (ISY and OOSY) received the NBC television spots/messages with regards to HIV/AIDS prevention in the previous three months in Oshana Region.

Figure 5. 10: ISY and OOSY who received NBC television spots/messages during the previous three months in percentages.

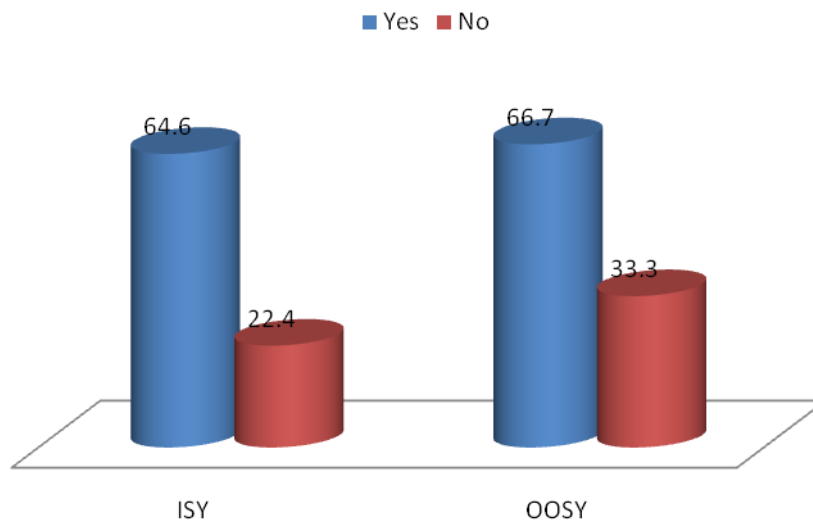


Table 5.19: Time frequency when ISY and OOSY have received NBC television spots/messages in the previous three months.

	ISY%	OOSY %
Number of days	23.6	24.7
Everyday	25.7	32.9
Once a week	21.3	27.1
Never watches TV	23.5	15.3
Not applicable	6.0	0

Table 5.19 shows youths who watched NBC television and received spots/messages in the previous three months in Oshana Region. Both youth groups (ISY and OOSY) watched NBC television. They watched it for an hour or more a day.

Reading newspapers spots/messages on HIV/AIDS prevention

Respondents were asked to state if they usually read newspapers/magazines and other printed materials.

Figure 5.11 indicates that both youth groups (ISY and OOSY) have read HIV/AIDS prevention spots/messages in the newspapers and other printed materials during the surveyed period, in Oshana Region.

Figure 5. 11: ISY and OOSY who read newspapers/other printed materials in Oshana Region

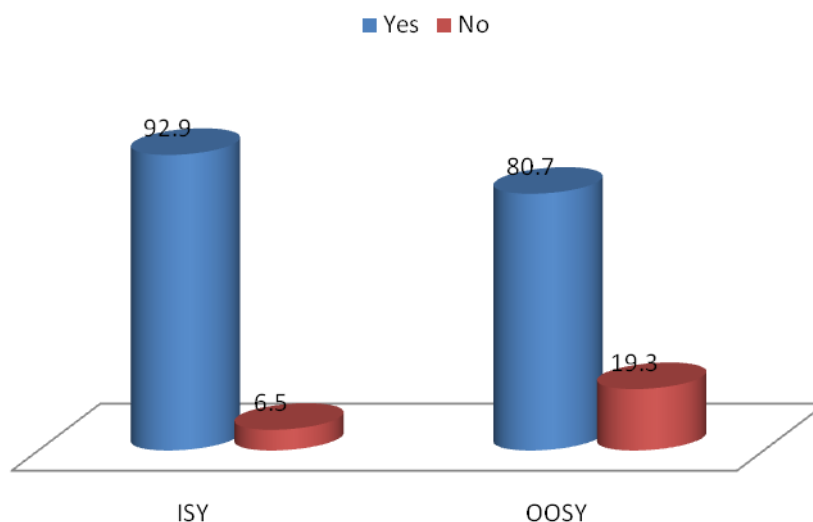


Table 5.20 indicates that both youth groups read printed materials weekly. This means that ISY and OOSY were exposed to mass media messages at least on a daily and weekly basis.

Table 5. 20: ISY and OOSY who had read spots/messages with regards to HIV/AIDS prevention during the previous three months

	ISY %	OOSY %
Almost every day	29.0	31.8
Once a week	50.4	42.4
Once a month	15.1	8.2
Not at all	3.7	12.9
Not applicable	1.7	4.7

Respondents were also given various statements and asked to indicate if they agreed or disagreed with them or did not know. The statements asked respondents to examine whether mass media campaign messages empowered youths to understand and make informed decisions on their lives.

Table 5.21 shows that the majority of the ISY agreed that mass media campaigns did disseminate information to the public that HIV/AIDS could be prevented if people had one sexual partner (83.2%), used condoms (87.4%) and abstained from sex (81.6%). Only less than a half of the respondents (ISY) either disagreed or did not know any information about the statements (see Table 5.21). Over two thirds (77.5%) of the OOSY agreed that media messages were probably empowering youths through health education messages. Both ISY and OOSY lack information in the areas where they indicated that they did not know.

Table 5. 21: Mass media campaign messages examining ISY and OOSY empowerment skills

Statements	ISY %			OOSY %		
	Agree	Dis agree	Do not know	Agree	Dis agree	Do not know
Have one sexual partner	83.2	11.1	5.3	77.5	11.2	11.2
Use condoms	87.4	9.8	2.6	77.1	12.0	10.8
Abstain from sex	81.6	10.1	7.6	73.8	13.8	12.5
Adhere to cultural norms and values	50.1	25.8	23.5	32.1	37.2	30.8
Control social situations such as peer pressure	58.2	23.2	18.4	45.6	24.1	30.4
Change sexual behaviours	79.5	8.8	11.4	66.7	16.0	17.3

Both youth groups were asked to state whether they regarded HIV/AIDS as a serious health problem in their areas. Almost all ISY (95.7%) and three quarters (76.7%) of the OOSY agreed that HIV/AIDS is a serious problem among the youth in their respective communities/areas. However, about a quarter 23.3% of OOSY said that HIV/AIDS is not a problem in their areas. This number (23.3%) of OOSY without information on HIV/AIDS is high and has not been reached by media campaigns.

5.2.5 ISY and OOSY results from open-ended questions

The last section of the survey sought the views and opinions of the youth on mass media campaign programmes in Oshana Region, northern Namibia.

Several issues were raised in the open-ended questions such as the type of information (topics) which were given to the youth during media campaigns, the reaction of the youth to the given information and how the information has influenced them. The analysis of the comments and opinions of the youth was analysed through content analysis and presented in this section, 5.2.5.

5.2.5.1 The most popular mass media campaign programmes or organisations for HIV/AIDS prevention in their areas.

Respondents stated that the following media campaign organisations were available in Oshana Region northern Namibia during the surveyed period; My Future is My Choice (MFMC) Programme, New Start Centres/Catholic AIDS Action, Open Talk-Youth Paper in the Namibian Newspaper, NBC radio and television, Total Control Epidemics and TKMOAMS (Tate Kalunga Mweneka Omukithi wo AIDS Moshilongo Shetu). All these media organisations are briefly explained in the next paragraph.

MFMC is a non-governmental organisation operating in senior and junior secondary and combined schools in the region. It functions as a peer education intervention on sexual health issues targeting adolescents aged 15 years and above. Its aim is to provide young people with information and life skills required to face peer pressure around HIV/AIDS prevention (UNICEF, 2006).

Catholic AIDS Action is a faith based organisation working with HIV/AIDS issues including community care activities (UNICEF, 2006).

Total Control Epidemics (TCE) is a community based organisation available in schools and communities, aimed at educating people on HIV/AIDS prevention issues (Otaala, 2000a).

Open Talk-Youth Paper in the Namibian Newspaper is an insert printed materials for young people, educating them on issues such as HIV/AIDS prevention.

NBC, radio and television, is the national public broadcaster, aimed at educating the general population, including youths, on diverse topics.

TKMOAMS is Oshiwambo (the local language spoken in Oshana Region where this study was conducted) acronym. The acronymy means **Tate Kalunga Mweneka Omukithi wo AIDS Moshilongo Shetu**, which is translated in English as “Our Mighty Father Protect Our Nation From The Deadly Disease AIDS”. TKMOAMS is a voluntary, non-profit, non-governmental social welfare and independent community-based organisation working with community health workers/volunteers who are caring for sick people in various communities/homes (MoHSS, 2007c).

5.2.5.2 Information/topics on HIV/AIDS prevention

Some youths stated that they received information (topics) on HIV/AIDS prevention from the radio, television and printed materials. This information is necessary to increase youths’ knowledge and skills on HIV/AIDS prevention.

The following information was highlighted.

- Use condoms, HIV/AIDS kills
- The danger of alcohol and drug abuse in relation to HIV/AIDS among the youth.
- Peer pressure among teenagers' sexual relationships
- Prevent HIV/AIDS through avoiding unprotected sex
- Teenagers and HIV/AIDS
- Youth and HIV/AIDS
- How to live positively with HIV infection

5.2.5.3 Reactions of the youth to the media messages/spots

Youths who received information from the radio, NBC television and printed materials, have also revealed that they have reacted to this information. Youths' reactions to information are associated with knowledge and understanding of issues affecting their lives.

Therefore, youths' reactions were summarised as appears in Table 5.22.

Table 5. 22: Results of ISY and OOSY reactions to media campaign messages

Percentage	Statements
85.6%	Happy to get information on HIV/AIDS prevention
78.7%	Realised that it is vital to share information with other youths/peers
63.4%	Realised that they need more information on HIV/AIDS prevention
61.2%	Were shocked, scared and need to know their HIV status,
60%	Decided to change their life styles
57.8%	Decided to negotiate sex
55%	Decided to discuss condom use
50%	Decided to be tested and know their HIV status for sure
44%	Decided to abstain from sex
36%	Decided to stop sex activities
28%	Were afraid of HIV/AIDS
15%	Started carrying condoms everyday

5.2.5.4 Effects of information on the youth

Both youth groups stated that the information they received from the NBC radio, television and printed materials raised awareness that could influence their lifestyles and sexual behaviours. Data indicate that some youths were influenced by the information they received from mass media communication and decided to act according to the advice. This means that the information youths received from mass media has influenced their knowledge, beliefs, understanding and attitudes towards HIV/AIDS prevention. Both youth groups' responses are summarised and listed in Table 5.23.

Table 5. 23: ISY and OOSY responses indicating how media campaign messages have influenced young people' lives (in percentages)

Percentage	Statements
70%	Some youths decided to change their life styles by dropping their boyfriends/girlfriends
65%	Started negotiating sex and use condoms with their sexual partners
60%	Accepted people who are HIV positive
57.6%	Decided to discuss/share with friends/peers information about sexual encounters and condom use freely
51.4%	Decided to stop unprotected sex
50%	Decided to be tested, know their HIV status and advice others to be tested
44%	Listening to parents' advice
36%	Stopped their sex activities
25%	Attended community meetings
18%	Listening to peer advice

5.2.5.5 Strategies that could be used to facilitate behaviour change among the youth towards HIV/AIDS prevention.

Youths were asked to list strategies that could be used in the HIV/AIDS campaign programmes in order to facilitate change in lifestyles and sexual behaviours among young people. They stated that the following strategies were needed to improve the current situation of using a conventional model in educating the public, including youths.

- Educate/train youths on negotiation and communication skills (life skills);
- Train youths on peer education and networking approaches for them to become peer educators;
- Provide more information to communities on how to prevent HIV/AIDS;
- Parents need to discuss HIV/AIDS prevention at family and community meetings;
- Youths should also adhere to cultural norms and values;
- Media campaigners/ health educators should make use of real life HIV cases as examples during their education campaigns to motivate young people to promote safer behaviour as they may increase feelings of susceptibility among the same population group (peers).

The data indicates a one-way educational approach that is being used to disseminate information through mass media to youths. The latter approach is a gap in the teaching-learning environment that needs to be bridged. Therefore, a reciprocal interaction among the youth (as receivers) and senders of information is required to improve the current situation and ensure the effective mass media communication.

5.3 Summary

This chapter has dealt with data analysis from the survey of the ISY and OOSY in Oshana Region, northern Namibia. The following are the main findings of the study data.

- The data indicates that ISY and OOSY who answered the questionnaires are from various socio-demographic backgrounds, live in different environments and these influences their lives and are homogeneous in nature. Youths have primary and secondary education; therefore they (ISY - 86.5% & OOSY - 74.2%) could read, write and understand information on HIV/AIDS prevention.
- Sources of information - Youth from both groups (ISY- 43.6% & OOSY- 30.9%) indicated that they had received information on HIV/AIDS prevention from mass media campaigns regularly through the radio, NBC television and printed materials. It is shown in this results that mass media is the main source of information for both youth groups.
- Knowledge on HIV/AIDS prevention - Data reveals that in actual fact both youth groups have adequate knowledge on HIV/AIDS prevention since they confirmed three correct causes and three correct preventive measures for HIV/AIDS. They have also dismissed myths as causes of HIV/AIDS.

- Youth sexuality - Data indicates that young people had sexual partners (see Figure 5.2), and are sexually active. Some had sex at the early age between 16 - 20 years and some also are dating at early age of 13 years.
- Youth self-efficacy on condom use - Data explains that some youth of both groups had used condoms (see Figures 5.3 to 5.7). The usage of which they had discussed and negotiated with their sexual partners, whereas others did not use anything. This is a risk factor. The study data indicated that some youth of both youth groups had adequate knowledge and understanding coupled with moderately high levels of self-efficacy on condom use (see Tables 5.7 to 5.12), because some youth could agree or disagree with their sexual partners either to use condoms or not. Based on the study data, those youths from both groups had negotiated and discussed condoms use. As the results, they refused to have sex.
- Youths' vulnerability to HIV/AIDS - Data indicates that youths are vulnerable and at risk of contracting HIV infection due to the fact that some had unprotected sex (see Figure 5.3). Some youth lack knowledge, understanding and critical thinking, therefore, they hesitated neither to refuse unprotected sex nor to discuss/negotiate condom use in their sexual relationships (see Table 5.5 and 5.6).

- Youths perceptions towards HIV/AIDS and condom use – Data indicates that youth of both groups (ISY -74.5% & OOSY – 66.7%) agreed that condom is the best protective measures against HIV infection (see Tables 5.7 to 5.10). Again, some youths refused to have sex without condoms. They agreed to negotiate and discuss condom use and took joint decisions, irrespective whether they were males or females (see Tables 5.9 and 5.10).
- However data also reveals that some male youths slightly dominated their female partners when making decisions on condom use. Even though, youths also indicated that they had in general high levels of self-efficacy on attitudinal beliefs and problem solving approaches towards condom use as shown in Tables 5.11 to 5.13.
- The study data also indicates that there were media campaign organisations available in Oshana Region, disseminating HIV/AIDS prevention information during the surveyed period (ISY - 79.6% & OOSY - 70.7%).
- Language use in mass media campaigns - Data shows that English as an official language in Namibia (ISY - 59.1% and OOSY - 49.4%) was used to disseminate information to the Namibian population in Oshana Region. The results further indicate that local languages were only used by few mass media campaigns organisations. The local languages (ISY-31.3% and OOSY- 47%) were used by few respondents.

- Youths 'exposure to mass media campaigns and messages - Data indicates that youth of both groups (see Table 5.15) were exposed to mass media messages, regularly. The data shows that respondents received information daily and weekly through radio, NBC television and printed materials.
- Perceived impact of mass media messages on the youth - Data indicates that some youth of both sexes and ages have adequate knowledge on HIV/AIDS preventive measure, had high levels of self-efficacy beliefs on condoms use, and understand issues affecting their lives. Therefore, some youths could “definitely” refused (disagreed) to had unprotected sex and “definitely” (agreed) to discussed and negotiated condom use in their sexual relationships.
- The study data reveals that youth have received information from mass media campaigns provided by media campaigners who are experts and youths received information as passive listeners through non-interactive conventional health communication (educational) approach.

The next chapter deals with the interpretation and discussion of the data that has been presented in this chapter.

CHAPTER 6

DISCUSSION AND IMPLICATIONS OF THE STUDY RESULTS

6.1 Introduction

This chapter discusses and interprets the study findings in relations to HIV/AIDS prevention, exposure to mass media messages and its perceived impact on youths' sexual behaviours. The discussion covers the respondents' profile, their sources of information, sexuality and vulnerability to HIV/AIDS and their perceptions/views on condom use and mass media campaigns and its effects. The discussion in this chapter is based on the presentation of the results of the quantitative analysis of the survey and content analysis of the open-ended questions. The interpretation of the data is presented according to the overall objectives of the study.

Namibia is one of the most affected countries in SSA by HIV/AIDS epidemic (UNAIDS, 2008). In response to this epidemic, many media campaign organisations, private and public, in the country focus on HIV/AIDS awareness, prevention and behaviour modification (LeBeau, 2004). The purpose of this study was to explore the perceived impact of mass media campaigns in communicating information on HIV/AIDS prevention among the youth in Oshana Region.

The study also conducted a survey to explore youths' knowledge, opinions and views about the effects of mass media campaigns and whether their exposure to information was translated into increased knowledge, awareness and understanding about the prevention of HIV/AIDS (Case, 2002; Groves et al., 2004). Based on its findings, the study proposes the implementation of the dialogical health communication model that could facilitate behaviour change among the youth in Oshana Region.

6.2 Discussion of the study results

6.2.1 Respondents' profile

A survey was conducted among the ISY and OOSY. A total of 920 ISY (825) and OOSY (95) from schools and youth organisations in Oshana Region participated in this study. From the study findings, youths' demographic characteristics, knowledge, perceptions /views and behaviours were related to previous social science studies both in SSA and Namibia on HIV/AIDS prevention and behaviour modifications.

Namibia has a large youth population as indicated in its 2001 Population and Housing Census (NPC, 2003); close to 40% of the population are young people under the age of 15 years. This is in accordance with the study results that the majority of the respondents were in the age group 17-21 years. In general, young people can easily be tempted and convinced to have sexual relations, especially when they have older sexual partners or live in state of poverty.

Otaala (2000a) claims that young people in Namibia are engaging in risky sex behaviours at an early age and special efforts are needed to rescue them from the HIV/AIDS pandemic. More than a half of the respondents were females (53.1%) and lived (71.8%) in rural areas.

The 2001 Namibia Population and Housing Census (NPC, 2003) report confirmed the findings of this study that Namibian youth live more in rural than urban areas. Therefore, the study was conducted in Oshana Region, with its rural and urban characteristics. Some ISY were living in boarding schools, away from their families and support systems which cause fragmentation in social networks and put youth at higher risk of HIV infection (Hedgepeth & Helmich, 1996).

LeBeau (2004, p.7) claims that in general, youths who live in rural areas are more disadvantaged because they have limited resources such as no electricity, walk long distances to nearby schools; some do not have radios and television, because they live in poverty with their grandparents who are pensioners or parents without any income. In some situations, youths have no money to buy batteries for radios (even when they have them) or buy newspapers. Owing to poverty and other social structures (these social situations were not identified in this study, but are general situations applicable to most rural areas, Oshana Region included). In general newspapers are either scarce or not available in rural areas for many reasons; maybe therefore youths could only read newspapers once a week or monthly. However, data from previous research in Namibia has also implicated poverty as a contributing factor to HIV risk taking behaviours (Ipinge et al., 2004; Brown, et al., 2005).

In contrast, results of this study revealed that 45.3% of the OOSY lived in towns away from their parents. Pisani (2003, p.10) argue that “life in urban areas has various social and cultural influences”.

Mufune (2003) argue that weakening of the link between community morals and sexual behaviours, results in more liberal sexual attitudes. All these situations could be contributing or leading factors that influence youths to have early sexual relationships that could make them prone to infection or to contract HIV/AIDS at younger age. It is interesting also to note that almost all respondents (ISY- 97.2% and OOSY- 82.1%) in this study spoke one vernacular/local language (Oshiwambo), although Namibia has a multi-ethnic society with diverse cultures and languages. This is because the study was conducted in one geographical region with mainly one homogenous ethnic group which speak one vernacular language (Oshiwambo).

The study results indicate that all youth groups, males and females (86.5% vs 74.2%) could easily read and understand information related to HIV/AIDS prevention, because the majority had basic education, have completed either Grade Nine or Ten or Eleven. It is perceived that most youths are literate (able to read and write). Only a small number (4.2%) of the OOSY was illiterate (difficulties in reading and writing) with no grade indicated and could not read and understand disseminated information in the newspapers or printed materials. However, some youths were exposed to audio-radio messages. Very few youths who were illiterate (4.2%) are implicated that they could not read the instructions on condoms or understand the need to use condoms consistently (Otaala 2000a).

6.2.2 Sources of information

The study explored and identified the main source of information for the youth. The study results revealed that both youth groups (ISY- 98.2% and OOSY - 88.4%) have heard about HIV/AIDS from mass media communication sources. This is a proof that mass media campaigns are disseminating information to the public, including young people in Oshana Region (Chanda et al., 2008). The study results also indicate that mass media were identified as the most common source of information about HIV/AIDS prevention and awareness campaigns among all youths in Oshana Region (ISY- 43.6% and OOSY -30.9%).

Although youths were exposed to various interpersonal and mass media messages in different settings, NBC radio, NBC television and newspapers were listed as the main sources of information. In addition, some young people stated that they got their information from multiple sources including home, schools, churches, youth organisations and health facilities. These data are supported by recent research on the relationship between gender roles and HIV infection in Namibia (Iipinge et al., 2004) that found that community members including youths do have basic knowledge of HIV/AIDS which comes from mass media health information campaigns. This study results reveal that youth of both sexes have adequate knowledge and information from mass media campaigns.

Other sources of information identified in this study were parents, teachers, youth organisers, peers, health workers and religious leaders. In supporting the study results, from the Namibian perspective, parents are the primary agents of socialisation for youths in learning norms, values and cultural practices (UNFPA, 2004). In contrast, many parents are still not comfortable discussing sexual issues with their children because sex is a taboo subject in many African cultures (Mufune, 2003). Mufune argues that any communication between adults and youth on sexual matters such as STIs and HIV/AIDS is restricted and invariably a “top down” approach.

The conventional approach recognises parents as experts and youths are taught without discussion (Cherie, Mitkie, Ismail & Berhane, 2005). However, in this study parents serve as a major source of information for 47.6% (ISY) and 38% (OOSY) (Freire, 1985). In contrast parents are being guided by their cultural norms and traditional values when they are grooming youths towards adulthood (LeBeau, 2004).

The study results also listed teachers as a second source of information (ISY-21.4% and OOSY-14.1%) and agent of socialisation, who are responsible for the education of young people, including disseminating information on HIV/AIDS. The study results also reveal that health professionals (ISY- 13% and OOSY- 9.7%) and religious leaders (ISY-1.6% and OOSY-1.1%) played a less significant role in disseminating information to the youth. For those youths who are sexually active, it is difficult for them to go to religious leaders because youths are reluctant to discuss sex issues with them.

However, peers (ISY- 9% and OOSY- 2.2%) were also identified as influential source of information. Young Namibians meet in various settings and can influence each other positively (advice and discussing facts of life such as condom use) or negatively (peer pressure from male partners to have sex without condoms). Peers are known as a common source of pressure to indulge in sexuality and in alcohol abuse, and at the same time some young people lack the skills to overcome such pressure (Agha & Van Rossem, 2002).

The study results did not mention any political leaders or traditional leaders or regional structures such as the Oshana Regional AIDS Coordinating Committee (RACOC), Constituency AIDS Coordinating Committee (CACOC) and any line Ministry as sources of information for youths. In contrast, these committee coordinating bodies representing and coordinating the execution of the Namibian Government policies, strategies and guidelines at regional and constituency or local levels. These committees are responsible for coordinating and supervising HIV/AIDS activities at various levels in the region (GRN, 2004; NPC, 2008). This indicates a lack of coordination and networking of HIV/AIDS activities in the region as well as lack of knowledge on these committees presence in Oshana Region (appendix 7).

On the question about young people's level of knowledge on HIV/AIDS, respondents from both groups indicated knowledge of at least three correct modes of transmission and three correct preventive measures against the disease.

Youths also dismissed myths and misconceptions on HIV/AIDS transmissions and knew that kissing does not cause HIV/AIDS. The study findings validated the MoHSS (1994) report which found out that youths have a basic knowledge of HIV/AIDS. Ipinge et al. (2004, p. 217) argue that Namibian youths have a good knowledge of HIV/AIDS prevention from the mass media campaigns. However, what is missing is the translation of knowledge into practice, increased knowledge, awareness and prevention of HIV/AIDS that could facilitate behaviour change (Keating, Meekers & Adewuyi, 2006).

However, other social science research in Namibia has also revealed that the basic HIV/AIDS knowledge that the Namibian youths have is not being transformed into practice, for example using effective HIV/AIDS prevention strategies (Brown et al., 2005).

Bandura (1977) argues in his social cognitive learning theory that knowledge and behaviour change are highly interactive and interdependent. The theory also recognises that knowledge is power; therefore youths need to be equipped with necessary pivotal information to alter risky behaviours; negotiation and communication skills and self-efficacy are needed as guiding principles to use these skills consistently and correctly (Kelly, Parker & Lewis, 2001).

Based on these findings, it is clear that youths are getting initial information on HIV/AIDS from NBC radio, television and newspapers supplemented by secondary information from parents, teachers, peers, health professionals and religious leaders.

What is still needed however is the transformation of knowledge into awareness and practice. From these findings, it can be concluded that youths' knowledge, self-efficacy and belief need to be strengthened as echoed by Freire in his empowerment theory (Freire, 1985).

6.2.3 Youths' sexuality

The study results revealed that over two thirds (71.6%) of OOSY and about a quarter (26.1%) of ISY claim to have sexual partners. The UNDP Human Development Report (2000) (cited in LeBeau, 2004, p.7) concurred with the study finding that most youths are sexually active (Chanda et al., 2008). However, the study also found that more than two thirds of the respondents who had sexual partners during the surveyed period had penetrative sex (ISY- 67.4% and OOSY- 79.4%) with their regular partners.

Based on these study results, it is confirmed that OOSY (71.6%) had sexual partners and were more sexually active (58.1%) than ISY (17.8%). OOSY lived outside the influential confines of parents, whereas ISY were still under the guardian of their parents. The above study results show the impact of parenting roles. On the other hand, respondents who had sexual encounters had it with their regular partners and very few had sex with others (multiple sex partners).

The study findings indicate that both youth groups had few multiple sexual partners. Therefore, it is assumed that youths are not at high risk of contracting infections from multiple relationships. According to the NDHS report for 2006/7, multiple and concurrent partnerships contribute to the spread of STI's and HIV infection in Namibia (MoHSS, 2007a; MoHSS & Macro, 2008).

This result also reflects an individual's ability to make quality decisions. When living with parents, in Oshiwambo culture, parents make decisions on behalf of their children. Perhaps parents need guidance on how to empower their children to make their own decisions prepare them for adult life.

This study results also reveal that the vast majority of young people are dating at an early age, as from 13 years, (ISY - 73.3% compared to OOSY - 71.6%) and had their first sex when they were between 16 - 20 years. This is an indication that youths were becoming sexually active at an early age of their lives and became victims to emotional and social problems such as STIs and HIV/AIDS, if they fail to use protective measures or negotiate safe sex with their partners or adhere to cultural norms and values (Byrnes, 2001). These results are similar to other Namibian studies (Iipinge et al., 2004) which found that youth are becoming sexually active at an early age of between 15 -17 years, for both males and females.

What is encouraging in the study findings is that of the youth, who had penetrative sex, fifty six of the OOSY and 22% of the ISY had used condoms (the protective measure against infection) and very few (3% - ISY and 17% - OOSY) did not use condoms.

Youths who used condoms during their last sexual encounters had an understanding to use HIV/AIDS preventive measures to protect themselves against infectious diseases. This understanding is advocated by Bandura (Cognitive Social Learning) and Freire (Empowerment) theories an important aspect of life. However, youths who did not use any protection during their last sexual encounters were at risk of contracting STIs and HIV infection. Although only a small fraction of these respondents did not use any protection, such youths should not be ignored because with HIV infection one individual could ruin the community with his/her risky behaviour. Therefore, strategies must be explored to win them over to healthier sexual behaviours (Bouare, 2009; Hutchinson et al., 2007).

Based on the study results youths (of both sexes) who used condoms during their last sexual encounters had successfully negotiated the use of condoms with their sexual partners and took decisions jointly (ISY - 11.8% vs OOSY - 28.7%). If youths had the negotiation skills, they would practise dialogue in their sexual relationship as promoted by Freire in his Empowerment Theory.

However, data also reveals that male youths in both groups (ISY and OOSY) slightly dominated female partners in decision-making on condom use. One can argue that female youths were either hesitating or dominated by their male counterparts in their sexual relationships, regarding condom use. This is a sign of the strong African cultures in which youths believe. However, culture influences the life of the people. Even though, data indicate that youth of both sexes had adequate knowledge on HIV/AIDS preventive measures.

The study data indicate that some youths had an understanding and knowledge on communication and negotiations skills (life skills) for safe sex. If youths had these skills, it means they are self-directed beings who are able to think critically. The latter is advocated by the Diffusion of Innovations and HBM (see Chapter 3).

The study also revealed that youth of both sexes in both youth groups had self-efficacy beliefs towards condom use. This means that the messages youths received from mass media and other sources had influenced them. However, Paulo Freire (1985) argue in his Empowerment/Participation Theory that the area of essential skills among the youth needs to be strengthened to empower young people with knowledge, information and power for them to assess their own situations, identify their problems and have control over their lives and take constructive decisions (see Figure 5.3) Rogers (1995).

The respondents in both groups who had penetrative sex and did not use any protective measures during their last sexual encounters gave reasons why they did not use condoms. The reasons stated were the unavailability of condoms and difficulties to negotiate condom use or no agreement being reached on condom use.

The study finding indicates that some males (ISY-10.8% and OOSY- 30.5%) dominated their female partners (ISY-16.2% and OOSY-16.6%) on decision-making about condom use. In Oshiwambo culture, females are groomed to be obedient and not to argue with men or question them on issues under discussion.

This result reflects the socio-cultural effects of the Oshiwambo culture which could impact women in decision- making. Female youths generally failed to negotiate condom use because they were in majority and historically perceived as being obedient and powerless to resist sexual advances, especially from older men. Ipinge et al. (2004) support this argument and the finding. Ipinge et al. (2004, p. 229) also claim that “women are powerless and do not have abilities to enforce protective measures that could save their lives”. But according to Bandura’s Cognitive Social Learning Theory, youths need to be assertive and self-directed to reaffirm that if they say no to sex they really mean “no” and not something else (Schunk, 2000).

Rogers (1995) and Freire (1985) share the same sentiment with the study finding that youths, especially girls, are either powerless to negotiate safe sex with their sexual partners or lack negotiation and communication skills in their sexual relationships.

Therefore, Freire (1985) emphasises the importance of empowering youths through awareness, dialogue and conscientization as methods to facilitate change and allow youths to gain or strengthen assertiveness abilities.

On the issue of youths lacking negotiation and communication skills, according to Roger's Diffusion of Innovation Theory (1995) and Freire's (1985) Empowerment Model, youths need to be assertive and innovative to make informed decisions and have control over their own lives. This characteristic is needed among youths as stated in the HBM (Thomas, 2001) that youths need to have knowledge to be able to perceive their vulnerability and susceptibility to HIV/AIDS and to be able to become agents of change, even during the HIV/AIDS awareness campaigns.

The study findings also listed unavailability of condoms as the second reason for some youths' failure to use condoms during their last sexual encounters, although almost all youth in both groups (ISY- 82% and OOSY - 86.7%) knew where condoms could be collected free of charge or bought them in their areas. Both youth groups (ISY - 68% and OOSY - 75.5%) reveal in the study that it is easy to get condoms in their areas at different places such as clinics, public rest rooms, cuca shops, bars, offices and work places. This is in contradiction with the statement that condoms were not available in their areas, maybe youths mean condoms were not available when needed. Youths need to prepare themselves to be proactive in their behaviours.

In this study the knowledge of those respondents in both youth groups who knew where to obtain condoms from their areas was positively associated with increased HIV/AIDS awareness, perceptions and use of condoms. Only 17.4% (OOSY) and 4.5% (ISY) respectively, said that it was difficult to get condoms in their areas. The respondents who experienced difficulty in accessing condoms could be those who could neither use nor access condoms for safe sex even if condoms were available in their areas.

The unavailability of condoms in the area could be a barrier that needs to be removed to ensure social change. The study results confirmed that condoms were not accessible to all youths even if they were available in Oshana Region. This means that youths need to overcome barriers to be able to negotiate safer sex according to Bandura' Theory.

The study results also reveal that youths' sexuality is associated with the initiation of sex (having sexual intercourse for the first time), reported engagement in sex, reported number of sexual partners and the use of condoms (ISY- 21.3% and OOSY- 55.4%) as a protective strategy. Therefore, the study concludes that youths are sexually active at an early age and have sex with regular sexual partners. This is a risk factor which they need to perceive to be able to be safe.

6.2.4 Youths' vulnerability to HIV/AIDS

Having confirmed that youths have sexual partners, had penetrative sex (sexually active) and that some youths did not use any protective measures (condoms) (ISY-3.2% and OOSY-16.3%) while others did use condoms (ISY-21.3% and OOSY-55.4%) during their last sexual encounters, it is important to assess youths' vulnerability to HIV infection. The study confirmed that those young people who were sexually active, had sex and did not use condoms during their last sexual encounters were vulnerable to STIs and HIV infections because of their intimate sexual relationships without any protection.

The study results concurred with other social sciences research studies in Namibia (Shapumba et al., 2004) that youths are vulnerable to HIV infection because of their involvement in intimate sexual relationships without protection. Therefore, they need to be aware of the risk involved so that they will be able to perceive their susceptibility to HIV infection (Thomas, 2001).

According to the study results, youths had adequate basic knowledge on causes, spread and preventive measures (ISY- 91.4% and OOSY-77.1%) against HIV/AIDS as well as the myths and misconceptions (ISY-73.8% and OOSY-56.2%) of the disease. The results also revealed that youth of both sexes had moderate levels of self-efficacy beliefs on condom use towards HIV/AIDS prevention.

Therefore, it is argued that youths as individuals need to perceive themselves as being vulnerable or susceptible to HIV infection, perceived the consequences of infection (contracting HIV/AIDS and death), perceived the seriousness of the disease (HIV/AIDS as a real killer disease among the youth) and perceive protective actions as consistent and correct use of condoms every time they have sex. Freimuth (1995) argue that youths should perceive themselves as vulnerable to HIV/AIDS and need to act as self-directed individuals empowered with knowledge and understanding from interpersonal and mass communication to be able to be safe from HIV infections. Youths need to practise abstinence as a traditional and religious norm, value and practice to reduce their vulnerability to infection (Bouare, 2009; Kelly et al., 2001).

Youths' vulnerability to infection could be exacerbated by various factors in their complex environment. Young people have different needs; some are poor, almost illiterate and homeless, whereas others live in violent and dangerous conditions where they are struggling to survive (Lévesque, 2002). Stein (2001) echoes Lévesque's view that sexual intimacy might bring young people money, affection, sexual comfort, shelter or protection, despite the risks involved.

Freire (1985) also elaborated that if youths are vulnerable to infection, they need to be empowered with relevant knowledge and skills to become critical thinkers and responsible decision-makers to be able to prevent HIV infection. Therefore, this study suggests that youths need to be self-directed, be critical thinkers, be assertive, empowered with knowledge and understanding and have communication and negotiation skills and good interpersonal relations to be able to act responsibly.

Theorists and educational scholars such as Albert Bandura, Everett Rogers and Paulo Freire stressed these qualities in their theoretical perspectives. Such qualities are crucial to mould youths to become facilitators of change and role models in their respective communities, practising collective actions (Adams & Berzonsky, 2006).

6.2.5 Youths perceptions/views on condom use

In this study youths were given a series of statements on condom use and were asked to state whether they agreed or disagreed or had opinions regarding condom usages. Both youth groups stated their views/beliefs and perceptions on condom use. More than a half of (ISY - 74.9% and OOSY- 66.7%) both youth groups agreed that condoms were the best protective measure against HIV/AIDS. Again, both youth groups (ISY and OOSY) also agreed that women had the right to initiate the discussions on condom use and everybody in the sex relationships including women had the right to ask a partner to use condoms (ISY-77.7% and OOSY -73.7%), whether a partner is a fiancées or sex worker or a friend. Respondents also confirmed that condoms should be used as a protective measure against infection.

The results indicate that youths have basic knowledge of condom use as to who, how and when to use it. Youth of both sexes have a basic knowledge and understanding of HIV infection, beliefs and perceptions on condom use (see Tables 5.7 and 5.8 in chapter 5). What is missing here is that this knowledge needs to be strengthened or transformed into positive behaviour among all youths.

Therefore, Cherie et al. (2005) emphasised that information; education and communication on HIV/AIDS need to be sufficient to increase youths' knowledge, influence their attitudes and practices and also address their needs and expectations.

In this study youth were given attitudinal statements to assess their self-efficacy or self-directed characteristics.

The results reveal that youths (ISY- 48.9% compared to OOSY- 43.8%) could refuse to have sex without condoms which is a risky behaviour, could negotiate sex (ISY - 42.2% compares to OOSY - 43%) with their sexual partners (negotiation skills) and could discuss (ISY - 44.1% compares to OOSY - 37.2%) with their sexual partners as to when to have sex, and could use condoms correctly and consistently (communication skills). However, some females were overruled by their male partners on the issue of condom use (Table 5.10 and 5.11). This finding demonstrates that the youth of both groups have moderately high level of self-efficacy beliefs on condom use. Youths also have negotiation and communication skills which need to be strengthened and transformed into practice. This means that youths have an awareness and knowledge that need to be internalised as advocated by Freire in his Empowerment Theory.

The study results confirmed the number (percentage) of youths who used condoms (ISY - 21.3% compares to OOSY - 55.4%) during their sexual encounters.

Therefore, Everett Rogers (1995) in his Communication of Innovation Theory argues that youths should act as innovators and facilitators sharing information with others as peer educators (modelling) and agents of change. In this study youths who are innovators are few in number (3%).

The study result reveals that over one third of young people took a joint decision (ISY- 41.9% and OOSY - 34.6%) on condom use. Even though, females were slightly dominated by male partners in this decision. Paulo Freire (1985) asserts that education and training in the communication process need to be learner-centred and not top-down and conventional in nature. He also argues that providers of information should be facilitators of dialogue and promoters of critical thinking. In this way, youths could learn from experience and became facilitators of change in decision-making processes. Parents in families should also interactions and mould youths to create a platform for sharing information and opportunities and not dominate their children. These are cultural issues which cannot overcome within a short time.

Respondents were also given statements asking how they perceived whether they could solve daily problems and unexpected situations in life including conflicts resolutions.

Over two thirds (ISY - 76.4% and OOSY - 73.3%) of youths indicated that they could solve problems on their own and the majority of the ISY (87.9%) and 70.4% of the OOSY believed they could discuss and understand issues related to sex and condom use with their sexual partners and could find solutions to problems/unexpected situations through negotiations (ISY- 80% and OOSY - 74.7%). This is an indication that some ISY and OOSY of both sexes lack some self-directed characteristics as advocated by Communication (Rogers) and Cognitive Social Learning (Bandura) Theories. Therefore, the translation of youths' knowledge into practice in real life situations is needed to empower them. In contrast, the study reveals that about a third of both youth groups (ISY - 28.5% and OOSY- 39%) did not have the required characteristics such as negotiation and communication skills.

However, some youths need to be empowered with knowledge and skills (communication and negotiation skills) to understand their active involvement and participation in decision-making issues pertaining to their lives as advocated by adult educator Paulo Freire in his Empowerment Theory (Freire, 1985). De Martin, Seidhein, Deen, Pinder, Walraven and Greenwood (2001) also stress that a high level of participation by individuals in decision-making processes is important for the success in behaviour modification rather than youths being informed and persuaded by others to implement change. Therefore, the active involvement and participation of political leaders and policy makers in the health education campaigns, is vital to reinforce change as they serve as influential (opinion) leaders in their communities.

The current situation in Oshana Region where there is a fragmentation in the execution of HIV/AIDS prevention activities need to be corrected and an integrated dialogical approach should be implemented to rectify the situation.

6.2.6 Mass media campaigns and the effects of media messages

6.2.6.1 HIV prevention communication

Respondents were asked whether there were mass media campaign organisations in Oshana Region.

The study results confirmed that there were a variety of mass media campaign organisations in Oshana Region which disseminated information on HIV/AIDS prevention during the surveyed period.

Some mass media campaign organisations active in Oshana Region during the study period were given as follows: Catholic AIDS Action through its various New Start Centres, Total Control Epidemics, MFMC, TKMOAMS with the English translation of “Our Mighty Father Protect Our Nation From the Deadly Disease AIDS”, The Namibian Youth Paper - Open talk insert and the Namibian Broadcasting Corporation (NBC) for radio and television. The question is whether these organisations and programmes are sustainable in the region to maintain the education and training of the people, including youths.

The study results reveal that youth were aware of the various mass media campaigns organisations which are implementers of HIV/AIDS prevention activities available in the region. These organisations were disseminating health information to the public, using mass media and interpersonal communications. This means that mass media campaigns use multiple channels of communications such as radios, television, printed materials and face-to-face individual talks or group discussions to disseminate information on HIV/AIDS prevention.

This study results confirm that young people were exposed to interpersonal and mass media messages in different settings. In support of this finding, Cherie et al., (2005, p.75) argue that mass communication could create good awareness of HIV/AIDS issues while interpersonal communication could strengthen individual perception and action.

The study results also reveal that youths indicated that these communication campaigns used slogans and themes such as: “Be your own hero -Take control”; “Do you know your status”; “Get tested and know your HIV status for sure”; “Alcohol and HIV/AIDS” “Youth and HIV/AIDS”, “Be your own hero - use condoms” and many more to disseminate health information (see chapter five). These slogans and themes were communicated mainly in English to the public.

Slogans and themes were articulated into sub-themes such as living with HIV positively, abstinence, faithfulness, HIV testing, the danger of alcohol and drug abuse and the risk of HIV infection, condom use, the ABC HIV/AIDS prevention strategy and its importance, HIV/AIDS prevalence in Namibia, HIV/AIDS mode of transmission and preventive measures, youths and HIV/AIDS, how to live positively with HIV/AIDS and many more (see table 5.23 in chapter 5).

The information which youths received from mass media campaigns covered essential information vital to ensure a basic level of knowledge and understanding of HIV infection. The study result reveal that the information youths received through mass media campaigns has little influence on them, because youths are not involved in the planning and implementation of media messages. The information has increased their awareness on HIV/AIDS issues but did not mould them to think critical and reflect on their situations. For example youths who know their HIV status have information on how to protect themselves and those who are HIV positive will know how to live positively with the disease, but the interpretation and transformation of the information is missing. This is what Freire called active participation, assertiveness and critical thinking that youths need to be able to dialogue and facilitate change.

Youths were given information in English; a language which not all receivers could understand clearly and so this could impinges the understanding of the information from the media campaigns. Therefore, this knowledge and information youths have needs to be transformed into practice, through dialogue and facilitation as argued by Freire in his Empowerment Model (Freire, 1985).

The information which was given to public on HIV/AIDS was communicated and promoted nationally through national radios, television and print media materials focussing on targeted audiences such as truck drivers, young people and other high-risk individuals. The information is being given to individuals and communities using a top-down approach through persuasive messages (Freire, 1985; Rogers, 1995; Schunk, 2000; Parker et al., 2007).

The study results suggest the implementation of the proposed Human-centred Dialogical Health Communication Model as advocated by Paulo Freire. The integrated approach will facilitate individual and collective community actions which aimed to have an informed public.

6.2.6.2 Mass media messages/spots and its effects on youth

The findings reveal that almost all youths (ISY - 95.6% and OOSY - 83.7%) confirmed that they had heard about a person who had died of HIV/AIDS. Youths also confirmed that HIV/AIDS was a serious health problem among the Namibian population, including youths in Oshana Region. The study results concur with the report by MoHSS and USAID (2007, p. vii) that HIV infection was spreading through Namibia and increasing among various age groups, and people were dying from HIV/AIDS.

The study findings indicate that according to about half of the respondents revealed that mass media campaigns (ISY - 59.1% and OOSY - 49.4%) used mainly English as the communication language when disseminating health information to the public, especially through NBC television. Only 31.3% (ISY) and 47% (OOSY) respectively stated that media campaigns used local languages when disseminating information. The use of English as an official language, which is not familiar to many Namibians, to disseminate information, may cause communication problems (Agha & Van Rossem, 2002).

However, local languages are only used by a few of the mass media campaign organisations. The use of local languages (ISY - 31.3% and OOSY - 47%) to disseminate information is appropriate to ensure that the correct message is given, received, interpreted correctly, understood and implemented to enhance change among people (Allegrante & Sleet, 2004). Barker (2004) argues that the language used to give information to the people should be the local language to ensure that the message is correctly understood, interpreted and internalised.

It is interesting to note that both youth groups (ISY and OOSY) reveal that they have received HIV/AIDS prevention information through radios and television everyday or weekly for an hour or more for the past three months (see Table 5.14). Both youth groups confirmed that they listened to the public broadcaster (NBC) radio, Oshiwambo service, and NBC television that transmitted information to the general Namibian population. This is an opportunity for the people, because an informed public could help in stemming HIV prevalence (Chanda et al., 2008).

The radio broadcasts in local languages in various regions in Namibia, but NBC television uses English as a means of communication. On the same note all youth groups reveal that they read newspapers (and other printed materials, mostly written in English) weekly to get information on HIV/AIDS prevention. The study results indicate that the vast majority of respondents (ISY - 92.9% and OOSY - 80.7%) read the “The Namibian Youth newspaper insert and Open talk insert” in The Namibian newspaper. These inserts focus specifically on youths with the aim to educate them on youth issues such as HIV/AIDS prevention (NPC, 2005).

The findings also reveal that the majority of the youth have access to information from both mass media and interpersonal communications. This is indicative that a variety of channels of communication (radio, television, printed materials, face-to-face talk and group discussions) were used to give information in Oshana Region, in diverse settings. This finding was also echoed by Chanda et al. (2008) that an in-depth coverage of HIV/AIDS issues can have an impact on attitudes and behaviours. Myhre and Flora (2000) agree with the study results that other supplementary media information providers are peer educators, volunteers and community health educators who are employed by media campaigns organisations to persuade youths and communities to change their sexual behaviours and prevent HIV/AIDS.

In this study, respondents also reveal that they have heard radio, watched television and read printed materials spots/messages with regards to HIV/AIDS prevention in the previous three months.

The respondents who had received mass media messages had obtained them daily on radios, weekly on television and from newspapers. This data confirms that both youth groups (ISY and OOSY) were exposed to mass media messages frequently. However, youths who did not receive any mass media messages (OOSY radio - 24.1%, TV - 33.3% and printed materials - 19.3%) from any mass communication are missing essential information on causes, spread and preventive measures of HIV/AIDS, since that mass media was identified as the most common source of information in the region. Some youths did not also respond to this question, which also indicates that they do not listen to radios or watch television or read newspapers (NPC. 2003).

This study did not examine in detail how messages/information received by youth groups through mass media communication were given and formulated. This is a limitation in this study. However, Myhre and Flora (2000, p. 38) are of the opinion that mass media messages should be in a simple form (providing factual information on HIV transmission), convey preventive messages (describing how to avoid HIV risk behaviours) and aimed at influencing individual behaviours and social norms. Relevant literature (Freire, 1985; Maibach & Parrot, 1995) asserts that mass media can be criticised in general for presenting contradicting and conflicting messages that arouse sexual feelings through television films, advertisements and printed materials.

In general, mass media messages are being given to the public without reference to other prevention alternatives, such as “use condoms” and “take control”, and are devoid of instructions on use.

These types of media messages could be misinterpreted or mislead youths and result in faulty decisions (Cherie et al., 2005, p. 75). For example, a young person could practise unprotected sex according to information from the radios or television which was not clear to him/her.

Thomas (2001) also highlight that mass media messages should help youths to perceive their susceptibility to infection and reduce risks by taking into account the conflicting environment where youths live with many challenges such as peer pressure. Therefore, what is missing is the active involvement of youths in message formulation or production coupled with practical information to enable youths to perceive and reflect on realities in their real life situations.

The latter is missing because the currently mass media campaigns are using the conventional health education model that is teacher-centred or adult controlled (Freire, 1972, 1985). People in Oshana region are given information according to the needs of the implementers and coordinating bodies.

Other research studies have maintained that people, including youths, are active information seekers and perception is an active and motivated process (Byrnes, 2001; Case, 2002; Dominick, 1999; Figueroa et al., 2002; Hofstede, 2001). Therefore, young people's personal interests, wants, concerns and expectations govern what they perceive. However, media messages should be of immediate, concrete and explicit relevance to the audience in order for it to be attended to internalised and effect change (Myhre & Flora, 2000).

In this study respondents reveal that they received a variety of information from mass media campaigns that has increased their awareness on causes, spread and preventive measures against HIV/AIDS. Therefore, youths stated that they react to this information as described in Table 5.22. The information youths received from mass media messages/spots has raised awareness on HIV/AIDS that has made them to realise that HIV/AIDS is real and is a serious health problem in Namibia. Therefore, some youths went for HIV test to know their HIV status because they would be in a better position to know how to protect themselves or, if they were positive, to know how to live positively with the virus.

This is an attitudinal outcome of youths' awareness, knowledge, understanding, sharing of information and the perception of their susceptibility to HIV infection as discussed in the theoretical framework for this study. This means that media campaigns messages created good educational and learning opportunities among the youth that need to be strengthened.

Study results indicate that some youths because of the information they obtained realised that as partners in sexual relations they needed to discuss issues related to their own lives and not to force each other into sexual activities. This means that youths perceived HIV as a risk factor and their vulnerability to the disease. Youth of both sexes and groups (ISY & OOSY) reveal that they had moderate self-efficacy beliefs towards HIV/AIDS prevention.

Schooler et al. (1998) found that mass media messages influenced people's behaviour when communicated over a period of time through multiple channels rather than through a single modality. Schooler et al. (1998) further argue that mere exposure to persuasive mass media messages during media campaigns did not guarantee immediate behaviour change among the target audience. This is the current situation with the existing conventional health education model.

Rogers (1995) in his Communication of Innovation Theory supported the argument that knowledge is power, therefore it is pivotal for youths to have knowledge and understanding before any informed decisions are taken.

Case (2002) also argues that successful media campaigns ensure that youths (receivers/ audience) should reflect the desirable behaviours coupled with perceived norms, perceived self-efficacy and empowerment, critical thinking and modelling to be able to effect change. The results from this study concur with Rogers and Case that media messages need to be learner-centred to be able to be internalised by the receivers with the aim to encourage change. Youths as receivers should act as agents of change and facilitators of dialogue as advocated by Freire (Freire, 1985; Agha & Van Rossem, 2002).

It is interesting to report that youths have also stated that media campaign messages have influenced a small number of them (See Tables 5.21 and 5.22) and they decided to share information (communication skills) with others, especially their peers.

This means that mass media campaigns aimed at increased the likelihood that both youth (ISY & OOSY) groups would have adequate knowledge and understanding on HIV/AIDS prevention and this needs to be strengthened for youths to be able to discuss safe sex relationships with their partners without pressurising each other. The use of peers as educators during HIV/AIDS prevention campaigns is recommended to effect change.

In turn, the understanding and discussion of safe sex relationships and HIV/AIDS prevention measures with partners had influenced some youths' intention to negotiate safe sex relations, abstain from sex and use condoms consistently and correctly. Therefore, if all youth groups were not equally influenced by media messages, then the method used to educate the public (existing conventional method) needs to change. Therefore, the study proposes the implementation of the Integrated Dialogical Health Communication Model (Schiavo, 2007).

6.2.6.3 Perceived impact of media messages on youths

Youths, who were sexually active, had sex and used condoms were slightly influenced to reflect on their lives and act as radio listeners, television watchers and readers of printed materials. Youth of both sexes and of various ages indicated that they perceived self-efficacy beliefs on condom use towards HIV/AIDS prevention, since the results reveal that some youths could “definitely” refuse to have unprotected sex and “definitely” discuss and negotiate condom use in their sexual relationships.

Therefore, the study concludes that some youths after receiving information had reflected on their lives, and indicated that they had basic knowledge on negotiation and communication skills. This knowledge held by both youth groups needs to be translated into practice and strengthened.

However, information dissemination through media campaigns influenced some respondents to desire change in their lifestyle and sexual behaviours. Yet findings show that some youths lack the skills to make informed decisions. Hence there is uncertainty whether such desires will be implemented.

Some of these wishes are to “drop sexual partners, negotiate with their sexual partners safe sex relationships, to abstain from sex till marriage, to use condoms correctly and consistently at all times, and get tested and know their HIV status for sure” (see Table 5.22).

The study findings also reveal that some youths who were not having sexual partners and never had sex during the surveyed period, had the desire “to practise abstinence and protect themselves against the infection, including STIs and HIV infection”. The increased knowledge and information the youth have after exposure to mass media messages has influenced some of them to understand and implement traditional and religious norms, values and practices. Youths claim that mass media and interpersonal communication messages had influenced their cognitive, affective and psychomotor domains.

This was suggested by Bandura's Social Cognitive Learning Theory (1977), Paulo Freire's Participatory Model (1985) and Rogers' Communication Innovation Theory (1995). It is assumed that the knowledge the youth received from the mass media campaigns has been somewhat translated into desirable actions, although these findings need to be investigated further. However, mass media efforts had positive effects on some young people.

But there were some youths who did not benefit from mass media messages, especially those who are illiterate, did not respond to some questions and those who stated that they did not have information on statements assessing their knowledge and views on issues related to sex and condom use.

In conclusion, youths' exposure to mass media messages has increased their willingness and desire to discuss HIV/AIDS prevention issues with their partners, as well as increased their knowledge about the benefits of consistent and correct use of condoms to reduce HIV/AIDS risks.

It is further asserted that information sharing has enabled some youths to understand and apply the modelling abilities such as assertiveness, self-efficacy, and motivation to learn and understand issues affecting their lives. But not all youths were influenced by media messages, hence the importance for the implementation of the Integrated Health Communication Model.

6.3 Summary of the discussion

Namibian youth come from diverse demographic backgrounds as indicated in their profile. Some youths have difficulties in reading and understanding instructions on condoms. This has put Namibian youths at risk of contracting HIV/AIDS since that Namibia is one of the most affected countries in Africa.

Respondents also revealed that they had an adequate basic knowledge on causes, spread and preventive measures of HIV/AIDS received mainly from mass media (radio, television and printed materials) communication.

The regional HIV/AIDS committees such as RACOC and CACOC were not mentioned by any youth. Despite the Namibian Government's political will and responses on the issues of HIV/AIDS prevention, this result indicates fragmented HIV/AIDS prevention activities in the region.

The study revealed that some youths especially OOSY were sexually active. This is a serious concern because the youth's sexuality makes them prone and vulnerable to HIV infection. Therefore, all youths need to be aware of their vulnerability to HIV infections and how to protect themselves. The study results show that some male youths slightly dominated their counterparts when deciding on condom use, whereas some female youths hesitated to discuss and take decisions on condom use.

These actions put some male youths at sexual risks because of their refusal to use condoms while female youth were put at risk of HIV infection through the actions of their partners. This result also shows a strong cultural norm in Oshana Region.

On this note, youth of both groups need life skills (negotiation, listening, decision-making and communication) that will empower them to think critically and make constructive decisions on issues affecting their lives.

The study also reveals that some youths were exposed to media messages received from radios, televisions and printed materials. The study explored the effects of these messages on both youth groups. Therefore, the study findings reveal that both youth groups have received mass media messages that were communicated to them through the conventional health communication approach. The latter approach dominates and tells youths what to do and how to do it without dialogue or active participation of its audiences. This result also have a limitation that youth as individual may change but it is against the African cultures that aim at collective actions of communities. Therefore, both youth groups did not internationalise media messages they were given and perceive HIV/AIDS as a general health problem and not a community issue.

Even though, mass media messages from the conventional model influenced some youths to think critically (refused to have unprotected sex) and understand themselves as individual beings able to solve their own problems holistically through dialogue (definitely agreed to discuss condom use with partners).

But a community effort is vital to ensure collective change and the implementation of the integrated dialogical approach is recommended.

The study concludes that some youth have high levels of self-efficacy towards condom use; therefore joint decisions were taken by some youth of both groups who perceived themselves to be vulnerable to HIV infection. Some youth in both groups indicate their perception on mass media campaigns whilst others illustrated their uncertainty towards HIV/AIDS prevention strategies. These findings conclude that youth of both groups need to be part of the media campaign organisations when information on HIV/AIDS prevention is planned and communicated to the public in the region. A user-friendly approach is needed to remedy the situation.

This chapter discussed and interpreted the study results. The next chapter proposes the implementation of the integrated human-centred dialogical health communication model as advocated by Paulo Freire (1985) as an active learning approach and the best option for change.

CHAPTER 7

THE PROPOSED MODEL OF DIALOGICAL HEALTH COMMUNICATION FOR SOCIAL BEHAVIOUR CHANGE THAT COULD BE APPLIED TO HIV/AIDS PREVENTION IN NAMIBIA

7.1 Introduction

In the previous two chapters, the study results were presented and discussed and it has been shown that there is a need to improve the communication (educational) model used during HIV/AIDS prevention campaigns. More importantly, it has been shown that an integrated dialogical approach in the communication of information during HIV/AIDS prevention campaigns is the best approach to effective health education in Namibia and need to be implemented. An integrated dialogical health communication model during awareness campaigns is required for social and behavioural change. There are currently many mass media campaign organisations in Oshana Region but they are operating in isolation using a conventional communication approach. Therefore, this chapter discusses the proposed Integrated Dialogical Health Communication Model, as the best option forward.

From the results it is clear that youth of both groups received information on HIV/AIDS prevention from media campaigns which was disseminated through a conventional communication approach.

This approach is teacher-centred and impedes receivers (youth) from internalising the received information and changing their lifestyles and sexual behaviours. Therefore, the internalising aspects need to be strengthened.

On the question of what strategies can be used to facilitate behaviour change among the youth, respondents indicated that a learner-centred approach and sharing of information need to be used to strengthen and ensure a more user-friendly approach. Such an approach will help the communication of information between the sender and the receiver to be assimilated through facilitation and dialogue.

The literature reviewed reveals that in Namibia as in other African countries, HIV/AIDS has become the leading cause of hospitalisation and death (UNAIDS, 2008). Media awareness campaigns have been considered as means of national development using mass communications (radio, television and printed materials) to achieve the country's communication and development goals. The concern is that mass media campaigns (in many countries worldwide in general and in Namibia in particular) operate on a Conventional Persuasive Educational Model, which is "authoritarian, hierarchical and banking education" (Freire, 1972). The latter model does not facilitate social behaviour change because of its non-interactive approach.

The conventional model operates on the assumption that health educators and media campaign officers are experts, who hold, know and reveal knowledge to learners/recipients who are passive receivers of information.

It creates a “culture of silence” among recipients. This means that the receivers (participants/target audience/youth) of information are being told what to do and how to do it without their active involvement.

The study results revealed that the Conventional Persuasive Educational Model used to disseminate information to the public in Oshana Region, whilst it has given adequate knowledge on HIV/AIDS prevention to the youth; it has had little impact on changing their lifestyle and sexual behaviours (Schiavo, 2007). Therefore, the researcher proposes the use of an Integrated Dialogical Health Communication Model that is “a two way dialogical model” based on the Empowerment/Participatory Model for change developed by an adult educator, Paulo Freire (Freire, 1985).

7.2 The proposed integrated dialogical health communication model for social behaviour change that could be applied to HIV/AIDS prevention in Namibia

7.2.1 Introduction

The discussion in chapter 6 has shown that there is a need to raise awareness about the conventional communication model as compared to the integrated dialogical health communication model. The proposed integrated dialogical model in mass media campaigns in Namibia will take in consideration the survey data as presented and discussed in Chapter 5 and 6, and the findings of the literature review in Chapter 2.

Some of the concepts presented in the theories and models of social and behaviour change will inform the design of the model developed in this chapter. The Social Cognitive Learning Theory (Bandura, 1977), Diffusion of Innovation Theory (Rogers, 1995), HBM and Empowerment Theory (Freire, 1985) will be critiqued in relation to the proposed model for HIV/AIDS prevention in Namibia.

This chapter will propose an Integrated Dialogical Health Communication Model for mass media campaigns when communicating information during HIV/AIDS prevention in Oshana Region. The model can be adapted to the HIV/AIDS prevention campaigns with similar conditions in Namibia. The proposed model in mass media campaigns is the Integrated Dialogical Health Communication Model as advocated by Freire (1985) in his participatory/empowerment theory. The reason why this model was selected is because of its guiding philosophy and application as recommended by the Brazilian adult educator, Paulo Freire (1972), in which communication is defined as a “dynamic, cyclical process of dialogue and information-sharing” (Freire, 1985, p. 17). It is also defined as a “multifaceted two-way dialogical human development centred approach” (Schiavo, 2007, p.7.). It aimed at creating cultural identity, trust, ownership, commitment and empowerment among people. The model is concerned with building of its audience information base and a person’s confidence, self-esteem, sense of self-worth and self-respect. The integrated model builds on development communication, developed by practitioners, communication activists and scholars, such as Everett Rogers, Albert Bandura, Paulo Freire and others. The theories and models of these scholars focus on communication as a dialogue and conflict resolution activity (Rogers, 1995). This is the major shortcoming in the existing conventional model.

The integrated dialogical model recognises communication as dialogue, like Paulo Freire who conceived communication as dialogue and participation.

The proposed model is understood as a process by which participants create and share information between themselves in order to reach mutual understanding through a participatory process of social change (Waisbord, 2001). All participants in this process as proposed by Paulo Freire are actively involved in their health communication environment as active participants and active receivers of information (1972, 1985).

In the dialogical settings, media technologies (radio and television) are supplementary sources of information pivotal for effective communication interventions and for reinforcing learning. The relationship among participants in the Health Communication Model is horizontal and symmetrical in nature, ensuring social, political, historical, religious and individual outcomes (Schiavo, 2007)

According to Figueroa et al. (2002, p. 214) the proposed model has empowerment (transference of knowledge, skills and resources which enable individuals to take actions, be responsible and remove obstacles they had in the past) and development (growth and advancement of both individuals and communities) as key requirements for the dialogical educational programme. It is not a hierarchical communication relationship but horizontal in nature.

According to Schiavo (2007, p. 12) the integrated health communication model has the following characteristics to enable it to ensure maximum participation and empowerment of target audiences. The model is audience-centred, research based, multidisciplinary, participatory, strategic, process-oriented, cost-effective, and creative in support of strategies, audience and media specific, relationship building and aimed at behavioural or social change. These characteristics distinguish the dialogical health communication model as a “dynamic ongoing cyclical process” from the conventional persuasive health education model, widely used in Africa for HIV/AIDS prevention. Therefore, the proposed integrated dialogical health communication model should make use of communication strategies that are designed to improve public health and promote behaviour change.

7.2.2 Aspects of an Integrated Dialogical Health Communication Programme

The proposed model describes various aspects of mass media campaigns on HIV/AIDS prevention in Oshana Region that could be used when disseminating information to the public (youths) with the aim to raise awareness, increase knowledge, motivate recipients, ensure mutual understanding and influence public opinion in an interactive way through dialogue and participation.

The various aspects are as follows:

- Communication environment
- Target audiences (in this study, the youth)

- Channels of health communication (mass media)
- Media campaigner (sender) as an agent of change
- Policies and policy makers/political leaders
- Human development centred approach
- Participatory monitoring and evaluation

7.2.2.1 Communication Environment

The study findings reveal that before any health education session is conducted, communication problems and needs of young people should be assessed and identified. Currently, media campaigners are assuming youth's needs and communication problems through a conventional education approach. Therefore, in Oshana Region all relevant stakeholders are campaigning against HIV/AIDS without active participation of individuals and communities. This situation lacks community involvement, a collaborative approach and teamwork as advocated by Freire (1985) in his Empowerment Theory. Therefore, as a remedy to the conventional approach, an in-depth health and development needs assessment vital for identifying all root causes, suggest solutions and set priorities and objectives in an interactive manner needs to be done. The proposed integrated dialogical health communication model suggests a collegial in-depth communication environment with the active involvement of all relevant stakeholders (Schiavo, 2007).

The dialogical model has catalysts that initiate dialogue through team work. Specific issues of concern to target audiences are cultural, traditional, political, economic and social factors as well as health beliefs and practices in that society. In this way, young people will understand and analyse their needs and significant learning will take place that enhance individual and social change without persuasion (Rogers, 1995; Figueroa et al., 2002). The integrated dialogical model recognises the interrelatedness of all aspects of life in which communication is taking place in a holistic environment (historical, political, religious, economic, health and social issues). This means that all these factors are pivotal in communication for development (Waisbord, 2001).

7.2.2.2 Target audiences

In this study, audiences are ISY and OOSY. The study results reveal that youths are passive receivers of information in Oshana Region during the conventional model. Youths are being told by media campaigners to use condoms and prevent HIV/AIDS. On this note, the Conventional Health Education Model instructs young people, irrespective of their culture and tradition, to gain knowledge and change their attitudes towards condoms use and HIV/AIDS prevention (Thomas, 2001). Therefore, in the integrated model audiences consist of receivers of information (individuals, families and community members who are parents, peers, leaders at diverse levels) and senders of information (community or village health workers and other stakeholders such as other professionals and volunteers in various media campaign organisations) who are working, sharing information and experience as a team (Schiavo, 2007).

In the proposed model audiences and media campaigners should interact, dialogue and exchange information as recommended in the Empowerment Theory (Freire, 1985) with the aim to increase knowledge and understanding that will effect change.

The proposed model uses the dialogical, ongoing, two-way interactive approach as recommended by Paulo Freire (1985) to remedy the current situation. In the Freirean approach, young people/learners are recognised as risk takers but equal partners during awareness information-sharing processes. Therefore, study results have identified the need for the target audience (youths) to be trained in life skills (communication and negotiation) development. The training will empower youths to understand issues affecting their lives; perceive risks towards HIV infection and teach them how to make constructive decisions (Freire, 1985). The developmental skills are vital to mould young people to become self-directed individuals (Bandura' Theory) who are capable, well informed to make constructive decisions and have control over their lives.

7.2.2.3 Channels of health communication

Mass media technologies such as radio, television and printed materials (posters) are the channels of communications identified in this study used to disseminate information to young people.

The conventional top-down approach uses mass communication alone as the means of giving information to the pre-determined population with pre-defined needs, designed programmes with messages to remedy the situation. This conventional approach lacks democracy, participation and dialogue in its mode of communication (Simons-Morton et al, 1995).

The study results confirm that radio, NBC television and printed materials were the main most common sources of information for youths. Respondents also reveal that mass media messages gave general information, and English was used as a medium of instruction, when information was given to the audiences (young people).

The integrated model, which modified the Freirean dialogical model, recommends a combination of channels of communication to share information with audiences. These are community meetings, face-to-face talks with parents, peers, leaders and teachers through group discussions. Literature reveals that sex education is a taboo topic in many African cultures (Mufune, 2003), but for change to take place dialogue is pivotal during its discussions. Therefore, the implementation of the integrated dialogical human development centred approaches is necessary to remedy the situation (Schiavo, 2007).

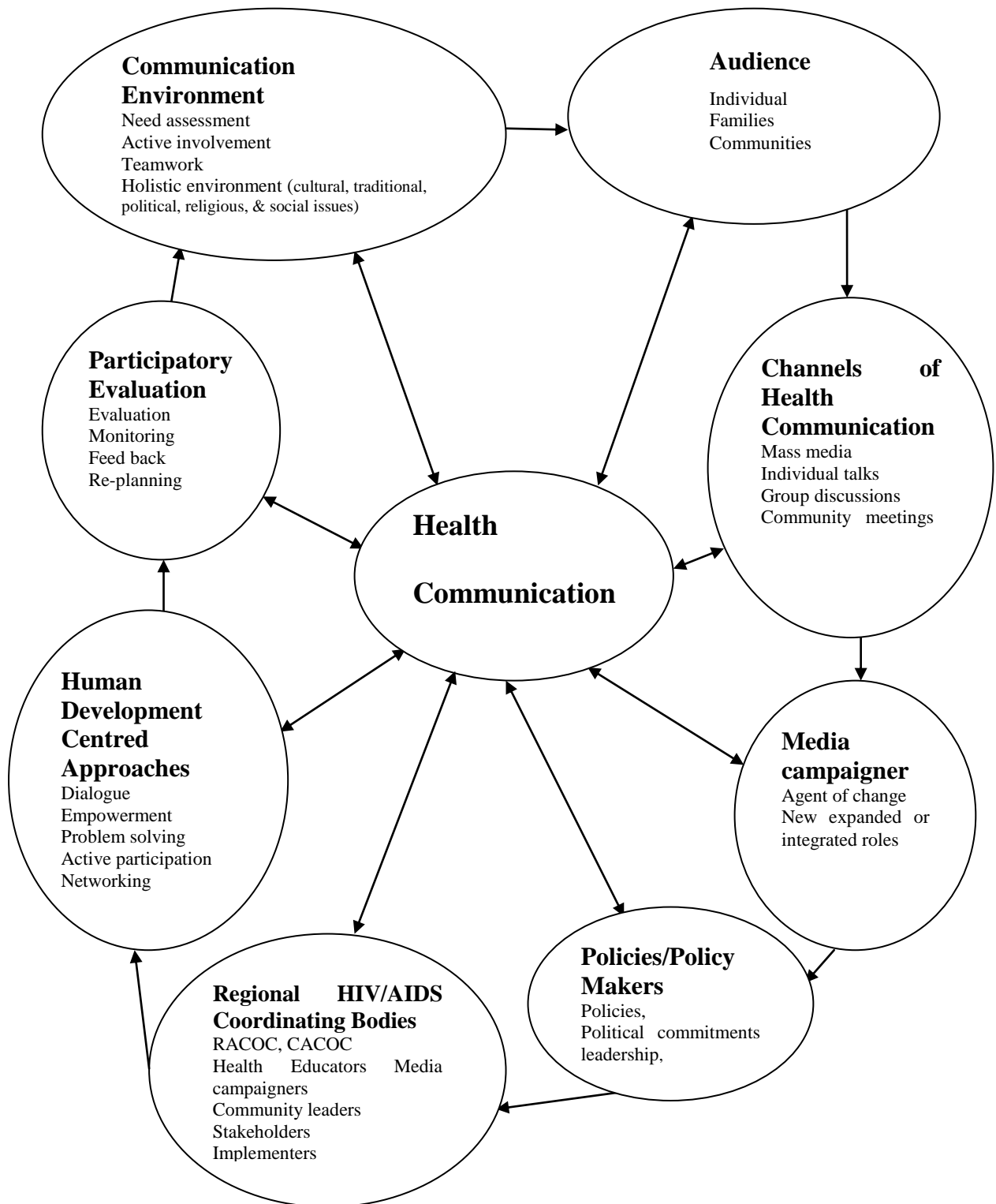
In the dialogical setting local (spoken) languages /vernaculars should be used during mass media campaigns to ensure proper and full understanding and interpretation of messages during the mass communication process.

In this study, respondents reveal that media campaigns use more English (OOSY - 49.4% and ISY - 59.1%) than local languages (OOSY- 47% and ISY- 31.3%) when disseminating information to the public. In general media messages need to be simple, clear and specific, but when it is communicated in English it is complex and uses difficult terms. Such messages should also tell audiences exactly what, when, why, how a person should prevent HIV infection or how to use condoms. Therefore, media campaigners need to develop concepts, materials, messages and stories in collaboration with all key stakeholders using a participatory process to ensure learning (Allegrante & Sleet, 2004). According to Maibach and Parrott (1995) people do not change behaviours when they are given strict instructions. This could may be the reason why people' behaviours are not changing in Oshana Region, despite the fact that media campaigns organisations (implementers) are disseminating information on HIV/AIDS prevention.

7.2.2.4 Media campaigner as a facilitator of change

In the conventional model the senders are experts, transmitting information into “empty vessels” (the recipients) and it is up to them (audiences) to memorise this information and act on it. Senders in the existing model are not facilitators of change but experts who are educated to control the information-sharing forum (Freire, 1985; Allegrante & Sleet, 2004). But in the dialogical model, media campaigners are facilitators/agents of change with integrated roles as indicated in Figure 7.2.

Figure 7. 1: The Proposed Integrated Dialogical Health Communication Model



For the implementation of the proposed model to be smooth, the media campaigners/health communicators in Figure 7.2 should act as facilitators of change with integrated roles. In the dialogical setting media campaigners are catalysts, innovators, peer educators, role models, facilitators, communicators, coordinators, evaluators, motivators, team leaders and above all as an agent of change. These integrated roles need to be strengthened in the proposed model to effect change. These integrated roles are briefly discussed in the next part of this study.

A catalyst is either an internal or an external stimulus that triggers community dialogue about specific issues of interest or concern. In the proposed model, a catalyst initiates dialogue among participants in the HIV/AIDS awareness campaigns. This action of a catalyst is a missing part in the existing health education model (Figueroa et al., 2002).

An innovator is an individual who is an initiator of events/actions. The role of an innovator is to facilitate learning through devising appropriate experience and facilitating reflection. An innovator encourages learners/youths to believe in themselves and act as equal partners in the teaching-learning environment (Freire, 1985).

A role model is an exemplary individual, who teaches through examples and imitation. In Oshana Region, opinion leaders and peers are role models who promote change in daily work through various methods such as community meetings (Schwarz, 2003).

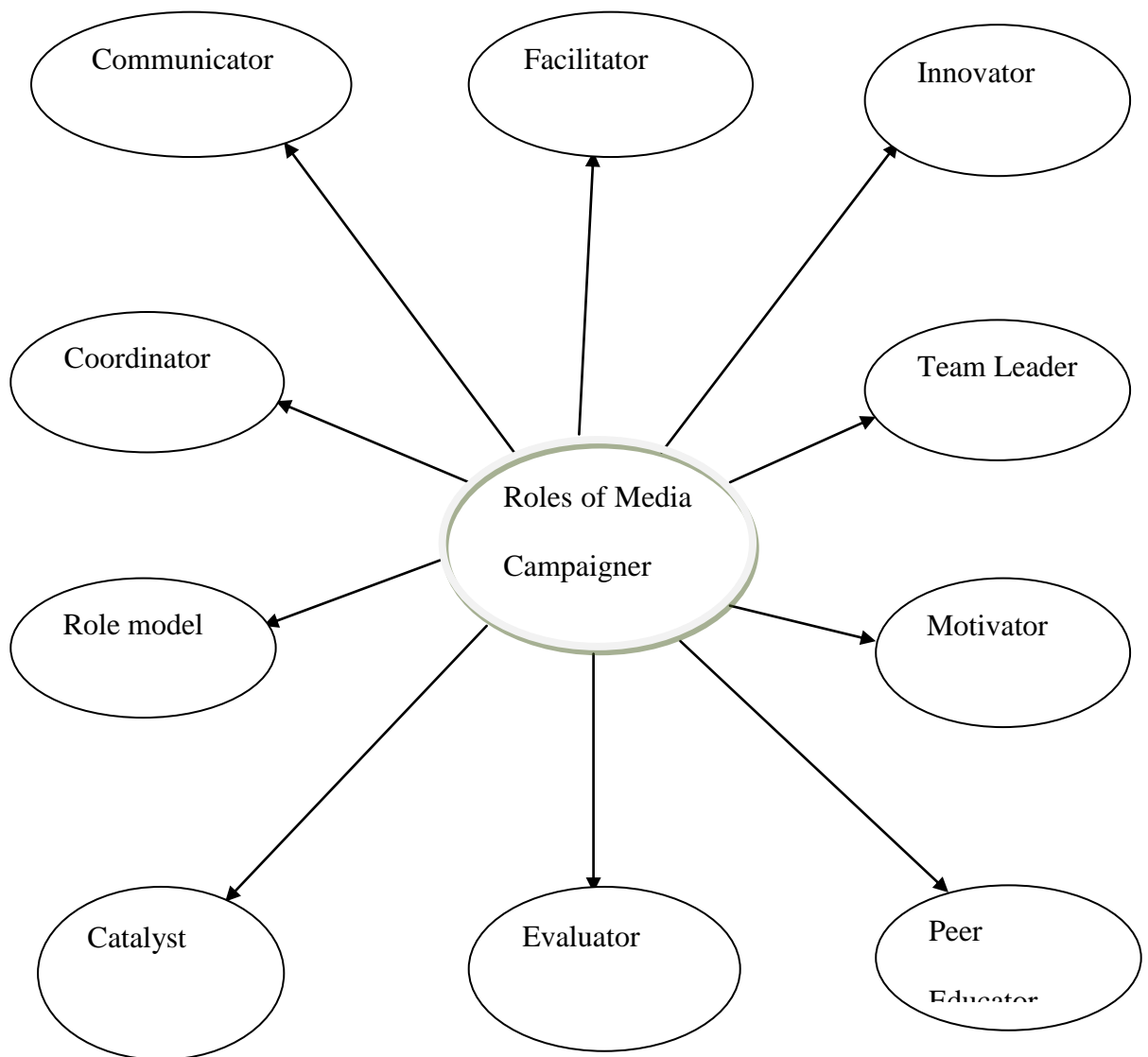
A facilitator has the role to set up an environment conducive to learning. A facilitator encourages and leads discussions in groups using participatory, dialogical approaches. For the implementation of this model, the sender and receiver should interact through dialogue (critical thinking and democracy) to ensure change (Freire, 1985).

A communicator is one who exchanges or shares information with other members of the community based on dialogue. A communicator is a good listener, who should have a shared vision to form a link between students, communities and other stakeholders (Northouse & Northouse, 1985; Stephenson, 2006)

A peer educator is one who is of equal standing with the others, teaches or guides other colleagues at a certain level. A peer educator is responsible for empowering individuals and communities through critical thinking (Schwarz, 2003).

A coordinator is a person who draws people's actions and events together in a way to support and strengthen one another without competition. Media campaigners in the proposed model are coordinators of learning in the teaching-learning environment, fostering the team approach and cohesion among audiences. A coordinator is responsible for moulding youth from dependency to be self-directing, self-governing and self-controlling beings (Figueroa et al., 2002).

Figure 7. 2: Media campaigner as a facilitator/agent of change



Source: Allegrante & Sleet, 2004

An evaluator is one who conducts an assessment of issues or needs of the community depending on their situations. In Oshana Region, an evaluator should set objectives, assess goal achievements and shortcomings in a collaborative approach in the HIV/AIDS prevention campaigns (Schiavo, 2007).

A motivator is one who encourages others to participate in community activities and share their experiences as a team (Maibach & Parrott, 1995).

A team leader is a manager or supervisor of decision-making processes. She/he encourages dialogue on the process of monitoring in relation to participatory evaluation to enhance progress (Freire, 1985).

Media campaigners are experts in the existing model, whereas in the proposed model media campaigners are agents of change with expanded multiple roles. These roles are not new but its application in the integrated model is vital because these roles are demanding and challenging, needing new knowledge, skills and abilities to implement them. For the implementation of this model in Oshana Region, media campaigners need to have the following qualities that enable them to perform their expanded roles. They need to be visionary, motivated, exemplary, strategically, critical thinkers, enthusiasm, and flexible, approachable, innovative, creativity and have good interpersonal relationships. On the same note, media campaigners should also have abilities to negotiate, communicate, organise, empower, motivate, co-ordinate and facilitate change.

These roles are vital for media campaigners who are facilitators of change as advocated by Paulo Freire in his Empowerment Dialogical Model (Freire, 1985; Schiavo, 2007).

From the Namibian perspective, in Oshana Region the dominant class (the educated in mass media campaign organisations) hold power over people, therefore it is a challenge to practise empowerment as suggested by Freire (1985). The implementation of the proposed model may bring feelings of anger and resentment among media campaigners. Therefore, it is vital and crucial to note that media campaigners implementing Freire's educational ideas need to be dynamic, mature, confident and well skilled in active teaching-learning methods such as group discussions, drama, role-play to be able to implement and apply change in HIV/AIDS prevention campaigns. They need to comply with changes and not to conform to their routine. This is a challenge for senders (health educators/media campaigners) in the existing model (Figueroa et al., 2002).

From the researcher's experience, change is painful and demanding. Therefore, it is essential for media campaigners to have cordial relationships with community leaders and other key players (opinion leaders) who may be influential and of help with the implementation of the proposed model. A collaborative approach (team work) is necessary to implement this dialogical and participatory approach.

However, it is a challenge to shift the focus from the conventional health model that transfers knowledge to the dialogical participatory approach that shares and dialogues information with recipients. The dialogical approach is vital to ensure effective communication for development and empowerment of media campaigners and receivers of information at all levels.

7.2.2.5 Policies and policy makers

Since independence in 1990, the Namibian Government has adopted strategic planning as a management tool to help ensure effective decision-making. This planning process has strategies, policies, goals, guiding principles and integrated coordinated programmes. Therefore, Namibian leaders (political, policy makers, traditional and religious) have realised that HIV/AIDS is a national issue that needs multiple national responses. This cognizance has made Namibia to be a signatory to a wide range of international and regional agreement, treaties, conventions, declarations and commitments.

However, the Namibian Government in partnership with other national and international stakeholders has established and developed various policies (for example National HIV/AIDS Policy) and management planning strategies (Vision 2030 and Medium Development Plans) vital to fostering HIV/AIDS prevention campaigns, treatment, support and care.

Because of the multi-faceted nature of the HIV/AIDS epidemic, an effective institutional framework for national HIV/AIDS response was established in the country coupled with an expanded multi-sectoral management and coordination plans. These processes were aimed at facilitating the implementation of the HIV/AIDS awareness and prevention campaigns in the country. The latter processes link with Freire' Empowerment Theory and need to be strengthened (GRN, 2004; MoHSS & USAID, 2007).

The proposed integrated dialogical health communication model suggests that implementing partners and coordinating bodies in the mass media campaigns should be responsible and accountable for achieving effective communication goals.

In Namibia, the implementation process is facilitated and supported by the Namibian Government plans (Vision 2030 and MTP plans) and its broad political leadership and commitment at national, regional and local levels. The establishment of various HIV/AIDS committees at all levels also ensure that multi-faceted roles are executed to tackle the challenging developmental health problem (HIV/AIDS) in the country and in Oshana Region (GRN, 2004; MoHSS, 1994). The practice part of all these processes need to strengthened at all levels.

7.2.2.6 Regional Coordinating Bodies /Committees

In Oshana Region, where this study was conducted, various HIV/AIDS committees and organisations, were established and constituted to coordinate HIV/AIDS issues at regional, constituency and community levels. The active involvement of Namibian leaders, individuals and communities in HIV/AIDS prevention, treatment, support and care is what Paulo Freire has advocated in his Empowerment Theory. But what is taking place in the real life situation in Oshana Region is the fragmentation of HIV/AIDS activities. Both public and private media campaign organisations as implementers and coordinating bodies/committees need to strengthen the coordination and networking in the HIV/AIDS prevention activities.

Oshana Regional HIV/AIDS committee (RACOC) is chaired by the Regional Governor as a political leader. For the smooth implementation of the proposed model, a collaborative approach needs to be strengthened. Regional structures on HIV/AIDS prevention were not mentioned by any youth in the survey, but the regional HIV/AIDS structures need to be advocated during the awareness campaigns for them to be known by the audience (the youth) (GRN, 2004). In the current situation Namibian leaders and their active roles in HIV/AIDS prevention are not known, despite their commitment and political will, care and support involved.

The current situation needs to be corrected with the implementation of the proposed Integrated Dialogical Health Communication Model. In the Namibian context the proposed dialogical model could easily be implemented because of the availability of a strong political will, structures and strategies towards HIV/AIDS prevention approaches in Namibia (NPC, 2005).

7.2.2.7 Human development centred approaches

Sharing of information is a political activity with its underlying hidden messages about what is valued, what learning is, who is in power, in control and on top (Freire, 1985); hence the importance of human development centred approaches.

In the Integrated Dialogical Health Communication Model, active communication-learning methods such as group discussions, face to face talk, role-play and traditional media such as drama and songs should be used to facilitate sharing of information (dialogue) and the practice of freedom (democracy) in the communication-learning environment. During media campaigns, campaigners should facilitate dialogue and not lecture as is the current practice in the existing model (Freire, 1985; Figueroa, et al., 2002; De Martin et al., 2001). In the proposed model, human development centred approaches facilitate learning that is self-initiated and involves the process of enquiry and self-discovery by all participants (Schiavo, 2007).

Human development centred approaches as advocated by adult educator Paulo Freire (1985), includes the following elements, namely liberating education, problem-solving, dialogue, empowerment, peer education and networking. These elements facilitate the implementation of the Integrated Health Communication Model even in Oshana region.

Liberating education for HIV/AIDS prevention

The proposed model explains that education should aim to liberate human beings. Liberating education means raising awareness and recognises learners as subject and active participants in their own lives and societies. This type of education aims to encourage people to believe in themselves according to the HBM, achieve self-actualisation and promote awareness raising/conscientization (the process of creating critical awareness or self consciousness among individuals and communities)/critical consciousness as advocated in the Empowerment Theory (Freire, 1985). Freire (1972) argues that critical consciousness is integrated with realities. He also (1985) contends that people need to be critical and conscious of the world in which they live. Therefore, according to Freire, critical consciousness opens up possibilities and opportunities for change when executing HIV/AIDS activities.

In the suggested dialogical process during the HIV/AIDS awareness campaigns, individuals and communities need to interact and solve their common problems, because people need to think critically and integrate their problems with their realities.

In this study, the dialogical approach will fill the gap between study results and realities demonstrated by the conventional model in real life situations (Boulton, 2004). For instance, during community meetings, community members and media campaigners should start from root causes in communities, using active learning methods such as group discussions, face-to-face talks, drama, role plays and songs for people to collectively determine their own needs and priorities. This area poses a challenge in the existing conventional model (Allegrante & Sleet, 2004).

Problem-solving approaches

The problem solving strategies are methods used to solve problems with the active involvement of all participants. These strategies pose problems and stimulate interactive engagement. They incorporate assessment, planning, implementation and evaluation. In problem-solving approaches, audiences are recognised as creative and critical human beings. Therefore, media campaigners should facilitate learning through problem-solving approaches and all constituent parts should look for practical ways in which they can change the situations themselves and plan their actions collaboratively as a team. Problem-solving approaches are appropriate in area of conflict resolution to help young people to negotiate and discuss condom use in their sexual relationships.

An example is the joint decision taken by the youth to use condoms and avoid unprotected sex or to definitely refuse to have sex before marriage. Youths who have knowledge and understanding will dialogue and reflect on their lives. This dialogical, participatory, self-reflective approach is lacking in the existing conventional model, hence the importance of the proposed model (Freire, 1985; Figueroa et al., 2002; De Martin et al., 2001; Schiavo, 2007).

Dialogue

Dialogue is a conversation between two or more people. The challenge to the media campaigns system in Namibia is to build an egalitarian platform in mass media campaigns. Egalitarian is the process where the campaigner and target audiences (in this study the youth) are equal partners in the communication environment. This is a way of eradicating the perception of dominance in mass media campaigns, in which the academic climate should change to foster partnership and interaction. This means that the proposed model may dismantle power structures (dominant and hierarchical) through dialogue, mutual disclosure and shared vision (Freire, 1985). The distribution of power relationships between target audiences and media campaigners needs to be reconceptualised and realised to reflect an enriched caring practice in the implementation of the proposed model in Oshana Region (Boulton, 2004). However, it is a challenge for media campaigners to give up their power and share with receivers (target audiences) in the communication environment. The political legacy and tendency of rigidity may still exist among the senders (Figueroa et al., 2002; Boulton, 2004; Schiavo, 2007).

What is needed is the creation of a real educational sharing forum. Therefore, Freire (1972) argues that a real humanistic approach can be identified more by a person's trust in others. In the proposed model it is the role of the media campaigners to create an environment where genuine dialogue can take place and expanded roles are executed smoothly. This is a challenge to the existing model.

Peer education

Peer education is a method, where peers are teaching other youths. For example, MFMC is a peer education intervention programme for youths in secondary schools in Namibia.

The study results indicate that Namibian young people received information on HIV/AIDS prevention from mass media but infrequently from peers and parents. Study results further reveal that some youth are being overruled by their peers as sexual partners in their intimate relationships. For example, male youths slightly dominated their female partners when they were making decisions on condom use. This finding confirmed that peer education is an essential educational programme to promote sexual health and empower youths to implement dialogue and active participation in education. Media campaigners should make use of peers in the Oshana region to promote change (MoHSS, 2007b).

Peer education is explained as an essential element in dialogical model that involves training and supports other group members by modifying norms and stimulating collective action.

On the same note, peer education educates peers to act as role models, modelling healthy sexual behaviours and advocating change. This means that peers will act as agents of change. This intervention is a missing aspect in the existing model and a missing role of media campaigners in the conventional hierarchical model. In Oshana Region, peer education will facilitate empowerment (UNESCO, 2006; Schiavo, 2007).

Empowerment

Empowerment is not the power to dominate others, but rather an interactive process, to have power and act with others to effect change. The study find out that some youths are not empowered, therefore they could not make decisions on condom use and were overruled by their counterparts (Gow & Desmond, 2002). Therefore, media campaigners should aim to empower themselves, youths, and communities to have control over their lives in all environmental settings. Freire (1985) explains that empowerment education is vital since lack of control over one's life is a risk factor. If youths are empowered, the process ensures self-reliance, self-care and self-development which promote health and prevent illnesses including risky behaviours through networking (Page & Czuba, 1999).

Networking

The implementation of the proposed model requires networking, forming a web of human relationships. Networking implies sharing of ideas, information and resources. This is an approach that needs to be implemented by stakeholders and media campaigners in Oshana Region as promoted and recommended by WHO member states during the Alma Ata declaration, where PHC was discussed as a global strategy for Health for all (as cited in MoHSS, 1992, p. 7) and by Freire (1985) in his Participatory Theory.

All relevant stakeholders, as discussed in Section 7.4, need to form a team, planning a coordination programme that will enhance networking and collaboration. Networking needs to be facilitated by key stakeholders at international, national, regional, local and community levels through meetings, seminars, workshops, conferences, formal training and exchange programmes in a collaborative manner. Currently, networking need to be strengthened at all levels in Oshana Region in all HIV/AIDS prevention campaigns, with the blessing of the Namibian Government's strong political will (GRN, 2004; MoHSS & USAID, 2007).

7.2.2.8 Participatory monitoring and evaluation

Participatory evaluation is a continuous process, involving participants and programme management members, reflecting critically on what is planned to take place. However, monitoring is a process of observing whether media campaigns programme occurs as planned (Freire, 1985). The aims, objectives, process, progress and products of media campaigns are evaluated regularly using various evaluation methods. This evaluation should be a group evaluation and not the individual evaluation. In the current situation, the Regional Committee as a coordinating body is overseeing the regional HIV/AIDS activities.

Evaluation (reflection and action) should measure and identify problems, proposed solutions and worked out action plans to ensure smooth running of the prevention campaigns. This stage is missing in the existing conventional model (Maibach & Parrott, 1995).

In the proposed model, evaluation involves real learning and radical change, in which media campaigners present a situation where both the sender and receivers can stop and reflect critically upon what they are doing, identify any needed information or skills, and then plan the action collectively. In this process, the sender and receivers set a cycle of reflection and action (evaluation) in which they are questioning the situation, celebrating the success and analysing critically failures and weaknesses in the educational programme.

Therefore in the proposed integrated dialogical health communication model there is no tendency towards routine as being inherited from the conventional model. Campaigners and all key stakeholders should monitor the programme, exercise transformation and reflect actions. The active involvement of all key players is vital to ensure collective change (Freire, 1985; Figueroa et al., 2002; Schiavo, 2007).

Having reviewed the existing model and discussed the proposed health communication model, it is pivotal to draw a Table (7.1) which offer comparisons between the existing Conventional Persuasive Model and the proposed Integrated Dialogical Health Communication Model as a summary to the models discussed in this study. It is also important to discuss key players/stakeholders in the implementation of the proposed model.

7.3 Key players in implementing the proposed model

The key players are stakeholders who facilitate the implementation of the proposed integrated dialogical health communication model. Stakeholders are individuals and groups who have interests or shared responsibilities in the HIV/AIDS prevention. In this study, key stakeholders are, for example, the youth as individuals, the Namibian Government with its governmental ministries, departments, regional and local authorities and non-governmental organisations (NGO).

Non-governmental organisations (such as TKMOAMS, MFMC, TCE, USAIDS, Yelula Khai project, AIDS Trust and many more), Churches and their affiliated organisations (such as Catholic AIDS Action and its New Start Centres), Traditional Authorities, Media Institutions (NBC, New Era, The Republikein, Namibia Today, Sister Namibia and many more), educational institutions such as universities, colleges and technicons, as providers and communities and individuals as receivers of information (UNICEF, 2006; Schiavo, 2007).

Table 7. 1: A comparison between the existing Conventional Health Educational and the proposed Integrated Dialogical Health Communication Model.

Existing Conventional Health Education Model	Proposed Integrated Dialogical Health Communication Model
Persuasive, conventional health education	Dynamic process, creating understanding as a basis of development
Attempts to change a set of behaviours	Attempts to increase knowledge and understanding of health related issues
Authoritarian	Democratic and ensures interaction
Hierarchical	Participatory in nature to empower participants
Top-down approach	Bottom-up approach
One way directional approach	Two-way dialogical approach, with an interchange (sharing) of information
Audience are passive listeners	Active involvement of participants
Health educator is an expert	Media campaigner is a facilitator
Teacher-centred (adult-controlled)	Learner-centred human development centred
Victim blaming and telling people what to do	Team work aimed to influence, engage and support all stakeholders

Source: Freire, 1985; Schiavo, 2007

Freire (1985) argues that in the existing conventional model, stakeholders have inherited the attitudes of viewing themselves as “experts” and the students/audience as “empty vessels” that need to be filled with information. This attitude has a major impact on the media campaigns. Therefore, attitudes of providers and receivers are crucial in the implementation of the proposed integrated dialogical health communication model. In the existing conventional model, stakeholders are working in isolation as individuals or organisations in HIV/AIDS prevention. They are responsible to raise awareness among people in communities and expect audiences (receivers) to change their sexual behaviours.

But the Namibian Government and its leaders as key stakeholders in HIV/AIDS prevention campaigns have committed themselves through their strong political will and coordinated human development management plans (Vision 2030) to plan and control the HIV/AIDS prevention strategies (GRN, 2004). What the Namibian Government and its leaders are planning is what the proposed integrated dialogical health communication model is suggesting, but the challenge is what takes place in real life situation. The implementation of the integrated approach will change the practice.

The roles of stakeholders are to provide comprehensive humanitarian assistance to combat HIV/AIDS and ensure support and holistic care. What is needed is for stakeholders to collaborate and for media campaigners to perform their integrated roles as a team, interacting with others and sharing responsibilities. Key stakeholders need to create strategic partnerships and coalitions in the HIV/AIDS prevention to be able to ensure collective change (Schiavo, 2007).

7.4 Supporting and sustaining the proposed model in the context of HIV/AIDS prevention.

One of the study findings indicates that mass media campaigns are using the top-down persuasive conventional education model that lacks an analysis of audience needs, their active participation and dialogue. For the integrated model to be supported and sustained it is necessary for the HIV/AIDS prevention approaches to change from top-down conventional education to the dialogical participatory education as advocated by Freire (Freire, 1977; 1985; Figueroa et al., 2002; Schiavo, 2007).

The Namibian Government through line ministries and departments in collaboration with non-governmental organisations as well as media institutions, educational institutions and traditional authorities in the country need to be sensitised about the existing conventional approach which is an obstacle to achieving goals towards the HIV/AIDS prevention (GRN, 2004).

All key stakeholders in the country should understand and work as a team, collaborating to achieve communication goals/objectives with the aim to effect social collective change. They should network with each other because HIV/AIDS cannot be tackled in isolation. The collegial team needs to work together and identify needs, set communication objectives, programmes and action plans.

All policymakers, political leaders, opinion leaders, traditional leaders and all relevant managers and key figures at national, regional and local levels should make a strong commitment, for example, all budgets for the HIV/AIDS prevention should make provision for ongoing training in communication for development. This action may promote behavioural change (GRN, 2004).

Constant programme monitoring and evaluation (as advocated by Freire in his Empowerment Theory) should be advocated to ensure that problems are speedily identified and rectified and prompt progress is made. With professionally trained and skilled peer educators, volunteers and media officers driving media campaigns in various organisations and institutions in the country, the implementations of dialogical liberated education will be possible when they adopt their integrated multiple roles as agents of change (Freire, 1985; Figueroa et al., 2002; Schiavo, 2007).

At a community level traditional leaders and parents should act as opinion leaders/role models/facilitators and agents of change. They will re-shape and influence their communities on HIV/AIDS prevention during community information meetings, because the social and political environment in which people live and work is very important in the implementation of the Integrated Dialogical Health Communication Model. The Namibian Government should be used as an advocacy tool towards strong partnerships and networking in the implementation of the proposed model in Oshana Region (De Martin et al., 2001; Schiavo, 2007).

7.5 Summary

The chapter discusses that the youth (ISY & OOSY) received information from mass media communication through the Conventional Health Education Model. The latter is a hierarchical communication model that is non-interactive in its approach. The conventional model is a challenge in the HIV/AIDS prevention campaigns because it operates on the assumptions of a victim-blaming approach. The latter approach has created a gap in the communication-learning environment, between the senders and receivers of information that need to be bridged.

The study findings proposed the Integrated Dialogical Health Communication model, as a two-way dialogical model, which is user-friendly in the HIV/AIDS awareness/prevention campaigns. This model's learning take place through dialogue, facilitation and participation which influence youths to understand their conditions, issues and environments in which they live as individuals and members of communities. The proposed model empowers youth to become critical thinkers and self-directed individuals, who will be able to negotiate and discuss issues affecting their lives. The proposed model is based on a framework of interventions which is based on moving away from viewing people as objects of change, towards people and communities as agents of change; moving away from delivering message towards supporting dialogue and debate on key issues; moving away from a focus on individual behaviour towards a focus on social norms, policies, culture and supportive environments; moving away from persuasion towards negotiation and partnership and moving away from external technical expertise towards.

The dialogical model aimed at integrating communities to assess issues of concern at the local level (Parker, 2004; Schiavo, 2007). Finally, the Dialogical Health Communication Model is a practical approach to facilitate learning and enhance social change in communication awareness campaigns. The next chapter summarises and concludes the study.

CHAPTER 8

CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

8.1 Introduction

The previous chapter focussed on the proposed integrated dialogical health communication model which could facilitate dialogue and active participation in the mass media awareness campaigns. This chapter discusses the study conclusion, limitations and recommendations. It also gives an overview of the study objectives with its interpretations and conclusion. The study's contribution to the proposed model will also be highlighted, as well as areas for further research.

8.2 Conclusion

The purpose of this study was firstly to explore the perceived impact of mass media campaigns in communicating information on HIV/AIDS prevention to ISY and OOSY in Oshana Region. Secondly, the study describes and analyses methods used by mass media campaigns in communicating information on HIV/AIDS prevention. Thirdly, the study proposed and described a health communication model that could be applied to HIV/AIDS prevention in Namibia. The study data were collected using a self-administered questionnaire. Questions were answered by ISY (825) and OOSY (95).

Both youth groups were from various socio-demographic backgrounds, lived in different environments with various historical, social, religious and cultural characteristics which influence their socialisation in diverse ways.

8.2.1 The overall purpose and objectives of the study

The overall purpose of the study was to explore the perceived impact of mass media campaigns in communicating information on HIV/AIDS prevention to ISY and OOSY in Oshana Region, northern Namibia. The study objectives are illustrated with its main study findings.

Objective 1: Conduct a survey to explore youth's knowledge and views on the effects of mass media campaigns.

The first objective was met. A survey was conducted among the in-school (ISY) and out-of-school (OOSY) in Oshana Region, in Namibia. The study result revealed that most youth have a basic knowledge on the causes and preventive measures of HIV/AIDS. The literature has supported this finding, for example, Iipinge et al. (2004). The study findings also revealed that some youth groups have access to information, because the majority of them are literate and have heard about HIV/AIDS from mass media communication. Youths could also read and understand information (instructions on condoms) related to HIV/AIDS prevention in mass media communication technologies, namely radio, NBC television and printed materials.

The study findings also found that mass media communication is the most common source of information for the youth in HIV/AIDS awareness prevention campaigns. The results of this objective indicate that most youth groups have adequate knowledge and understanding of HIV/AIDS prevention and have aired their views, opinions and perceptions on mass media campaigns. MoHSS and USAID (2007) report also emphasised that Namibian youth are receiving information from mass media campaigns.

Objective 2: Describe methods used in mass media campaigns

The study findings reveal that mass media communications such as radio, television and printed materials were identified as technologies used to disseminate information to the youth/respondents. Study findings also stated that most youth of both groups listen to radio, watch television and read printed materials regularly, weekly or daily and get information on HIV/AIDS prevention. Hutchinson et al. (2007) argue that various media channels are used to educate the public on HIV infection.

The study results show that the method most commonly used by many mass media campaign organisations and individuals to give information to the youth is the conventional, teacher-centred, top-down health education approach. Freire (1985) explains that the conventional method is authoritative and hierarchical in nature and aimed at telling people what to do and how to do things. This means that this model operates by giving strict instructions to youths (audience) to follow and media campaigners anticipated correct adherence to the information given.

The senders/media campaigners in the existing conventional approach are recognised as “experts”, who are operating on the assumption that they know everything and audience/youths are “empty vessels” that need to be filled with information. The conventional approach lacks dialogue, participation and interaction that enable youths to understand issues, perceive their vulnerability to HIV infection and make informed decisions about their lifestyle and sexual behaviours. The conventional health education model is found to increase knowledge acquisition but is ineffective in creating sexual behaviour change among the youth because of its non-interactive approach. Discussion of sexual behaviour is a taboo in many African cultures (Mufune, 2003); therefore it is a challenge to change it using a non-interactive education approach when communicating information to the youth (Hutchinson et al., 2007).

Objective 3: Explain effects of mass media campaigns and messages and its perceived influence on knowledge, attitudes and behaviour of the youth towards HIV/AIDS prevention.

The study results reveal that youths were exposed to mass media messages provided through mass media communication. Messages were given in the form of “slogans” such as “use condoms” and “take control” and similar themes. These messages were mostly communicated through English, as a means of communication. Elder et al. (2004) emphasise that the use of English as an official language which is not always understood could mislead the target audience to misinterpret the meaning of messages.

The study results reveal that media messages do influence some youths to have basic knowledge, moderate self-efficacy on condom use and understanding on HIV/AIDS preventive measures. The literature has supported this finding (Freire, 1985; Smith, 2004; Iiping et al., 2004; Chanda et al., 2008). Therefore, in this study some youths could “definitely” discuss and negotiate condom use with their sexual partners. These youths who have moderate self-efficacy towards HIV/AIDS prevention could also discuss and take decisions jointly with their sexual partners on condom use. This is a positive attitude towards condom use and safer sex relationships, because youths who could discuss condom use have the ability to think critically, negotiate issues affecting their lives, communicate with their partners and make informed decisions.

However, some youths reacted that they could not force their sexual partners to use condoms and avoid unprotected sex or refuse it. Those youths who could not refuse or negotiate unprotected sex, did not understand the dangers of HIV/AIDS nor did they perceive their vulnerability to HIV infection. The study findings also reveal that some female youth of both groups were reluctant or hesitated to refuse unprotected sex or negotiate safe sex. The latter action put youths at risk of HIV infection through their actions and attitudes of their sexual partners.

On the other hand, some youths mainly males, could slightly dominate their female partners not to use condoms and this made them engage in sexually risky behaviour because of their actions. Bouare (2009) and Page and Czuba (1999) echoed this finding that some female youths lack power to control issues affecting their lives and make informed decisions.

In contrast some male youths misused their power to control their partners. In conclusion, both youth groups need knowledge to understand issues affecting their lives. These youths also need communication and negotiation skills that will empower them to become critical thinkers and self-directed individuals as recommended by Freire (1985) in his Empowerment Theory.

Objective 4: Describe the proposed Integrated Dialogical Health Communication Model as an effective media campaign/awareness approach and its implementation strategies

The study has identified the existing Conventional Model as a teacher-centred approach, used by mass media campaigners and health communicators to educate individuals and communities about HIV/AIDS issues. The conventional model is non-interactive and this is a challenge in the health communication-learning environment, hence the importance of the implementation of the proposed Integrated Dialogical Health Communication Model. The latter is a learner-centred, dialogical, reciprocal health communication model. Freire (1985) argue that in the dialogical model media campaigners/ health communicators have integrated roles that facilitate learning, individual and collective social change.

Perkins and Zimmerman (1995) also agree with the idea that the dialogical reciprocal approach uses active communication-learning methods, such as group discussions, problem-solving strategies, role play, drama and many more, to identify needs, set objectives, prioritise problems and plan actions.

The integrated dialogical health communication model has various key implementers and stakeholders who need to collaborate, interact and network with each other to ensure knowledge acquisition and promote behaviour change as the end result. Stein (2001) argues that community-based initiative approaches are more effective in knowledge acquisition than the “top-down conventional education” through mass communication.

The Namibian Government (GRN, 2004) and MoHSS and USAID (2007) clearly indicate in its policies, strategies, Vision 2030 and other coordinated management plans that HIV/AIDS prevention should be tackled by all stakeholders as a national issue using a collaborative approach as advocated by Freire in his Empowerment Theory (Freire, 1985; Bouare, 2009). The Namibian Government’ political will supporting its management plans to ensure teamwork is a vital instrumental tool in the HIV/AIDS prevention campaigns.

In conclusion, the study concludes that the existing conventional health model used to disseminate information to the youth during mass media campaigns is non-interactive in nature; therefore a dialogical, reciprocal, participatory health communication model as the best option. The literature also supports the dialogical model as discussed in Chapters 2 and 3 in this study. Based on the study findings recommendations will be highlighted.

8.3 Recommendations

The study findings conclude that it is easy to acquire knowledge from mass media communication but to change sexual behaviours is a mammoth challenging task. Therefore, in this study the following recommendations are made in terms of the study findings and the youth/audience who are key players in the field of health communication.

Recognition of the youth/audience/communities

The study findings reveal that a total of 920 youth (ISY and OOSY) answered the questionnaires in Oshana Region, northern Namibia. Youths as individuals are the focal point in the information-sharing sessions during mass media campaigns. It is recommended that youths need to be recognised by media campaigners as equal partners and unique individuals (during media campaigns), who can think and decide for themselves on issues affecting their lives such as HIV infection. Therefore, educational meetings should focus on target audience in a dialogical manner, to ensure knowledge acquisition, understanding and behaviour change.

Education and training

The study findings reveal that youth were sexually active, vulnerable to HIV/AIDS and are at risks of contracting HIV infection, because some youth lack knowledge and understanding on issues affecting their lives. The study results indicate that some youth could not neither refused unprotected sex nor able to negotiate condom use.

Therefore, it is recommended that at the regional, constituency and community levels, youths as individuals in Oshana Region need to be trained in life skills development (communication and negotiation skills) that will empower them to understand issues affecting their lives and to make constructive decisions. The knowledge the youth will acquire during training, especially during community and youth groups meetings in the region, will strengthen their knowledge on HIV/AIDS prevention. This knowledge will influence youths to become critical thinkers and self-directed individuals who will also be able to change their norms with respect to decision-making.

Peer education

The study finding indicates that youth were receiving information on HIV/AIDS prevention from mass media campaigns through radio, NBC television and printed materials. At grass roots level mass campaign should be launched to strengthen peer education strategies in the region. A collaborative exercise between youth organisations and various regional HIV/AIDS committees in Oshana Region will facilitate a peer education approach during information-sharing meetings. A youth campaign should address both youth groups through a networking approach. This means that youths should be addressed by their peers with examples of other youths who are HIV positive as role models to increase their level of perception of risky behaviours, their vulnerability to HIV infection and the importance of using condoms during sexual intercourse, especially when young people have multiple relationships. The creation of a collaborative networking approach and active involvement of all key stakeholders including peers/youths in the HIV/AIDS campaigns will facilitate a collective social norm that will enhance new knowledge and behavioural change.

Regional Networking on HIV/AIDS

The study finding reveals that there is poor regional networking among all stakeholders on issues of HIV/AIDS prevention, because regional coordinating bodies and committees were not mentioned as source of information in the region. Despite the Namibian Government in its policies, strategies and coordinated management plans that have indicated HIV/AIDS as a national issue which needs a collaborative approach. Therefore, it is recommended that regional networking meeting between all media campaign organisations as implementers in collaboration with the Regional HIV/AIDS Coordinating bodies in Oshana Region need to be strengthened. Regional networking plans and programmes need to be planned in a collaborative approach with all relevant stakeholders. Again, at regional, local and communities levels all stakeholders and implementers should actively involved in all HIV/AIDS prevention activities. The suggested dialogical and participatory approach is what Freire (1985) has advocated in his Empowerment Theory.

Media technologies

The study finding reveals that radio, NBC television and printed materials are the main source of information for the youth in Oshana Region during HIV/AIDS prevention campaigns. It is further indicated that a lot of information were received from media but with little behaviour change. It is therefore recommended that a combination of channels of communications should be used when communicating information to youths.

For examples, mass media technologies (such as radio, television and printed materials to ensure effective communication) and interpersonal communication (such as face-to-face talk, group discussion and community meetings) are the recommended channels of communications. Communication strategies need to be designed where youths are involved in planning, content formulation and production. This means that youths should interact and dialogue during the presentation of information and also presented with transmitting feedback. At this level youth should take part in the reflection and evaluation of campaigns outcomes. This action reflection process will enhance new knowledge and change.

Language use during HIV/AIDS prevention campaigns

The study results reveal that English as an official language is being used to disseminate information to the people in Oshana Region. Therefore, it is recommended that messages should design, plan and produced in the local languages/ vernacular that is clearly understood by the inhabitants. Media campaigners should find ways to be as clear as possible in their messages without crossing the line of cultural sensibility, because sex is a taboo subject in many African cultures. Namibia is not an exception. Therefore, all dimensions of education and training need to be accommodated in the communication-learning environment where the language use is known by all stakeholders. It is also vital to recognise culture as a new building block for individual and social change and not an obstacle for change.

Implementation of the integrated dialogical model

The study reveals that information during HIV/AIDS prevention campaigns are being disseminated to people through a conventional top-down approach. It is therefore, recommended that the implementation of the integrated human-centred health communication approach need to be advocated and strengthened in Oshana Region.

A training session should be organise in a collaborative approach between the Regional HIV/AIDS Coordinator and other media campaign organisations in Oshana Region to explain how to utilise and strengthened the implementation of the integrated dialogical model. During this information-sharing session all key stakeholders will work as a team, dialoguing with campaigners and audiences to identify why it is important to involve the audience (individuals and communities) when planning and implementing HIV/AIDS prevention campaigns and designing media messages. Two examples will be used to facilitate the implementation process. Firstly, implementers should make use of real life examples of youth who are HIV positive as peer educators and role models in Oshana Region. Secondly, the example of Uganda, one of the successful countries in Africa, uses the dialogical approach during HIV/AIDS prevention campaigns will also be used. The information session will also explain how an interactive approach will empower both implementers and stakeholders with knowledge and understanding as advocated by Freire' (1985) Empowerment/Participatory Model.

8.4 Area of further research

Follow-up research such as action research need to be conducted to examine how the proposed dialogical health communication model is being implemented in the mass media campaigns on HIV/AIDS prevention programmes in Oshana Region. In addition, it is vital to know reasons for the unequal gender-power relations of male dominance and female reluctance in condom use. Maybe it could be due to the social, behavioural, cultural and economic aspects or personal choices. A comparative study between two different population groups within the country could reveal the success/failures of media HIV/AIDS campaigns.

8.5 Limitations of the study

Limitations of a study are usually considered within the study design, method, population and sample, data collection instruments and analysis. Despite the fact that the study data are very rich, it is indicated that the study is limited by a number of facts. The fact that the study was conducted in Oshana Region, one of the thirteen political regions in Namibia is a limitation on its own. Oshana Region has both urban and rural settings with homogenous types of inhabitants. Therefore, the ability to generalize the study findings is limited due to the sample's demographic characteristics. The study explores sexual behaviour, which is a taboo subject in many African cultures, yet it lies at the centre of efforts as new building blocks to prevent the spread of HIV infection.

The other major weakness of the study might be the selection of a predominantly homogenous community but with a high prevalence rate of HIV/AIDS. This study population made the results predictable. More meaningful results might have been obtained if another urban and heterogeneous population (such as Windhoek in Khomas, Walvisbay in Erongo, or Gobabis in Omaheke or Oranjemund in Hardap) had been included. These areas have higher HIV/AIDS prevalence rates, heterogeneous populations and are frequented by visitors/tourists, truck drivers and /or sailors. Comparing the results from two different population groups within the same country might have added new insights regarding the success/failures of media HIV/AIDS campaigns.

Thirdly, the study findings would have yielded more useful information if detailed information from selected mass media campaigns which are disseminating information in Oshana Region could have been obtained. The researcher is of the opinion that information from specific mass media campaigns programme could reveal more detailed information on how specific media campaign programmes plan, produce, disseminate information on HIV/AIDS prevention and evaluate and monitor the outcomes.

Fourthly, data were collected only from questionnaires as the sole method used in this study. Therefore other methods, such as focus group discussions, could have been used to generate more information. In addition, information was gathered from youths as respondents who could give information they felt was required and socially desired but may not correlate with their everyday sexual behaviours in real life situations.

8.6 Contribution of the study

The study has various implications for theory and practice of the dissemination of HIV/AIDS prevention information during mass media campaigns.

As outlined in the statement of the problem of this study in Chapter One, the purpose of this study was to explore the perceived impact of mass media campaigns in disseminating information on HIV/AIDS prevention in Oshana Region, in northern Namibia. One of the contributions of this research is the integration of theories and models for social and behaviour change through the dialogical health communication approach. The application of this theoretical framework was one of the reasons for exploring the impact of the disseminated information through mass media campaigns on youths as illustrated in Figure 3.1. Therefore, the study results proposed the implementation of the integrated dialogical model as described in Chapter Seven.

The use of integrated dialogical health communication model could be replicated and/or adapted in any HIV/AIDS prevention media campaigns with similar situations as Oshana Region. The application and use of this approach can also be used in any communication-learning environment. However, the user needs a clear understanding of various aspects of life and issues in the learning process including the integrated roles of the media campaigners. It is implied that receivers of information (youths) need to have required characteristics to be able to become change agents and facilitators of change. In this way the theoretical framework in the field will highly developed.

The research was limited too by the selection of a predominantly homogenous community, Oshana Region, one political region in the country. But the study findings may go a long way and influence policy and practice because it focuses on urban and rural characteristics as well. The recommendations of this study can be used to improve the dissemination of information on HIV/AIDS prevention through mass media campaigns in Oshana Region and Namibia at large. The study could give mass media campaign organisations, governmental and non-governmental organisations (NGO's) a direction to improve the current approach used during HIV/AIDS prevention activities.

8.7 Summary

The study has achieved its aim of exploring the perceptions of the youth in Oshana Region, northern Namibia. It has also indicated that HIV/AIDS is a real health problem in Namibia; therefore people including youth should have knowledge and understanding to be able to prevent it. It has been demonstrated that the existing conventional approach used to disseminate information to the people on HIV/AIDS has created a gap in the communication-learning process. Again, it is revealed that in the communication-learning environment self-efficacy and dialogue are very important principles of learning and behaviour change. Several recommendations on how to improve the communication approach and ensure effective communication strategies has been made. Areas that required further research has been also highlighted.

The study concludes that mass media campaign is an instrumental tool to give information to people, but information alone cannot effect change. The information-sharing activities need to be coupled with knowledge, understanding, self-efficacy, dialogue, participation and democracy. There is a chance for all stakeholders and implementers in Oshana Region to collaborate and act as a team during the provision of HIV/AIDS prevention activities for effective communication and behavioural change.

REFERENCES

Adams, G.R. & Berzonsky, M.D. (Ed.) (2006). *Blackwell Handbook of Adolescence*. Oxford: Blackwell Publishing.

Agha, S. & Van Rossem, R. (2002). Impact of mass media campaigns on intentions to use the female condom in Tanzania. *Journal of International Family Planning Perspective*, 28(3),151-158. Retrieved April 15, 2005 from <http://www.guttmarker.org/pubs/journals/281510.html>.

Allegante, J.P. & Sleet, D.A. (Ed.) (2004). *Derry berry's Educating for Health, a Foundation for Contemporary Health Education Practice*. San Francisco: Jossey-Bass A Wiley Imprint.

Amon, J., Brown, T., Hogle, J., McNeil, J., Magnani, R., Mills, S. et al. (2000). Behavioural Surveillance Surveys (BSS). Guidelines for repeated behavioural surveys in populations at risk of HIV. *USAID, Impact Project and Family Health International*. Retrieved May 23, 2006 from <http://www.fni.org/publications>.

Andersen, B., Ostergaard, L., Moller, J.K. & Olesen, F. (2001). Effectiveness of mass media campaign to recruit young adults for testing of Chlamydia trachomatis by use of home obtained and mailed samples. *Sex Transmission Infections*, 77, 416 – 418.

Babbie, E. & Mouton, J. (2009). *The Practice of Social Research*. 9th Edition. Oxford: University Press.

Bandura, A. (1977). *Social Learning Theory*. Englewood Cliffs, New Jersey: Prentice Hall.

Barker, K. (2004). Diffusion of Innovations: A World Tour. *Journal of Health Communication*, 9, 131 – 137. Retrieved April 15, 2006 <http://www.ingentaconnect.com>.

Best, A. (2003). An integrated framework for community partnering to translate theory into effective health promotion strategy. *American Journal of Health Promotion*, 18 (2), 159–176.

Bigge, M.L. (1982). *Learning Theories for Teachers*. New York: Harper & Row Publishers.

Bouare, O. (2009). Modelling Contextual Determinants of HIV/AIDS Prevalence in South Africa to Inform Policy. *African Journal of Reproductive Health*, 13(3), 17-33.

Boulton, M. (Ed.) (2004). *Challenge and Innovation, Methodological Advances in Social Research on HIV/AIDS*. Southport: Taylor & Francis.

Burns, N. & Grove, S.K. (2001). *The Practice of Nursing Research, Conduct, Critique & Utilization*. New York: W. B. Saunders Company.

Byrnes, J. P. (2001). *Cognitive Development and Learning in Instructional Contexts*. 2nd Edition. Boston: Allyn & Bacon.

Case, D. O. (2002). *Looking for Information, A Survey of Research on Information Seeking Needs and Behaviours*. New York: Academic Press.

Chambers, R.L. & Skinner, C.J. (Ed.) (2004). *Analysis of Survey Data*. Chichester: John Wiley & Sons Ltd.

Chanda, M., Mchombu, K. & Nengomasha, C. (2008). The Representation of HIV/AIDS in the Media and its Impact among Young people in Namibia: a study of Windhoek and Katima Mulilo. *Information Development*, Sage Publications. Vol. 24, No. 3, p. 188 – 203. Retrieved February 22, 2010 from <http://idv.sagepub.com/cgi/content/abstract/24/3/188>.

Cherie, A., Mitkie, G., Ismail, S. & Berhane, Y. (2005). Perceived sufficiency and usefulness of IEC materials and methods related to HIV/AIDS among high school youth in Addis Ababa, Ethiopia. *African Journal of Reproductive Health*, 9 (1) 66 – 77. Retrieved April 13, 2006 from <http://www.commitnit.com/africa/evaluations/2005/evaluations-173.html>.

Cohen, D. (1999). Socio-Economic causes and consequences of the HIV epidemic in Southern Africa: A case study of Namibia. *UNDP, HIV and Development Programme*. Issues Paper 31. Geneva.

Cohen, L; Manion, L. & Morrison, K. (2007). *Research Methods in Education*. 6th Edition. New York: Routledge Taylor and Francis Group.

Coulson, N. (2004). Development in the use of the mass media at the national level for HIV/AIDS prevention in South Africa. Retrieved July 12, 2007, <http://www.commit.com/publications/pdf/hiv-AIDS/SA/campaigns>.

Creswell, J.W. (2008) *Educational Research Planning, Conducting, and Evaluating Quantitative and Qualitative Research*. Pearson International Edition. 3rd Edition. New Jersey: Pearson Merrill Prentice Hall.

Dailard, C. (2003). Understanding “Abstinence”: Implications for Individuals, Programs and Policies. *The Guttmacher Report on Public Policy* 6 (5). Retrieved November 2, 2006 from <http://www.guttmacher.org/pubs/tgr/html>.

De Martin, S., Seidlein, L., Deen, J.L., Pinder, M., Walraven, G. & Greenwood, B. (2001). Community perceptions of a mass administration of an anti-malarial drug combination in the Gambia. *Journal of Tropical Medicine and International Health*, 6 (6),442-448. Retrieved June 23, 2007 from <http://www.ingentaconnect.com/content/bsc/tmih>.

De Vos, A. S., Strydom, H., Fouche, C.B. & Delport, C. (2005). *Research at grass roots, for the Social Sciences and Human Service Professions*. 3rd Edition. Pretoria: J.L. Van Schaik Publishers.

de Beer, K. & Swanepoel, H. (2005). *Community development and beyond, issues, structures and procedures*. 2nd Edition. Pretoria: J.L. Van Schaik Publishers.

Di Clemente, R.J. & Peterson, J.L. (1995). Preventing AIDS: Theories and methods of behavioural interventions. *The New England Journal of Medicine*, 332(9), 617-618. Retrieved October 25, 2007 from <http://www.conent.nejm.org/cgi/content/full/332/9/617-a>.

Dominick, J.R. (1999). *The dynamic of mass communication*. New York: McGraw-Hill.

Elder, R. W., Shults, R.A., Sleet, D.A., Nichols, J.L., Thompson, R.S. & Rajab, W. (2004). Effectiveness of mass media campaigns for reducing drinking and driving and alcohol involved crashes, a systematic review. *American Journal of Preventive Medicine*. 27(1), 57 - 65. Retrieved September 08, 2009 from <http://www.thecommunityguide.org/mvoi/massmedia-ajpm.pdf>.

Ewles, L. & Simnett, I. (1995). *Promoting Health, a Practical Guide*. 3rd Edition. London: Scutari Press.

Fawcett, B.S., Paine-Andrews, A., Francisco, V.T., Schultz, J.A., Richter, K.P., Lewis, R.K., Williams, E.L. et al. (1995). Using Empowerment Theory in Collaborative Partnerships for Community. *American Journal of Community Psychology*. 23(5), 677 – 697.

Figueroa, M.E., Kincaid, D.L., Rani, M. & Lewis, G. (2002). Communication for Social Change: An Integrated Model for measuring the process and its outcomes. *Communication for Social Change Working Paper Series*, Retrieved June 8, 2008 from <http://www.communicationforsocialchange.org/pdf/socialchange/pdf>.

Fox, G. (Ed.) (1988). *Essential English Dictionary, Helping learners with real English*. London: Harper Collins Publishers.

Fraser, C. & Restrepo-Estrada, S. (1998). *Communication for development, Human Change for Survival*. London: I.B. Taurus & Co Ltd.

Freimuth, V. (1995). Mass media strategies and channels: a review of the use of media in breast and cervical cancers screening programs. *Journal of Wellness Perspectives*, 11(2), 79 – 97.

Freire, P. (1972). *Pedagogy of the oppressed*. London: Penguin Books & Garvey Publishers

Freire, P. (1985). *The Politics of Education, Culture, Power and Liberation*. Critical Studies in Education Series. London: Bergin & Garvey Publishers.

Freire, P. & Shor, I. (1987). *A Pedagogy for liberation, dialogue transforming education*. London: Bergin & Garvey.

Fullan, M. (2001). *The new meaning of educational change*. 3rd Edition. New York: Teachers College Press.

Ghana Demographic and Health Survey (GDHS). (2003). Accra: Ghana Statistical Service and ORC Macro..

Gouws, E., Kruger, N. & Burger S. (2000). *The Adolescent*. 2nd Edition. Cape Town: Clyson Printers.

Gow, J. & Desmond, C. (Ed.) (2002). *Impacts and Interventions, the HIV/AIDS Epidemic and the Children of South Africa*. UNICEF. Pietermaritzburg: University of Natal Press.

Government of the Republic of Namibia (GRN). (1990). *The Constitution of the Republic of Namibia*. Windhoek: GRN.

Graziano, A.M. & Raulin, M.L. (2004). *Research methods, a Process of Inquiry*. 5th Edition. New York: Pearson Education Group Inc.

GRN (2004). *Namibia Vision 2030, Policy Framework for Long-term National Development (Summary)*. Windhoek: Office of the President.

Groves, R.M., Fowler, Jr. F., Couper, M.P., Lepkowski, J.M., Singer, E. & Tourangeau, R. (2004). *Survey Methodology*. New Jersey: John Wiley & Sons Ltd. Publications.

Harting, J., Rutten, G.M., Rutten, S.T. & Kremers, S.P. (2009). A qualitative application of the diffusion of innovation theory to examine determinants of guidelines adherence among Physical Therapists. *Physical Therapy Research Report*. 89 (3) 221 -232. Retrieved September 4, 2009 from <http://www.ptjournal.org>.

Hedgepeth, E. & Helmich, J. (1996). *Teaching about sexuality and HIV, Principles and methods for effective education*. New York: New York University Press.

Hofstede, G. (2001). *Cultures Consequence, comparing values, behaviours, institutions and organisations across nations*. 2nd Edition. London: Sage Publishers.

Hutchinson, P.L., Mahlalela, X. & Yukich, J. (2007). Mass Media, Stigma, and Disclosure of HIV test results: Multilevel analysis in the Eastern Cape, South Africa. *AIDS Education and Prevention*, 19(6), 489 – 510.

Illeris, K. (2003). Towards a contemporary and comprehensive theory of learning. *International Journal of Lifelong Education*. 22(4), 396 – 406.

Iiping, S., Hofnie, K. & Friedman, S. (2004). *The relationship between gender roles and HIV infection in Namibia*. Windhoek: University of Namibia Press.

Jackson, H. (2002). *AIDS in Africa, Continent in Crisis*. Harare: SAFAIDS.

Johnson, B. & Christensen, L. (2008). *Educational Research, Quantitative, Qualitative and Mixed Approaches*. 3rd Edition. London: Sage Publications.

Keating, J., Meekers, D. & Adewuyi, A. (2006). Assessing effects of a media campaign on HIV/AIDS awareness and prevention in Nigeria: results from Vision Project. *Bio Medical Central Public Health*, 6(123), Retrieved May 7, 2008 from <http://www.biomedcentral.com>.

Kelly, K., Parker, W. & Lewis, G. (2001). Reconceptualising behaviour change in the HIV/AIDS context. *African Journal of AIDS Research*, 1(2). CADRE. Retrieved April 14, 2007 from <http://www.cadre.org./publications/html>.

LeBeau, D. (Ed.) (2004). 2002 Baseline survey on sexual and reproductive health and HIV/AIDS among adolescent and youth. *UNFPA*. Windhoek: University of Namibia and Solitaire Press.

Lévesque, R.J.R. (2002). *Dangers Adolescents, Model Adolescents Shaping the Role and Promise of Education*. New York: Kluwer Academic / Plenum Publishers.

Levy, D.T. & Friend K. (2000). Gauging the effects of mass policies: What do we need to know? *Journal of Public Health Management and Practice*, 6(3), 95 – 112.

Low-Beer, D. & Stoneburner, R.L. (2004). Behaviour and communication, change in reducing HIV: Is Uganda unique? *African Journal of AIDS Research*, 1(2). CADRE. Retrieved April 14, 2007 from <http://www.cadre.org.za>.

Maibach, E. & Parrott, R.L. (Ed.) (1995). *Designing Health Messages Approaches from Communication and Public Health Practice*. Thousand Oaks: SAGE Publications.

Ministry of Health and Social Services (MoHSS) (1992). The official National Primary Health Care/Community Based Health Care Guidelines. Windhoek: GRN.

MoHSS. (1993). *Namibia Demographic and Health Survey 1992*. Windhoek: MoHSS.

MoHSS. (1995). *Integrated Health Care Delivery: The Challenge of implementation. A situational analysis and practical implementation guide*. Windhoek: Namib Graphics.

MoHSS. (1999a). *Report of the 1998 HIV Sentinel Sero-Survey*: Directorate Primary Health Care and Nursing Services. Windhoek: MoHSS.

MoHSS. (1999b). *The National Strategic Plan on HIV / AIDS (Medium Term Plan 11) 1999 – 2004*. Windhoek: Namib Graphic Ltd.

MoHSS. (2000). *Epidemiological Report on HIV /AIDS for the year 1999*. Windhoek: NACOP, MoHSS.

MoHSS. (2001). *Report of the 2000 HIV Sentinel Sero Survey*. Health Directorate of Primary AIDS Co-ordination Programme. Windhoek: MoHSS.

MoHSS. (2003). *Namibia Demographic and Health Survey 2000*. Windhoek: MoHSS.

MoHSS. (2004). *The National Strategic Plan on HIV/AIDS. Third Medium Term Plan (MTP 111) 2004 –2009*. Directorate Special Programmes. Windhoek: MoHSS.

MoHSS. (2005). *Report of the 2004 National HIV Sentinel Survey. HIV prevalence rate in pregnant women, biannual surveys 1992-2004, Namibia*. Directorate of Special Programmes. Division: Expanded National HIV Response Coordination. Windhoek: MoHSS.

MoHSS. (2007a). *Report of the 2006 National HIV Sentinel Survey*. Windhoek: MoHSS.

MoHSS. (2007b). *National Policy on HIV/AIDS*. Windhoek: Namprint. Retrieved on May 7, 2009 from <http://www.undp.un.na/2009/hiv>.

MoHSS. (2007c). *United Nations General Assembly Special Session (UNGASS) Country Report. Reporting period April 2006 – March 2007*. Windhoek: MoHSS.

MoHSS & USAID. (2007). *HIV/AIDS in Namibia: Behavioural and Contextual Factors Driving the Epidemic*. Windhoek: Measure Evaluation, Macro International.

MoHSS. (2008a). *Estimates and Perceptions of the Impact of HIV/AIDS in Namibia*. Directorate of Special Programme. Windhoek: Namibia. Retrieved March 12, 2009 from <http://www.healthnet.org.na/documents/reports>.

MoHSS. (2008b). *Report on the 2008 National HIV Sentinel Survey*. Directorate of Special Programme. Windhoek: MoHSS.

MoHSS & Macro. (2008). *Namibia Demographic and Health Survey 2006-07*. Windhoek: MoHSS & Marco.

Mouton, J. (2001). *How to succeed in your master's and doctoral studies: A South African guide and resource book*. Pretoria: Van Schaik.

Mufune, P. (2003). Changing patterns of Sexuality in Northern Namibia: Implications for the Transmission of HIV/AIDS. *Journal of Culture, Health and Sexuality*, Taylor & Francis, Ltd, Vol. 5, No.5, p. 425 - 438. Retrieved February 22, 2010 from <http://www.org/stable/4005347>.

Murray, C.E. (2009). Diffusion of Innovation Theory: A bridge for the research-practice gap in counselling. *Journal of Counselling and Development*. 87, 108-116.

Myhre, S.L. & Flora, J. A. (2000). HIV/AIDS Communication Campaigns: Progress and Prospects. *Journal of Health Communication*, 5 (Supplement), 29-45. Retrieved May 22, 2006 from <http://www.informaworld.com/snapp/content>.

Ndyanabangi, B., Kipp, W. & Diesfield, H. (2004). Reproductive Health Behaviour among in-school and out-of-school youth in Kabarole District, Uganda. *African Journal of Reproductive Health*, 8(3), 55-67. Retrieved April 3, 2008 from <http://www.jstor.org/journal/publications/wharc/html>.

Nengomasha, C., Toivo, K., Hidinua, G. & Kabunga, F. (2004). *Socio-cultural research on adolescent and youth sexual reproductive health: Ohangwena Region*. Windhoek: University of Namibia Press.

Nieuwenhuijsen, E.S., Zemper, E., Miner, K.R. & Epstein, M. (2006). Health behaviour change models and theories: Contributions to rehabilitation. *Journal of Disability and Rehabilitation*. 28(5), 245 – 256.

Northouse, P.G. & Northouse, L.L. (1985). *Health Communication, a Handbook for Health Professionals*. New Jersey: Prentice-Hall.

National Planning Commission (NPC). (1997). *National Population for Sustainable Human Development*. Windhoek: National Planning Commission of Namibia.

NPC. (2003). *2001 Population and Housing Census, National Report, Basic Analysis with Highlights*. Windhoek: Central Bureau of Statistics:

NPC. (2005). *2001 Population and Housing Census, Oshana Region, Basic Analysis with Highlights*. Windhoek: Central Bureau of Statistics.

NPC. (2008). *Third National Development Plan (NDP3) 2007/2008-2011/12*. Volume /Executive Summary. Windhoek: NPC.

NPC, MoHSS, UNDP & UNAIDS. (2001). *Reference Documents for the National Initiative to fight HIV/AIDS in Namibia*. Windhoek: NPC.

Okware, S., Kinsman, J., Onyango, S., Opio, A. & Kaggwa, P. (2005). Revisiting the ABC strategy: HIV prevention in Uganda in the era of antiretroviral therapy. *Postgraduate Medical Journal*, Vol. 81, p. 625 - 628. Retrieved February 22, 2010 from <http://pmj.bmj.com.content/81/960/625.full.html>.

Oppenheim, A.N. (2008) *Questionnaire Design, Interviewing and Attitude Measurement*. New edition. New York: Pinter Publications.

Otaala, B. (2000a). *HIV /AIDS, the Challenge for tertiary institutions in Namibia: Proceedings of workshop held from October 9th - 11th 2000, at Safari Hotel Court Conference Centre, Windhoek: Printech.*

Otaala, B. (2000b). *Impact of HIV/AIDS on the University of Namibia and the University Response*. Windhoek: Printech.

Page, N. & Czuba, C.E. (1999). Empowerment, what is it? *Journal of Extension*, 37 (5). Retrieved June 22, 2005 from <http://www.joe.org/joe/1999october/comm1.html>.

Parker, W. (2004). Rethinking conceptual approaches to behaviour change: The importance of context. *CADRE*. Retrieved June 24, 2007 from <http://www.cadre.org/publications/html>.

Parker, W., Rau, A. & Peppia, P. (2007). HIV/AIDS communication in selected African Countries, Interventions, response and possibilities. *in CADRE*. Retrieved on April 24, 2008 from <http://www.cadre.org.za/present/publications/html>.

Perkins, D.D. & Zimmerman, M.A. (1995). Empowerment theory, research and application. *American Journal of Community Psychology*. 23(5), 569 -579.

Phororo, H. (2003). *HIV/AIDS and Private Sector in Namibia: Getting the Small Business on Board*. Occasional Paper 3. Hanns Seidel Foundation Namibia. Retrieved May 7, 2006 from <http://www.hsf.org.na/en/seminars.html>.

Pisani, E. (2003). *The epidemiology of HIV at the start of the 21st century: reviewing the evidence*. Geneva: UNICEF.

Polit, D.F. & Hungler, B. (1999). *Nursing Research, Principles and Methods*. 6th Edition. New York: Lippincott Company.

Rew, L. (2005). *Adolescent Health, a multidisciplinary approach to theory, research and intervention*. Thousand Oaks, California: Sage Publications.

Riehl-Sisca, J. P. (1989). *Conceptual models for Nursing Practice*. 3rd Edition. New Jersey: Appleton & Lange.

Robson, C. (2002). *Real World Research, a Resource for Social Scientists and Practitioner – Researchers*. 2nd Edition. Oxford: Blackwell Publishing.

Rogers, E. M. (1995). *Diffusion of Innovations*. 4th Edition. New York: The Free Press.

Ross, D., Dick, B. & Ferguson, J. (Ed.) (2006). *Preventing HIV/AIDS in young people. A systematic review of the evidence from developing countries*. Geneva: WHO.

Schiavo, R. (2007). *Health Communication, from Theory to Practice*. 1st Edition. San Francisco: Jossey-Bass John Wiley & Sons. Ltd.

Schooler, C., Chaffee, S.H., Flora, J.A. & Roser, C. (1998). Health campaign channels: Tradeoffs among reach, specificity and impact. *Human Communication Research; Thousand Oaks*, 24(3), 410-432. Retrieved July 6, 2003 <http://www.library.avu.org/cgi-bin/LIB...t>

Schunk, D. H. (2000). *Learning Theories, an Educational Perspective*. 3rd Edition. Columbus Ohio: Merrill Imprint of Prentice Hall.

Schwarz, B. (2003). *Young Namibians and HIV & AIDS, a baseline study with communication recommendations for the Adolescent HIV Prevention Programme for UNICEF Namibia*. Windhoek: UNICEF.

Shapumba, T., Apollus, F., Wilkinson, W., Shifiona, N. & Karirao, J. (2004). *Socio-cultural research on adolescent and youth sexual and reproductive health: Oshana Region*. UNFPA. Windhoek: University of Namibia Press.

Simons-Morton, B.G., Greene, W.H. & Gotlieb, N.H. (1995). *Introduction to Health Education and Health Promotion*. New York: Waveland Press.

Smith, D. J. (2004). Youth, Sin and Sex in Nigeria: Christianity and HIV/AIDS Related Beliefs and Behaviour among Rural-Urban Migrants. *Journal of Culture, Health and Sexuality*, Taylor & Francis, Ltd, Vol. 6, No. 5, p. 425 – 437. Retrieved March 3, 2010 from <http://www.jstor.org/stable/4005308>.

Stein, Jo. (2001). HIV/AIDS and the Media, a literature review. *The Centre for AIDS Development, Research and Evaluation (Cadre)*. Johannesburg: Cadre.

Steinberg, S. (1999). *Communication Studies: an introduction*. Cape Town: Juta & Company Ltd.

Steinberg, S. (1999). *Communication Studies, an introduction*. Cape Town: Juta & Company LTD.

Stephenson, M.T. (2006). Speaking of Health: Assessing health communication strategies for diverse populations. National Academy of Sciences. Retrieved May 24, 2007 from <http://www.nap.edu/catalogue/10018.html>.

Suter, W.N. (2006). *Introduction to Educational Research, a critical thinking approach*. Thousand Oaks: Sage Publications.

Talavera, P. (2002). *Challenging the Namibian Perception of Sexuality: A case study of the Ovahimba and Ovaherero culture-sexual Models in Kunene north in an HIV/AIDS context*. Windhoek: Gamsberg McMillan.

Thomas, S.S. (2001). Using the Health Belief Model to explain differences in mammography compliance among Black and White women. *Cancer Prevention Fellowship Program, National Cancer Institute*. Indiana University School of Nursing, Indianapolis, 301-496. Retrieved February 6, 2005 from <http://www.google.com/publications/journal>.

Tubbs, S.L. & Moss, S. (1994). *Human Communication*. 7th Edition. New York: McGraw-Hill, Inc.

UNAIDS. (2002). *Report on global HIV/AIDS epidemic*. Geneva: UNAIDS.

UNAIDS. (2004). *2004 Report on the global AIDS epidemic: 4th global report*. Geneva: UNAIDS.

UNAIDS. (2008). *Report on the global AIDS epidemic*. Geneva: UNAIDS.

UNAM/USDA/FSIS. (2004). Multi-year mass media campaign plan theoretical framework. *ORC MARCO / APCO*. Beltsville: ORC MARCO / APCO.

UNESCO. (2004). *HIV and AIDS Prevention in Education. A Training Programme for Teachers Educators in Sub-Saharan Africa*. Windhoek: Gamsberg Macmillan.

UNICEF. (2001). *The State of Health Behaviour and Lifestyle of Pacific Youth: FSM Report*. Suva: UNICEF Pacific.

UNICEF. (2006). *HIV and AIDS knowledge, attitudes, practices and behaviour (KAPB) study in Namibia*. Windhoek: UNICEF.

UNFPA. (2004). *Baseline survey on sexual and reproductive health and HIV/AIDS among adolescents and youth*. Windhoek: Solitaire Press.

United Nations Development Programme (UNDP). (2000). *Namibia Human Development Report*. Windhoek: UNDP.

USAID. (2003). *HIV/AIDS Lifestyles, Knowledge, Attitudes and Practices: A Baseline Survey of Greater Windhoek Youth in Namibia*. Windhoek: USAID.

Valente, T.W. & Saba, W. (1998). Mass media and interpersonal influence in a reproductive health communication campaign in Bolivia. *Journal of Communication Research*, 25(1) 96-124. Retrieved June 7, 2004 from <http://www.library.avu.org/cgi-bin/LIB...t>.

Waisbord, S. (2001). Family tree of theories, methodologies and strategies in development communication: convergences and differences. *The Rockefeller Foundation*. Retrieved February 6, 2006 from <http://www.commitnit.com/strategicthinking/stsilviocomm/sld-1774.html>.

Yanovitsky, I & Bennett, C. (1999). Media attention, institutional response, and behaviour change. *Journal of Communication Research*, 26(6), 429 - 453.

Zimmerman, M.A. & Warschausky, S. (1998). Empowerment theory for rehabilitation research: Conceptual and methodological issues. *Journal of Rehabilitation Psychology*. 43(1), 3 - 6.

Appendix 1: 1 Covering letter for research participants

UNIVERSITY OF NAMIBIA: NORTHERN CAMPUS

P.O. Box 2654, Oshakati, Eliander Mwatale Street, Namibia
Telephone (+264) 65-223 2000; Fax (+264) 65-223 2271; www.unam.na



17th November 2005

The In-school and Out-of-school youth

Oshana Region

Namibia

Re: Permission to participate in the research study

Dear Participant

I am a lecturer at the University of Namibia stationed at the Northern Campus and doing my research for a Doctor Degree in Philosophy in Information Studies on:

Perceived impact of mass media campaigns on HIV/AIDS prevention in Oshana Region, Namibia.

For data collection purposes, you are hereby requested to fill in the attached self-administered questionnaires designed for this study. I humbly do request you to assist the researcher in answering the questions contained in the questionnaires. Dear participant, be re-assured that your name will remain anonymous as you do not need to fill it in. The information you give will be treated with confidentiality and be used for academic purposes only.

I appreciate your kindness and assistance in this study.

Thanking you in anticipation

A handwritten signature in blue ink, appearing to read 'Regina Mpingana Shikongo', is written over a faint, light-colored watermark of the University of Namibia logo.

Ms Regina Mpingana Shikongo (**Doctoral student**)

UNAM Northern Campus, Oshakati

P.O. Box 1248 Oshakati

Tel: +264- 65 - 223 2270(w) Fax: +264 - 65- 223 2283(w)

Cell: +264 811275392

Appendix 1: 2 Request for permission to conduct research in schools

UNIVERSITY OF NAMIBIA: NORTHERN CAMPUS

P.O. Box 2654, Oshakati, Eliander Mwatale Street, Namibia

Telephone (+264) 65-223 2000; Fax (+264) 65-223 2271; www.unam.na



17th November 2005

The Permanent Secretary
Ministry of Education
Government Office Park (GOP)
P / Bag 13391
Windhoek
Namibia

Dear Sir / Madam

Re: REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN SCHOOLS IN OSHANA REGION

Topic: Perceived impact of mass media campaigns on HIV/AIDS prevention in Oshana Region, Namibia

I hereby would like to request for permission to conduct the above-mentioned study in Combined, Junior and Senior Secondary Schools in Oshana Region.

I am a lecturer at the University of Namibia, currently employed in the Centre for External Studies at the Northern Campus, Oshakati. I am currently pursuing my studies following a programme: Doctor Degree in Philosophy in Information Studies with the University of Namibia.

It is required that I carry out a research project as part of my studies. The envisaged visit to the above-mentioned schools is to explore and document views and ideas of the in-school youth towards the study topic. It is expected that the study will provide information that may be valuable theoretically and practically.

The study may further reveal some helpful information for possible behaviour change towards HIV/AIDS prevention among the youth by exploring questions to which the study addresses itself. The study population will be all in-school youth, who are doing grades 10, 11 and 12 in Combined, Junior and Senior Secondary Schools in Oshana Region.

The estimated period for data collection is from 1st November 2005 to December 2007. The period is long to cover possible data cross checking.

- Enclosed:
1. A copy of a letter from Prof. Zimba, the Director of UNAM Postgraduate Research Studies with the Resolution number authorizing me to do the course. (Date of my registration – 1st July 2005).
 2. A copy of my research proposal and questionnaires for the study.

Sincerely yours



Ms Regina Mpingana Shikongo (**Doctoral student**)

UNAM Northern Campus, Oshakati

P.O. Box 1248 Oshakati

Tel: +264 – 65 - 223 2270(w) Fax: +264 – 65 - 223 2283(w)

Cell: +264 811275392

Appendix 1: 3: Response from the Ministry of Education



REPUBLIC OF NAMIBIA

MINISTRY OF EDUCATION

EDUCATIONAL PROGRAMMES IMPLEMENTATION

Tel: 264 61 2933200
Fax: 264 61 2933922
E-mail: mshimho@mec.gov.na

Private Bag 13186
WINDHOEK
14 November 2006

Enquiries: MN Shimhopileni

File: 12/2/6/2

Ms Regina Mpinagna Shikongo
UNAM Northern Campus
P. O. Box 1245
OSHAkti

Dear Madam

RE: PERMISSION TO CONDUCT A RESEARCH IN SOME SECONDARY SCHOOLS IN OSHANA REGION

Your letter on the above-mentioned subject, dated 3 November 2005 has reference.

The Ministry welcomes and appreciates your intention to conduct a research on the level of HIV and AIDS awareness and knowledge through mass media, among in-school youth at some secondary school in the region referred to above.

Permission is hereby granted, in the belief that the research activity will neither disturb nor interfere with the normal school programmes.

It is advisable to identify the schools (through the Regional Office) you intend to involve in the research programme, so that the schools concerned would be informed accordingly and be able to make the necessary arrangements.

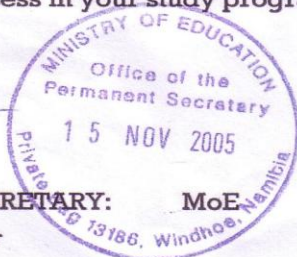
Also indicate, the number of the learners you may require to participate in the research per school.

We wish you success in your study programme.

Yours faithfully

.....
VI Ankama
PERMANENT SECRETARY:

cc: Regional Director



Appendix 1: 4: Request for permission and list of schools in Oshana region

UNIVERSITY OF NAMIBIA: NORTHERN CAMPUS

P.O. Box 2654, Oshakati, Eliander Mwatale Street, Namibia

Telephone (+264) 65-223 2000; Fax (+264) 65-223 2271; www.unam.na



16th November 2005

The Director of Education,
Oshana Region
P/ Bag 2020
Ondangwa
Namibia

Dear Ms Shinyemba

RE: A REQUEST FOR PERMISSION TO CONDUCT RESEARCH AND PROVISION FOR A LIST OF SCHOOLS IN OSHANA REGION.

Topic: Perceived impact of mass media campaigns on HIV/AIDS prevention in Oshana Region, Namibia.

I hereby would like to request for a permission to conduct the above-mentioned study in Combined, Junior and Senior Secondary Schools in the Oshana Region.

I am a lecturer at the University of Namibia, currently employed in the Centre for External Studies at the Northern Campus, Oshakati. I am currently pursuing my studies following a programme: Doctor Degree in Philosophy in Information Studies with the University of Namibia.

It is required that I carry out a research project as part of my studies. The envisaged visit to the above-mentioned schools is to explore and document views and ideas of the in-school youth towards the study topic. The study population will be all learners in Combined, Junior and Senior Secondary Schools in the Oshana Region.

Secondly, I am requesting a list of all Combined, Junior and Senior Secondary Schools with grade 10, 11 and 12 in the Oshana Region that will enable the researcher to sample the schools during data collection process. The selected schools will be communicated to you. A total of thirty (20) learners (in-school youth) per grade per school will be selected unless the number of learners registered in that grade is less than the stated number.

I have requested a permission to conduct this research project from the Ministry of Education. The office of the Permanent Secretary has granted the permission. Enclosed, please find a copy of the letter of the permission.

The estimated period for data collection is from 1st November 2005 to December 2007. The period is long to cover possible data cross checking during data analysis and report writing.

Sincerely yours

A handwritten signature in blue ink, appearing to read 'Regina Mpingana Shikongo', is written over a faint, light blue grid background.

Ms Regina Mpingana Shikongo (**Doctoral student**)

UNAM Northern Campus, Oshakati

P.O. Box 1248 Oshakati

Tel: +264 65- 223 2270(w) Fax: +264 65- 223 2283(w)

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Appendix 1: 5: Permission to conduct research in Oshana region



**REPUBLIC OF NAMIBIA
MINISTRY OF EDUCATION
OSHANA REGION**

**Tel: (065) 242500
Fax: (065) 240175**

**Private Bag 2020
ONDANGWA
NAMIBIA
21 November 2005**

**Eng: Ester Sakaria
Ref: 12/2/6/2**

**To: Ms Regina Mpingana Shikongo
UNAM Northern Campus, Oshakati
P. O. Box 1248
Oshakati**

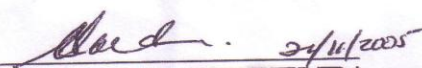
Dear Ms Shikongo

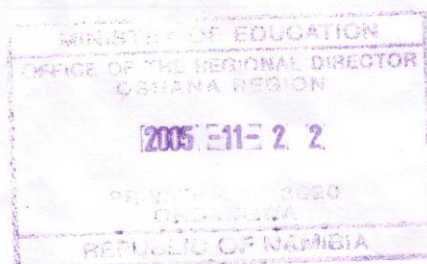
**SUBJECT: PERMISSION TO CONDUCT RESEACH AND PROVISION OF
A LIST OF SCHOOLS IN OSHANA REGION.**

1. Your letter dated 16 November 2005 has reference.
2. You are hereby informed that permission to conduct research in Junior and Senior Secondary Schools in Oshana Region has been granted. Attached please find a list of the schools.
3. Our office would like to know in which schools the research will be conducted or whether it will be conducted in all the schools, as we need to inform the schools accordingly.

We wish you all the best and would appreciate it if you could share your research findings with us upon the completion of your studies.

Yours sincerely


**MRS. DUTTE N. SHINYEMBA
DIRECTOR: OSHANA REGION**



Appendix 1: 6 Request for permission to conduct research in youth organisation

UNIVERSITY OF NAMIBIA: NORTHERN CAMPUS

P.O. Box 2654, Oshakati, Eliander Mwatale Street, Namibia

Telephone (+264) 65-223 2000; Fax (+264) 65-223 2271; www.unam.na



16th November 2005

The Manager of Speed Bike/ Oshana Youth Forum

Oshakati, Oshana Region

Namibia

Dear Sir / Madam

RE: A REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN A YOUTH ORGANISATION IN THE OSHANA REGION

Topic: Perceived impact of mass media campaigns on HIV/AIDS prevention in Oshana Region, Namibia.

I hereby would like to request for a permission to conduct the above-mentioned study in Speed Bike, a Youth Organisation in the Oshana Region.

I am a lecturer at the University of Namibia, currently employed in the Centre for External Studies at the Northern Campus, Oshakati. I am currently pursuing my studies following a programme: Doctor Degree in Philosophy in Information Studies with the University of Namibia. It is required that I carry out a research project as part of my studies. The study population will be all youth in youth organisations in the Oshana Region.

This letter serves to request for permission to access the out-of-school youth in your organisation.

Sincerely yours

A handwritten signature in blue ink, appearing to read 'Regina Mpingana Shikongo'. The signature is written in a cursive style with a large initial 'R'.

Ms Regina Mpingana Shikongo (**Doctoral student**)

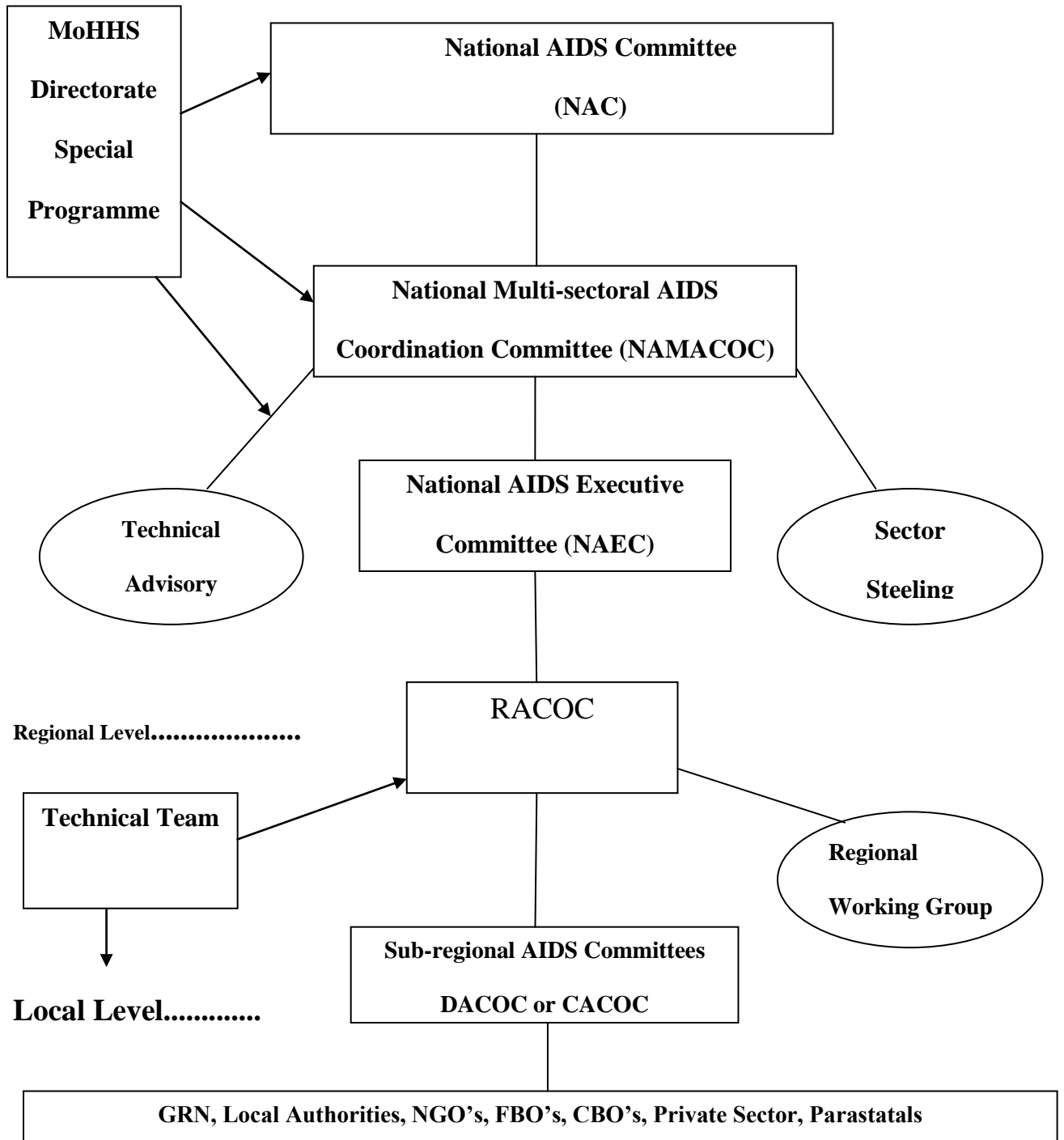
UNAM Northern Campus, Oshakati

P.O. Box 1248 Oshakati, Namibia

Tel: +264 - 65 -223 2270(w) Fax: +264 -65- 223 2283(w) Cell: +264 811275392

Appendix 1: 7 Organogram of the National AIDS Coordination Programme

National Level.....



Source: Adapted from MoHSS, 2004

Appendix 1: 7 - National AIDS Coordination Programme (continued)

1. **National AIDS Committee (NAC)** – responsible for leadership; policy, resource mobilisation
2. **National Multi-sectoral AIDS Coordination Committee (NAMACOC)** - responsible for multi-sectoral Leadership & coordination
3. **National AIDS Executive Committee (NAEC)** - Coordinates implementation
4. **Regional AIDS Coordinating Committees** - Coordinates multi-sectoral response at regional and local levels
5. **Sub-regional AIDS Committees – Constituency AIDS Coordinating Committee or District AIDS Coordinating Committee** - Coordinates local responses
Related Steering Committees
6. **Technical advisory** – provide technical input \
7. **Sector steering** – responsible to mainstreams, coordinates and monitor HIV/AIDS
8. **Governmental and non-governmental organisations** – implementation of HIV/AIDS media campaigns

Appendix 1: 8 Questionnaires

UNIVERSITY OF NAMIBIA: NORTHERN CAMPUS

P.O. Box 2654, Oshakati, Eliander Mwatale Street, Namibia

Telephone (+264) 65-223 2000; Fax (+264) 65-223 2271; www.unam.na



16th November 2005

Topic: Perceived impact of mass media campaigns on HIV/AIDS prevention among the youth in Oshana Region, Namibia

Instrument: Self-administered Questionnaire

The questionnaires will be answered by in-school (ISY) and out-of-school youth (OOSY). The in-school youth are learners in Combined, Junior and Senior Secondary Schools, in Oshana Region, Namibia. These learners should be doing grade 10, 11 and 12 respectively. Out-of-school youth are youth who are members of the youth organisations in Oshana Region.

All information related to the identity of the respondents or participants such as names in this study will remain confidential and anonymous according to the ethics of research. Individual permission will also be required prior to any question answered. All participants will participate voluntary with the right and freedom of withdrawal of their consent at any time without coercion or pressure.

The responses will be indicated by placing a tick in the appropriate box or by writing the information in the space provided by the researcher in the questionnaire.

A handwritten signature in purple ink, appearing to read 'Regina Mpingana Shikongo', is written over a faint, light-colored background.

Compiled by: Regina Mpingana Shikongo (**Doctoral student**)

Doctor Degree in Philosophy in Information Studies,

UNAM Northern Campus, Oshakati

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**Questionnaire for the in-school and out-of-school youth in Oshana
Region in Namibia: The perceived impact of mass media campaigns
in communicating information on HIV/AIDS prevention.**

A. Section 1: Respondents' background information

Q101. Age group

- a) 12 – 16 years
- b) 17 – 21 years
- c) 22 – 25 years
- d) 26 years and above

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Q102. Gender

- a) Male
- b) Female

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Q103. Where do you live?

- a) Town
- b) Rural
- c) Peri - urban
- d) Others (Specify).....

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Q104. What is your home / mother language?

- a) Oshivambo
- b) English
- c) Afrikaans
- d) Silozi
- e) Rukwangali
- f) Herero
- g) Others (Specify).....

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Q105. What is the highest grade / qualification you have completed?

- a) Grade 9
- b) Grade 10
- c) Grade11
- d) Grade12
- e) Certificate
- f) Diploma
- g) Others (Specify).....

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Q106 Can you read and understand easily or with difficulty information related to HIV/AIDS prevention in the newspapers and other printed materials?

- a) Easily
- b) With difficulties
- c) Not at all

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Section 2: HIV/AIDS background knowledge and information

Q201 Have you ever heard of HIV/AIDS?

- a) Yes
- b) No

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Q202 If yes, where have you heard about HIV/AIDS for the first time?

- a) Home
- b) School
- c) Church
- d) Media (radio, television, newspapers and other printed materials)
- e) Youth organization
- f) Health workers / facilities
- g) Others (Specify).....

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Q203 Who is your main source of information about HIV/AIDS?

- a) Parents
- b) Teachers
- c) Religious Leaders
- d) Peers
- e) Youth organizers
- f) Health workers
- g) Others (Specify).....

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Q204 Do you regard your level of knowledge on what HIV/AIDS means as

- a) Excellent
- b) Good
- c) Average
- d) Poor
- e) Very poor
- f) Do not know

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Q205 The following statements are the mode of transmission or causes of HIV/AIDS. Please indicate whether you agree or disagree with the statements below.

- a) Blood transfusion
- b) Unprotected sex
- c) Kissing each other
- d) Direct contact with human discharges
- e) Self-injection as drug users

	Agree	Disagree	Don't know
a) Blood transfusion	1	0	8
b) Unprotected sex	1	0	8
c) Kissing each other	1	0	8
d) Direct contact with human discharges	1	0	8
e) Self-injection as drug users	1	0	8

Q 206 State whether you agree or disagree with the following statements describing the preventive measures against HIV/AIDS.

	Agree	Disagree	Don' know
a) Abstain from sex	1	0	8
b) Have a faithful sex partner	1	0	8
c) Use of condom	1	0	8
d) Make informed decisions	1	0	8

Section 3: Sexual activity and self-efficacy of youth

Q301 Do you have a sexual partner?

- a) Yes
- b) No

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Q302 If yes to question 301, have you ever had penetrative sex with your sexual partner or boyfriend or girlfriend?

- a) Yes
- b) No

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Q303 If yes to question 302, how old were you when you had your first penetrative sexual intercourse?

- a) Below 10 years of age
- b) Age group 11 - 15 years
- c) Age group 16 - 20 years
- d) Age group 21 - 25 years
- e) Age group 26 years and more

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Q304 When was the last time you had penetrative sexual intercourse?

- a) Some days ago
- b) Weeks ago
- c) Months ago
- d) Years ago
- e) I cannot remember

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Q305 The last time you had sexual intercourse was with your regular partner or another person?

- a) Regular Partner
- b) Another person
- c) Refuses to say

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Q306 The last time you had sexual intercourse you and your partner did not use anything or use a condom.

- a) Did not use anything
- b) Used a condom
- c) Never heard of a condom

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Q307 If you have used a condom during your last sexual intercourse, who took a decision for you to use it?

- a) Respondent
- b) Partner
- c) Joint decision
- d) Do not know / Cannot remember

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Q308 If you did not use a condom during your last sexual intercourse, what was the reason for not using it? (**Tick only one answer**)

- a) No agreement about condom use
- b) No condom was available
- c) Difficult to negotiate condom use
- d) Don't know / Cannot remember

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Q309 Can you state the most important reason why you use condoms during sexual intercourse? (**Tick only one answer**)

- a) To avoid pregnancy
- b) To prevent a disease, HIV/AIDS
- c) To prevent STD's
- d) Do not know

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Q310 Do you know a place where a person can get condoms in your area?

- a) Yes
- b) No

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Q311 If yes to question 310, which places do you know where condoms can be collected free of charge or buying them?

- a) Clinics / health facilities
- b) Pharmacies
- c) Schools
- d) Public restrooms/ Bars / Cuca shops
- e) Workplaces / Youth offices
- f) Do not know
- g) Others (specify).....

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Q312 Do you think it is easy or difficult to get condoms in your area?

- a) Easy
- b) Difficult
- c) Do not know

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Q313 Read the number of statements below that reflect different opinions about condoms and people who use them. Please indicate whether you agree or disagree.

	Agree	Disagree	No opinion
a) Condoms are the best protective measures against HIV and other diseases	1	0	8
b) A woman does not have the right to ask her partner to use a condom	1	0	8
c) Only loose women or prostitutes ask their partners to use condoms	1	0	8
d) A woman asks a boyfriend / fiancée to wear a condom when she does not trust him	1	0	8
e) A man should only use condoms when he is having sex with prostitutes or sex workers	1	0	8

Q314

Life is full of problems and unexpected situations, especially among the youth. Read the following statements below and state your feelings and beliefs about them.

	Definitely could not	Probably could	Definitely could	Not sure
a) Could you force your partner to use a condom every time you have sexual intercourse, even if she/he does not want to use it?	1	2	3	8
b) Could you refuse to have sexual intercourse with your partner if she/he does not want to use a condom but you wanted to do so?	1	2	3	8
c) Could you refuse to have sexual intercourse with a person who wants to have sex with you without a condom but you do not want to do so?	1	2	3	8
d) Could you refuse to discuss with your partner the use of a condom every time you have sexual intercourse, even if she/he wants to use it?	1	2	3	8

Q315

Nowadays, everybody faces problems and solve them in his / her own way. Read the statements below and state your views and opinions.

	Not true at all	Somewhat true	Exactly true	Don't know or not sure
a) I can always manage to solve problems if I try to.	1	2	3	8
b) I can always deal with unexpected situations/problems on my own	1	2	3	8
c) I can usually find solutions to problems through negotiation when I need to do so.	1	2	3	8
d) I cannot solve problems or unexpected situations on my own	1	2	3	8
e) I cannot negotiate issues related to sex such as condom use with my partner / boyfriend/girlfriend.	1	2	3	8
f) I can always discuss and understand issues related to my life such as condom use as a preventive measure against HIV/ AIDS.	1	2	3	8

Section 4: Media Campaigns and exposure to mass media messages

Q401 Have you ever heard of a person die due to HIV/AIDS?

a) Yes

b) No

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Q402 Do you have HIV/AIDS mass media campaign programmes / organisations in your area?

a) Yes

b) No

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Q403 If yes to question 402, give the name of the most popular mass media campaign programme or organisation for HIV/AIDS in your area?

Q404 Can you remember receiving information from mass media campaigns through radio on HIV/AIDS prevention over the last three months?

a) Yes

b) No

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Q405 If yes to question 404, what was the topic of the information?

Q406 What was your reaction to the information you have received?

Q407 Did the information you heard from the radio influence your sexual behaviour towards HIV/ AIDS prevention? Please explain.

Q408 Do you normally watch the television?

- a) Yes
- b) No

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Q409 Can you remember receiving information from mass media campaigns through television on HIV/AIDS prevention over the last three months?

- a) Yes
- b) No

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Q410 If yes to question 409, what was the topic of the information?

Q411 What was your reaction to the information you have received?

Q412 Did the information you watched from the television influence your sexual behaviour towards HIV/AIDS prevention? Please explain.

Q413 Do you normally read newspapers and other printed materials?

- a) Yes
- b) No

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Q414 Can you remember reading information from newspapers, posters, magazines and other printed materials on HIV/AIDS prevention over the last three months?

- a) Yes
- b) No

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Q415 If yes to question 414, what was the topic of the information?

Q416 What was your reaction to the information you have read?

Q417 Did the information you read from the newspapers, magazines, posters and other printed materials influence your sexual behaviour on HIV/AIDS prevention? Please explain.

Q418 If yes to question 404, 409 and 414 that you have got information through radio, television, newspapers and other printed materials, do you think that media campaigns are succeeding in educating people like yourself about HIV/AIDS?

- a) Yes
- b) No

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Q419 If no to question 404, 409 and 414 that you did not receive any information from mass media campaigns through radio, television, newspapers / magazines / posters and other printed materials, does it mean that there is no mass media campaigns on HIV/AIDS prevention in your area?

- a) Yes
- b) No

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Q420 Which language is being used by mass media campaigns to educate people about HIV/AIDS prevention in your area?

- a) English
- b) Vernaculars
- c) Afrikaans
- d) Others (Specify).....

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Q421 Have you ever heard of any radio spots or messages with regard to HIV/AIDS prevention in the last three months?

- a) Yes
- b) No

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Q422 If yes to question 421, how many times have you heard such radio spots or messages during the last three months?

- a) Every day
- b) Once a week
- c) Once a month
- d) Never listen to the radio

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Q423 How many hours a day do you usually listen to the radio?

- a) An hour or more
- b) Less than an hour

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Q424 At what times of the day do you usually listen to the radio?

- a) Mornings
- b) Afternoon
- c) Evenings
- d) Cannot remember

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Q425 Which radio stations do you usually listen to?

- a) NBC Oshiwambo radio
- b) Radio Energy
- c) Omulunga radio
- d) Others (Specify).....

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Q426 How many days a week do you watch television?

- a) Number of days
- b) Everyday
- c) Once a week
- d) Never watches television

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Q427 How many hours a day do you usually watch television?

- a) An hour or more
- b) Less than one hour

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Q428 Have you seen any television spots or messages with regard to HIV/AIDS prevention in the last three months?

- a) Yes
- b) No

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Q429 If yes to question 428, how many times did you see such television spots or messages during the last three months?

- a) Number of days
- b) Everyday
- c) Once a week
- d) Never watches television

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Q430 Have you ever read a HIV/AIDS message from newspapers and other printed materials?

- a) Yes
- b) No

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Q431 If yes to question 430, how often do you read newspapers / magazines and other printed materials?

- a) Almost every day
- b) At least once a week
- c) Once a month
- d) Not at all

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Q432 Do media campaign messages empower youth to understand and make informed decisions on issues affecting their own lives? Indicate whether you agree or disagree with the statements below.

	Agree	Disagree	Don't know
a) Have one sexual partner	1	0	8
b) Use condoms	1	0	8
c) Abstain from sex	1	0	8
d) Adhere to cultural norms and values	1	0	8
e) Control social situations such as peer pressure	1	0	8
f) Change sexual behaviours	1	0	8

Q433 Do you regard HIV/AIDS as a serious problem among the youth in your area?

- a) Yes
- b) No

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Q434 If yes to question 433, what strategies can be used to facilitate youth behaviour change towards HIV/AIDS prevention in your area?
