University of Malawi
KAMUZU COLLEGE OF NURSING

THE IMPACT OF HIV/AIDS BEHAVIOURAL CHANGE MESSAGES ON THE MUONA COMMUNITY – NSANJE NORTH

BY

CAREFORD PHIMBA NEDSON MAGOMERO

RESEARCH PROJECT SUBMITTED TO THE FACULTY OF NURSING AT KAMUZU COLLEGE OF NURSING IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF A BACHELOR OF SCIENCE IN NURSING EDUCATION

AUGUST 2003

DECLARATION

I hereby declare that this work is of my own. It has never been presented before for any academic award elsewhere or in Malawi.

This document has been produced under the guidance of personal supervisor and presented to the faculty of nursing in partial fulfilment of requirements for an award of Bachelor of Science Nursing Education (BSc.N.Ed.).

Student's name: CAREFORD P.N. MAGOMERO

Student's signature: ----------

Supervisor's name: MR. P. MANDALAZI (B.Sc., M.Sc.)

Supervisor's Signature: ----------

Date:

DEDICATION

I dedicate this document to my lovely wife Chrissie and son Dennis for being very kind and cheerful to me all the times.

ACKNOWLEDGEMENTS

The writer sincerely acknowledges Mr. P. Mandalazi for his unconditional guidance and assistance during the entire process of research exercise. Without him it would not be possible to conduct this research study.

Special thanks should go to Mr. Kapulula for his assistance in analysing data using SPSS.

The Headmaster, Staff and students of Fatima Community Day Secondary School should be thanked for allowing this study to be conducted at this campus.

He is also grateful to Village Headman Marothi and all community members for their active participation in giving data and information.

Fellow students should also be thanked for their moral support rendered during the two-year study period.

I also thank all members of my family for their understanding and support needed in time of my absence.

TABLE OF CONTENTS

Chapter Six

References

List of appendixes

List of Figures Page

List Of Tables **Page**

ABBREVIATIONS:

ADP	:	Area Development Programme
AIDS	:	Acquired immuno deficiency syndrome
BCI	:	Behaviour Change Initiative
DHSSR	:	Demographic Health Survey for Sub- Saharan Region
HBM	:	Health Belief Model
HIV	:	Human Imunodefiency Virus
IEC	:	Information Education and Communication
MANASO	:	Malawi National AIDS Society
MDHS	:	Malawi Demographic Health Survey
MOEST	:	Ministry of Education Science and Technology
NACP	:	National AIDS Control Programme
NGO	:	Non- governmental organization
NSAPU	:	National Strategy AIDS Programme Unit
SPSS	:	Statistical Package for Social Sciences
SSDHS	:	Sub- Saharan Demographic Health Survey
STIs	:	Sexually Transmitted Infections
TCN	:	Trinity College of Nursing
UNAIDS	:	United Nations AIDS
VHC	:	Village Health Committee
WHO	:	World Health Organisation

OPERATIONAL DEFINITIONS

Community: People living in one particular geographical area

Community empowerment: Giving community members the official or legal authority or freedom to do something

Community involvement: Allowing community members to take part in a particular action

Conceptual framework: An abstract of set of concepts and assumption that explain a phenomenon and aid in understanding

Peers: People who are the same ages or have the same social position or have the same ability as the other in a group.

Perceive: To see something or some one or to become aware of the incidence

Or to have a belief about something or some one

Perception: Belief or opinion that a person holds based on appearance or experiences about something

RESEARCH ABSTRACT

The general objective of the research study was to find out knowledge level, awareness of behavioural change information and its impact on the Muona community.

Specifically it looked into the knowledge levels and awareness of BCI in relation to HIV/AIDS prevention. It also looked into the factors that hinder effectiveness of the BCI. It was intended to solicit suggestions from community members on how BCI should presented in order to achieve the intended purpose in the community. It assessed perception on how to avoid the risky social and cultural practices that predispose people to HIV/AIDS infection.

In the sample a total sample of thirty (30) was used of which 53.3% (n=16) were females and 46.7% (n=14) were males. This sample was comprised of students 63.7%(n=19), and village members were 36.6% (n=11). Participants were recruited through convenient method at the school and in their homes.

Data collection was done using a semi-structured questionnaire with closed and open-ended questions. It was tested during the pilot study that allowed for corrections and reliability.

Data were analysed using SPSS and content analysis under the guidance of the supervisor. This has minimised errors on the study findings. The study findings will be communicated to the community. A copy of findings shall be made available at Kamuzu College of Nursing Library, Trinity school of Nursing Library and at Fatima Community Day Secondary School Library.

Chapter One

1.0 INTRODUCTION

Adequate correct information or knowledge is a prerequisite to enable individuals make informed decisions. In utilizing knowledge and awareness on HIV/AIDS, the public is encouraged to avoid the risky behaviour and practices through Behavioural change approach.

Health workers at all levels have the responsibility to teach and motivate people for behaviour change. The public needs to have knowledge on the risky cultural behaviour and any related risk factors that may hinder the effectiveness of Behavioural change messages in their communities. Risky cultural practices differ from one community to another. An assessment of cultural practices in a particular community will be imperative in behaviour change of that community.

Communities/ societies have beliefs that govern behaviour of people in that area (Demographic Health Survey For Sub- Saharan Region-DHSSR-1995 in Kim 2000). In behaviour change, it is necessary to find out the effects of cultural beliefs. These may act as barriers to effective communication in the socio- cultural setting.

Behavioural change concept should be discussed in relation to socio-cultural beliefs in the community to enable people to realise the relevance and apply it in their own situation. It will help people to identify risky cultural practices within their community. Knowledge and awareness coupled with identification of own risky cultural behaviour

enhances Behavioural change decision making in fight against HIV/AIDS epidemic (Kathyola, 2001).

1.1 Back Ground

In the past decade or so, information, education and communication (IEC) was the main strategy in the fight against HIV/AIDS. In Malawi, the information on HIV/AIDS was spread through newspapers, radios and health talks in government facilities and in Non Governmental Organizations (NGO) (Kornfield and Namate, 1997, Nyasulu and Magai 2000).

The results of MDHS (2000) revealed that more people were infected with HIV/AIDS. This called for improvement in knowledge and skills of health workers on how to produce behavioural change messages for the prevention of HIV/AIDS and other sexually transmitted infections (STIs) (Kathyola, 2001). Behavioural change has been slow in Malawi regardless of 90%Malawians are knowledgeable and aware of HIV/AIDS and its dangers (MDHS, 2000, Eilish, 1994). It dwells on changes in the knowledge, attitudes and in behaviour. Community partnership is advocated for in identifying cultural beliefs and practices that are perceived to be risky behaviour for HIV/AIDS.

Behaviour includes all factors that are associated to individual's disposition and acts in relation to others in a society (Gillies, 1994). Therefore behavioural change is referred to as avoidance of one's act when its outcome is detrimental to oneself or to others.

Behavioural change information must be tailored in such a way to change perception, knowledge, attitudes and practices of people as they interact with one another within a community.

In this study, the variables to be looked into are knowledge levels, awareness and impact of HIV/AIDS behavioural change information on people in this community.

1.2 Problem Statement

Despite (BCI) messages through radios, newspapers and community based ANTI-AIDS clubs; people in Muona-Nsanje North seem not to change their risky sexual behaviour for HIV/AIDS. This problem has been identified through empirical observation on the increase in numbers of HIV/AIDS related conditions at Trinity Hospital. The observation was validated by increased numbers of HIV/AIDS cases in the register book.

Teenage pregnancies and abortions incident rate was high among out of school youths (Trinity Hospital Annual Report, 2001)

National wide, HIV/AIDS is affecting people within the reproductive age (15-49 years) as reported by Kathyola (2001). In this area HIV/AIDS is affecting both the youth and adults.

The investigator has strong feeling that possibly there are cultural practices that contribute to the spread of HIV/AIDS in this area. In addition to this may be the method of delivering BCI messages is not meeting the needs of people regarding change of risky cultural practices. Therefore, the researcher based on these observations in order to come up with a topic to be researched on. The intention of the investigator was to find out

knowledge level, awareness of behavioural change information and its impact on peoples' practices in the fight against HIV/AIDS. This study was intended to rule out subjectivity when people will be able to identify their own risky cultural practices in this community.

1.3 Significance Of The Study

The research findings will be incorporated in the HIV/AIDS prevention strategy in the community. The information will enable community health workers design culturally congruent messages on Behavioural change. Utilizations of this information will enhance community partnership and empowerment against the identified risky cultural practices. The main focus will be to assist individuals to assimilate the information in changing their behaviour in order to prevent HIV/AIDS. The community will benefit because people will be empowered to make informed decisions to fight HIV/AIDS. Nurse educators will incorporate this information in the existing HIV/AIDS education in various institutions.

1.4 Purpose of the study

The purpose of this study was t o find out knowledge, awareness of HIV/AIDS Behavioural change information. It was also intended to find out the impact of HIV/AIDS BCI messages on the people within childbearing age groups in Muona area (Nsanje North). In addition, it has discovered cultural factors that may hinder behavioural

change. The study has revealed some reasons why the risky cultural practices are being followed. It has solicited some ideas from the participants on how to solve the identified problems in the community.

The study was under taken as a requirement in partial fulfilment of the award of post-basic Bachelor of Science Degree in Nursing Education.

1.5 Objectives of the study

1.5.1 Broad objective

The aim of this study was to describe knowledge level, awareness of HIV/AIDS behavioural change information and its impact that it has had on the Muona community

1.5.2 Specific objectives

At the end of this activity the study should be able to:

- Describe knowledge levels and awareness of HIV/AIDS Behavioural change messages in relation to HIV/AIDS prevention.
- Explain the risky cultural practices for HIV/AIDS in the area.
- Explain the perceived benefits of behavioural change messages in the community.
- Describe ideal way of presenting the BCI messages for people to relate it in their daily life.
- Discuss suggestions from people in the community on how to avoid these risky cultural practices for HIV/AIDS.

Chapter Two

2.0 Review of literature

The behavioural change information is now being disseminated through radios, newspaper and newsletters from both governmental and Non-Governmental Organization (N.G.O.).

However, the magnitude of impact of HIV/AIDS behavioural change intervention (B.C.I) strategy is not well reported. The National Aids Control Programme (2001) postulates that during the past two decades information, education and communication (I.E.C) was the main strategy in the HIV/AIDS fight. In (1999) NACP in conjunction with Reproductive Health Unit conducted a study on IEC strategy in HIV/AIDS and STIs prevention. The results revealed that IEC did a good work on dissemination of information and brought about knowledge and awareness on HIV/AIDS. However behaviour change intervention was not included as a result there was no change in behaviour.

Behaviour change intervention was designed with an aim of instilling knowledge, attitudes and skills through participation in order to bring about change in individual's behaviour (NACP 2001 p.5). The (NACP) reports that there are perceived factors that may hinder the effectiveness of this newly born behaviour change intervention (BCI) strategy in the HIV/AIDS prevention.

In the related sense, Bennet and Baker (2001) classify these factors in two levels as individual level and community level factor. Individual level factors include knowledge,

attitude, self-confidence and motivation to try new behaviour. While the community level factors mainly are influences from other people (peers, family members, leaders, norms and cultural practices in a community).

2.1 Related studies done in Malawi

The results from a study that was conducted by Wynendaele, Makhumula-Nkhoma, M'manga and Fundi (1995) in Dowa, Dedza, and Mchinji districts indicated that 98% of people had adequate knowledge on HIV/AIDS. Kornifield and Namate (1997) conducted a study on cultural practices related to HIV/AIDS risky behaviours in Phalombe district. The results showed that 90% people had adequate knowledge and awareness on HIV/AIDS and its effects. The differences in findings were balanced when Damisoni and Bicego (2001) reported that Malawi Demographic Health Survey (MDHS) in 2000 had found out that national wide 99% of people had knowledge on HIV/AIDS prevalence. The awareness rate had increased by 9% from 90% to 99% people knew HIV/AIDS as an STI. Majority responded that avoiding unprotected sex with multiple partners could prevent HIV/AIDS. In 1994, Eilish et al conducted a study on the barriers to behaviour change. The results revealed that many people expressed sense of hopelessness in the fight of HIV/AIDS. They reported that HIV/AIDS could be spread through many ways, which they have no control over.

In Chikwawa and Nsanje districts a study on cultural practices and HIV/AIDS was conducted. It was found out that 89%of 216 respondents had adequate knowledge on

HIV/AIDS (Nyasulu, Magai and Tembo 2000). These results were similar to the results of a study by Kornifield and Namate (1997), which revealed that there were cultural practices that predisposed people to HIV/AIDS despite having adequate knowledge. People in Nsanje and Chikwawa practiced 'KULOWA KUFA' or wife inheritance. It also indicated that 25% of male respondents believed that they would develop high blood pressure if they could not engage in sexual intercourse. Other studies however have shown that 50% of other populations in rural areas do not know whether they are at risk or not (Wynendaele et al 1994, Kornifield and Namate 1997, Abdil and Kaunda 2001). Probably, this could be one of the reasons why there is little impact of the HIV/AIDS behavioural change information in the community.

Youths in primary and secondary schools have adequate knowledge on HIV /AIDS, about 90% had reported knowledge (Eilish et al 1994, Kachingwe et al 2001, Maluwa-Banda 2001). Rosters (1996) as cited by Maluwa Banda et al (2001), found out that more youths experience their first sexual intercourse at the age of 15.While recent study by Kachingwe et al (2001) reported a decline in age at which youths in both primary and secondary schools engaged in first sexual encounter at an early age of 10 with a mean age of 14. In schools more students (6o%)are sexually active, but only 16% of these had used condoms (Maluwa Banda et al 2001, Kachingwe et al 2001).

Kadzamira, Maluwa -Banda, Kamlongera, and Swainson (2001) found similar results. They revealed high knowledge Of HIV/AIDS among youth but behaviour change is very slow evidenced by low numbers of sexually active youths who had used condoms.

2..2 Studies done in other countries

The World Bank Policy Research Report (WBPRR) (1999) as cited by Bennet and Baker2001) revealed that HIV/AIDS knowledge and awareness was higher worldwide. Imane (2002) as cited in U.N.AIDS and W.H.O. (2002) reported that globally knowledge level on HIV transmission was 56% and about 34.3 million people were living with HIV/AIDS. The most affected area was Sub Sahara- Africa with four million people living with HIV/AIDS. This was similar to what World Health Organization (W.H.O. 2000) reported that 71% people with HIV lived in Sub Saharan-African region. The prominent high risk factor was un protected heterosexual behaviour which accounted for 37.5%.

Different results by Jackson (2002) indicate that a trend of HIV prevalence globally is increasing annually while decreasing in Sub Saharan region. Worldwide HIV prevalence has been increasing in this trend in 1999, 34.5 million people, in 2000, 36 million on people, and in 2001, 40 million people lived with HIV/AIDS.

In Sub Saharan region, in 1999, 4 million people lived with HIV/AIDS, in 2000, 3.8 million people and in2001, 3.4 million people.

Thee Sub Saharan Demographic Health Survey (SSDHS) 2001 as reported in W.H.O.-UNAIDS by Jackson (2002) compliments on the WBPRR (1999) results that the main mode of transmission was hetero sexual practices. This was associated with cultural beliefs and practices on sexual and reproductive health issues. Studies have shown that in most African countries, cultural beliefs, values and practices predispose men, women, boys and girls to HIV/AIDS infection. For example in Kenya, female genital mutilation

and polygamy had contributed to lack of sexual behaviour change (Jackson AIDS in Africa 2002 p.11). Smith (2002) reports that through out the world, cultural and social factors strongly influence the sexual and reproductive decisions mainly among women. Research that was done in Bangladesh (1997) found out similar results that cultural and social factors influence or limits woman's ability to make decisions about reproductive health issues including safe sex. However on contrary findings a recent research done in Thailand (2001) found out that interpersonal communication through household kinship networks both within and out side the villages facilitates spread of information and change of behaviour or beliefs with regards to social behaviour. It is also found out that if partners talk to each other behaviour may change (Smith 2002, Kim 2000)

2.3 Summary of reviewed literature

From the reviewed literature it is revealed that a lot has been done on risky cultural behaviours for HIV/AIDS. Emphasis was on knowledge, awareness and prevention of HIV/AIDS. Recommendations were made to adopt the behavioural change intervention strategy. However it is noted that there is a gap on impact of the HIV/AIDS behavioural change information on the communities.

Literature also reveals that more people are aware of HIV/AIDS although some people seem not to change their behaviour. Therefore this study will discover the in knowledge gaps, awareness, impact of BCI and its effectiveness in the HIV/AIDS fight. The study will build on what is already known from the IEC and relate it to individual's behaviour change.

Chapter Three

3.0 Conceptual frame work

The conceptual framework, which was used as a guide to this study, was the Health Belief Model by Rosenstock developed early 1950's. This model explains that individual's readiness to take action depends on his or her perception on health threats posed by a particular disease and motivation (Berger & Williams1999, Ellis & Nowlis 1989, Polit & Hungler 1994) It predicts different actions that individuals take toward an illness due to different perceptions and beliefs on the illness / disease. The model brings about an understanding of different behaviour that different people would portray with regard to their health. These behaviours are based on different beliefs and understanding of health (Berger& Williams 1999).

Within the Health Belief Model (H.B.M.) are four major variables that must be present in order to increase the likelihood of an individual's taking recommended preventive actions and to promote health. These variables are: perceived susceptibility to a disease, perceived seriousness of the disease, perceived benefits of preventive actions or treatment disregarding the barriers to taking actions, and cues or triggers to action.

A brief discussion on each variable is given below:

- Perceived susceptibility to a disease: this is a degree to which an individual agrees or accepts that he/ she stands a chance of contracting the disease. This action varies from denial, fear to acceptance of the perceived vulnerability (Berger& Williams, 1999). Thus when an individual identifies that he/ she is at risk may react with a feeling of anger as though is already in danger.

- Perceived seriousness/ threats of a disease: this refers to the extent to which an individual understands the difficulties or negative health consequences he/ she may encounter if he/she contracts the disease (Berger & Williams 1999, Polit & Hungler 1994, Nowlis & Ellis 1989).

The individual starts contemplating on effects of the disease on employment, social obligations, daily living and on his or her family. It is also argued that the degree of perceived seriousness may vary depending on individual's understanding of the negative health consequences of the disease.

- Perceived benefit of taking actions and barriers to taking action: This entails individual's awareness of the disease and perception that there are prompt actions to prevent contracting it. An individual should believe that the preventive action has a lot of benefits as opposed to the perceived barriers to taking the action. Elkan and Blair (2000) assert that an individual may take action to preventing an illness / disease when he or she recognizes threats posed by the disease. However it is argued that while willing to take preventive action, an individual may also consider the convenience, cost or expenses and any unpleasant effects of the intended action. This individual intrinsic conflict may become barriers to taking effective action (Adeyi, Hacht, Njobvu, and Soucat 2001).

- Cues or triggers to action: This includes internal and external stimuli that trigger an individual to take a recommended action (Stanhope and Lancaster, 1995). An individual becomes motivated to take action when three sets of beliefs are there: belief about severity of the disease, belief about an individual's ability to perform the preventive action and belief that there are benefits that will occur from the intended action. However as Wolff et al (1983) put it, these sets of beliefs may be modified by other factors. These factors are demographic, socio-psychological and structural variables. Twin et al (1996) support this argument as they suggest that these variables must be present in order to increase the likelihood of an individual's taking a recommended action to promote health. This is well illustrated in the model below:

The Health Belief Model

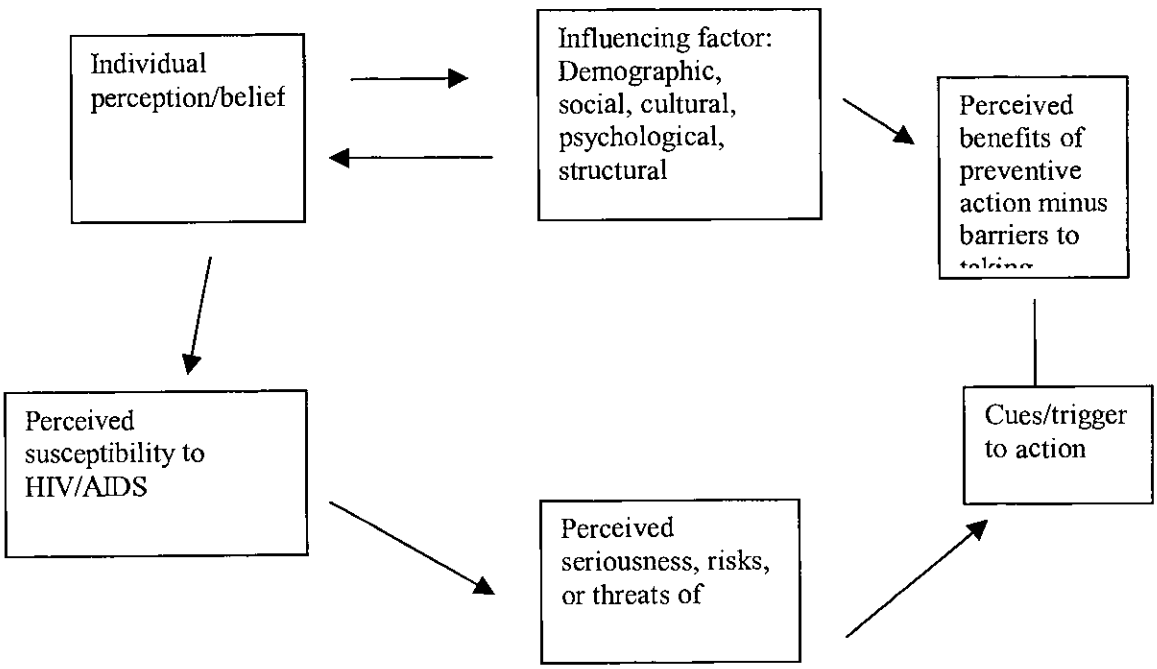

Diagram. 1

SOURCE: Berger and Williams (1996) Vol. 1. P.269.

Factors That Increase The Likelihood Of Taking Action

DEMOGRAPHIC FACTORS:
Sex, age, race, ethnicity

SOCIAL FACTORS

Socio – economic status
Personality
Peer and reference group

Structural variables

Knowledge about the disease

Prior contact with the disease

3.1 Application Of Health Belief Model To This Study

In reference to the model, individual perception or belief about a disease is influenced by demographic variables, socio-psychological variables, and structural variables. Stanhope and Lancaster (p.253) state that knowledge about the disease and prior contacts bring about perceived individual's susceptibility. Similarly in the fight against HIV/AIDS people ought to have adequate knowledge on behaviour change strategy in avoiding risky cultural practices that may perpetuate the spread of HIV/AIDS in their communities. People will be able to change their behaviour only if they know that they are susceptible to HIV/AIDS.

In the behaviour change intervention, an individual must recognize that he or she has equal chance to contract HIV/AIDS. However this is dependent on knowledge levels and awareness of behaviour change strategy. In this view, individuals must have adequate knowledge on transmission and prevention of HIV/AIDS. This entails providing information in order to change thought patterns and enable individuals change the risky cultural practices (Stanhope and Lancaster, 1995, Berger and Williams, 1999, Wolff et al, 1983).
Ulin et al (2002) adds that individuals must be given opportunities to discuss their own cultural practices. This will enable them to identify risky cultural practices in their community.

The role of community health workers mainly is to assist people to clarify their perception on benefits of taking preventive action. Health workers should persuade people to identify the anticipated benefits of the action to be taken in order for people to change behaviour.

The model suggests that it is imperative to consider a community as whole. Therefore social factors have to be assessed in relation to the spread of HIV/AIDS in the community. It provides a guide on formulation of practical questions on impact of behaviour change on cultural practices.

Questions that will be used in this study will encompass knowledge level on behaviour change, risky cultural practices that may predispose people to HIV/AIDS, suggestions on strategies to be used to curb the spread of HIV/AIDS in this area, and who would be on forefront in behaviour change initiative.

As cited by Twin et al (1996) Blaxter and Patterson suggest that dissemination of key health messages would be very effective if opinion leaders were working together with change agents. Similarly in behaviour change, opinion leaders of the community ought to be included in identification of risky practices and possible strategies. People will be willing to change the risky practices when they see influential people are on front line. This will cultivate in people a belief that the actions are beneficial to own life hence may change their behaviour.

The Health Belief Model (H.B.M.) advocates for behaviour change in line with cultural values, beliefs and practices. However, health workers have a task to encourage and support individuals to modify or change knowledge, attitudes, beliefs and practices in HIV/AIDS fight. (Refer to diagram: 1 page 15)

Chapter Four

4.0 Research Methodology

4.1 Research Design

In order to study the impact of behavioural change messages, the descriptive qualitative design was used. Descriptive study enabled the researcher to observe, discover, and describe knowledge levels on the behavioural change messages (Ulin, Robinson, Tolley, and Mc Neil 2002, Burns and Grove 2001, Polit and Hungler 1995). The investigator intended to come up with very effective and reliable results that would describe perceptions, experience, cultural practices and other practices in social reality as it is lived by the study participants in this community.

Ulin et al (2002) propose that qualitative research focuses on individual and cultural practices, the environment and that its purpose is to learn some aspects of the social world in order to generate new understanding. Polit and Hungler (1995) made similar assertion that possibly study on human knowledge may not be complete if there is not description of human behaviour, attitudes and experience as it is lived. Therefore, this design helped to describe the pattern of behaviour that is culturally being practiced in Muona area.

4.2 Setting and Sampling

The study was conducted in rural area of Muona Nsanje North, at Fatima Community Day Secondary School and in Marothi village. This site was chosen because other recent studies have shown that in this community probably people may not change their behaviour because of cultural beliefs that govern their sexual behaviours (Nyasulu et al 2001). More importantly the study intended to describe the impact of HIV/AIDS prevention behaviour change messages in this community.

Size of the sample was thirty (30) subjects. These comprised of fourteen (14) males and females were sixteen (16). Some participants were drawn from the school and others

from the nearby village. This sample represented the entire community in which the study was conducted. Participants were selected from the sexually active age groups within the age ranging from 14-49 years. It is reported that people within this age range are at risk of contracting HIV/AIDS, as they are sexually active, (MANASO, 2002). Therefore the researcher felt it worthwhile to target this study at the sexually active groups of people.

The sample size was chosen because descriptive qualitative design deals with in-depth study of peoples' experience and practices so it does not require large sample. Thirty participants were used because the study was a micro exploratory, in which small sample size is recommended, (Burns and Grove 2001, Polit and Hungler 1995). Further limitations on the ample size were due to financial constraints, time factor, and availability of other resources and scarcity of subjects in other stratum. Since it was an academic study, sample size remained manageable within the budget constraints.

4.3. Sampling Method

Convenience approach was used in order to reduce the likelihood of under representation in other sample stratum in which subjects would be scarce. This method was suitable because the sample has the same characteristics or practices that are close to those of the population (Polit and Hungler, 1995: 203). It was also used because the sample represented community with different socio- economic characteristics. This reduced extraneous factors that would influence the results. This method of sampling was chosen basing on the understanding, that sample must share approximately the same culture and social practices as of the entire population, (Polit & Hungler,1995).
This was justifiable because the sample shares the same cultural and social practices with the population it represents.

4.4 Plan For Data Collection

4.4.1 Instrument

Data was collected using a semi – structured questionnaire with both open and closed ended questions. Thirty (30) participants were interviewed. The questionnaire was administered to solicit short and specific responses from individual interviewee. In closed ended questions, the instrument provided options to elicit specific and short responses. Open-ended questions were used in order to collect more detailed information and views from individual respondent. This approach helped to reduce subjectivity and bias in the study findings. The open-ended questions were used to come up with the perceived risky cultural practices and suggestions on how to modify these practices in a participatory manner.

The questionnaire was divided in sections according to the information to be collected All questions were formulated in English but interpreted into the vernacular 'CHICHEWA' for the interviewees to understand what was expected of them. . This l enabled the interviewees to express them selves comfortably. Subjects were left free to express their experiences and feelings as part of their daily life.

4.4.2 Pilot Study

Data collection tool was tested by a pilot study to justify its feasibility and validity. The pilot study was conducted at Makhanga health centre and in the surrounding villages. This enabled the investigator to estimate time allocation for individual interviews. The investigator was able to make possible adjustments to the questionnaire, improve language structure and questioning technique before the actual study exercise had began. Revisiting language structure of the research instruments had significantly improved the acceptability and reliability of the questionnaire to the subjects.

Makhanga was chosen to be a pilot study area because it shares almost the same culture as of the intended study area.

4.4.3 Data Collection

The study tool was administered to individual subject. The investigator and two (2) research assistants were available to clarify if participants had any problem with the questions. Every point and what they ought to do was clarified to the subjects to enable them understand their role in the exercise. Individual interview was run between 30 to 40 minutes. Data was colleted within three (3) days with he help of two (2) research assistants.

4.4.4 Plan For Data analysis

Quantitative data were statistically analysed using descriptive statistic on soft window and statistical package for social studies (SPSS) on a computer. Manual and content analysis was used to analyse narrative information, comments and responses to open ended questions. The qualitative information was quantified and presented by graphs, tables, diagrams, figures and charts. This enabled the investigator to make interpretations and draw conclusion.

4.4.5 Ethical Consideration

Permission was sought from Ministry Education, Science and Technology (M.O.E. S.T) through the District Education Manager of Nsanje District. Letters were sent to the Primary school education advisor (P.E.A.) through the head teacher to seek permission to conduct the study at their school. Investigator had asked for informed consent from the data numerators and all participants before the exercise had began.

The village headman Marothi was consulted through a letter to ask for permission to conduct the study in his village. The purpose of the study was communicated to these people in order to gain their cooperation.

The subjects were offered an explanation on the purpose of the study and whom shall it benefit in their community. They were assured of confidentiality and anonymity concerning any piece of information they were going to give. They were assured that the information would never be shared publicly but will be utilized in the study findings. They were told that their names would not be written on any paper instead numbers only were to be used. The investigator explained to the subjects that the exercise was voluntary and that they were allowed to withdraw should they feel so.
All subjects were asked to give informed consent by signing the consent form should they accept to participate. They were also asked to have sorne body to bear witness as the subject as signing the consent form.

4.4.6 Plan for communicating study findings

In the dissemination of study results, the investigator intends to make copies available at Kamuzu College of Nursing (K.C.N.) library, a copy at Trinity College of Nursing (T. C.N), and one copy shall be at Fatima Community day secondary school. A round table discussion will be held at Trinity Hospital, which will involve the matron and staff of Trinity Hospital, the head teacher and his staff, the environmental health officer responsible for the area, health officer for World Vision International responsible for Mlolo Area Development Programme (A.D.P.), and the community leaders.

Chapter Five

5.0 Presentation Of Findings

This chapter presents findings of the study whose main purpose was to find out the impact of HIV/AIDS behavioural change information on the Muona Community. The study was intended to find out the knowledge levels of people on Behaviour Change Messages, factors that hinder the dissemination of Behaviour Change Messages, to solicit views from people on the possible ways of disseminating information on Behaviour Change and to find out socio-cultural practices that contribute to the spread of HIV/AIDS in Muona.

The findings are focusing on knowledge levels on behaviour change, aim of BC, its components, cultural practices that predispose people to HIV/AIDS, sexual behaviour of people in the community, communication among couples, perceived benefits of changing individuals behaviour, perceived ideal ways of disseminating Behaviour Change information and views on who should be involved in disseminating HIV/AIDS behaviour change messages.

5.1. Description of the sample

In the total study sample of 30, male participants were 46.7% (n=14) while females were 53.3% (n=16). The findings further show that among the participants majority 70% (n=21) were the youths in the age range of 15 to 24 years. Among these respondents 63.3% (n=19) were students, while 33.3%(n=10) were subsistent farmers and only 3.3% (n=1) were skilled workers.

Figure. 1 shows the distribution of participants by sex.

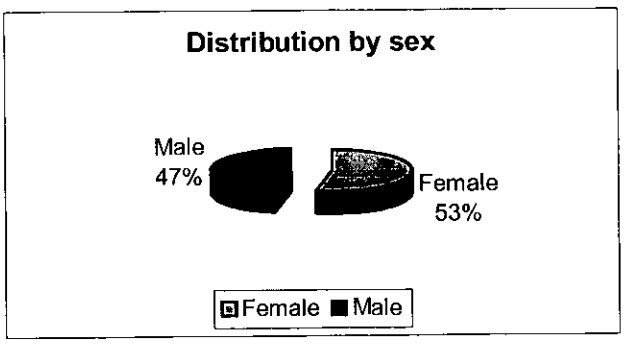

Figure 1 above shows percentages off participants by sex. Most of the respondents, 53% (n=16) were female.

5.1.2 **marital status and tribe**

The study findings indicated that majority of the participants were single 63.3% (n=19), those who were married accounted for30% (n=9), while the divorced and the widowed were each 3.3% (n=1).

Most of the respondents belonged to Sena tribe representing 53.3%(n=16), 36.7% (n=11) were Lomwe while Yao, Chewa, and Ngoni were each 3.3% (n=1).

Fig. 2: distribution by tribe

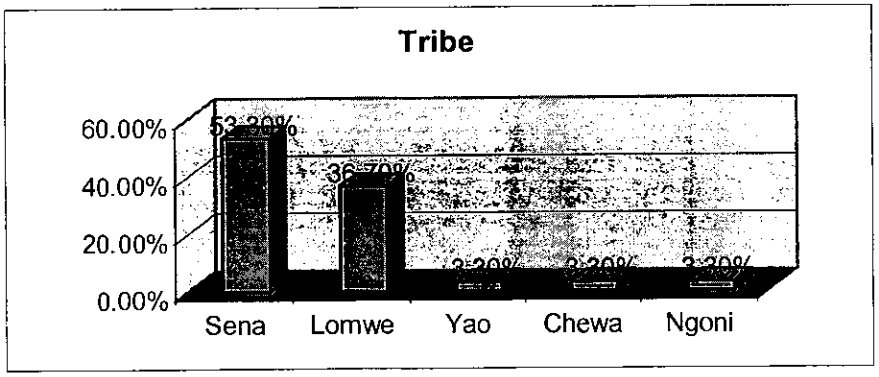

Figure 2 shows distribution of respondents by tribe. Majority were Sena.

5.1.3 Religion

The findings show that most respondents 43.3% (n=13) belonged to SDA Church. 36.6% (n=11) were Roman Catholics, Zambezi Evangelical Mission were 6.7% (n=2) while C.C.A.P were 3.3% (n=1) and other churches were 10% (n=3). These results revealed that all of the respondents were religious.

5.2 Knowledge on HIV/AIDS behavioural change information

Have you ever heard about behavioural change message?

On knowledge levels, study findings show that 100% (n=30) all Participants have knowledge on HIV/AIDS behaviour change information. There is no difference in knowledge levels among males and females.

However there have been variations in means of communication through which people get behavioural change information. Majority 96.7% (n=29) of respondents have heard about HIV/AIDS behavioural change messages through radio, 73.3% (n=22) of respondents heard the messages through community leaders, friends/peers and/or Anti-Aids clubs, which exist in the community. Those respondents who have heard the messages through health workers were 63.3% (n=19) and those who heard it through teachers were only 60% (n=18) despite that majority 63.3% (n=19) of respondents were students.

Table: 1 shows the distribution on the various means of communication through which people in Muona heard about the behavioural change messages:

Communication Media	Males	Females	Frequency N	Percentage %
Radio	13	16	29	96.7
News paper	9	9	18	60
Community leaders	11	11	22	73.3
Church leaders	10	21		70
Teachers	10	8	18	60
Health personnel	11	8	19	63.3
Friend/peers	11	11	22	73.3
Anti-Aids clubs	11	11	22	73.3

Table 1 shows media of communication in Muona community

5.2.1 Aim and components of behavioural change messages

The participants were asked if they knew the aim of HIV/AIDS Behavioural change initiative. Table below shows the responses. Majority 80% (n=24) of the respondents indicated that HIV/AIDS behaviour change is aimed at preventing HIV/AIDS. However, some 16.7% (n=7) and others 3.3% showed that HIV/AIDS behaviour change is aimed at preventing unwanted pregnancy and STI's respectively.

It also indicates that some people do not know the benefits of behaviour change as evidenced by only 3.3% (n=1) of respondents who know this. No respondent has indicated that behaviour change improves relationship among couples.

Table:2 Responses on the Aims of behavioural change initiative

Aim	Frequency (n)	Percentage (%)
Prevention of HIV/AIDS	24	80
Prevention of unwanted pregnancy	5	16.7
Prevention of STIs	1	3.3

Table 2 shows responses & percentages on the aims of behaviour change

Respondents were asked to mention components of behaviour change. The results showed that majority 66.7% (n=20) mentioned total abstinence, 40% (n=12) mentioned protected sex, others mentioned that having one sexual partner 36.7% (n=11), non penetrative sex 3.3% (n=1), knowing one's HIV status 16.7% (n=5), avoiding spreading HIV/AIDS 3.3% (n=1), avoiding risky cultural practices 13.3% (n=4).

Table: 3 Responses on Components of behaviour change

Component	Males	Female	Frequency	percentage (%)
Protected sex	5	7	12	40
Total abstinence	12	8	20	66.7
Have one sexual partner	5	6	11	36.75
Non penetrative sex		1	1	3.3
Knowing one's HIV status	2	3	5	16.7
Avoiding spreading HIV/AIDS		1	1	3.3
Avoiding risky cultural practices	2	2	4	13.3

Table 3 indicates percentages and responses on components of behaviour change

This reveals that people have low knowledge about components/what is involved in the behaviour change as evidenced by only low percentages on the responses. For example,

only 3.3% (n=1) of the respondents knew that there is non-penetrative sex and avoiding of deliberate spreading of HIV/AIDS in behaviour change.

5.3 Cultural practices that predispose people to HIV/AIDS in Muona community

When asked about risky cultural practices in the Muona community, majority of respondents 90% (n=27) reported that ***fisi practice*** (hyena practice) is commonly practiced in the area. Other risky practices mentioned were prostitution 80% (n=27,), *kupita kufa* 46.7% (n=14), polygamy 40% (n=12) and other practices 6.7% (n=2).

Fisi practice is commonly practiced as it is evidenced by 90% of the respondents have shown. In this study, the least practiced risky socio-cultural practice is polygamy 40% (n=12).

Table: 4 Risky cultural practices

Risky cultural practice	Males	Female	Frequency	Percentage
Polygamy	5	7	12	40
Kupita kufa	6	8	14	46.6
Fisi practice	13	14	27	90
Prostitution	13	11	24	80
Others	1	1	2	6.7

Table 4 shows risky social and cultural practices and percentages of respondents.

These percentages however, are far below especially on polygamy and kupita kufa. might not be perceived as risky practices by many people in Muona.

5.3.1 Respondents were asked to mention some ways how to reduce the Risky cultural practices

Majority of the respondents 70% (n=21) indicated that civic education on HIV/AIDS Behaviour change in the community would help to reduce the spread of HIV/AIDS. Of these majority 40% (n=12) were females as compared to males who were 30%(n=9). 30% (n=9) of respondents expressed interest in the use of community based Anti-Aids clubs.

Table: 5 what should be done to reduce risky cultural practices;

Method	Male	Female	Frequency	Percentage %
Civic education on HIV/AIDS	9	12	21	70
Community based Anti-Aids club	5	4	9	30

Table 5 shows Some of the general views that emerged from the respondents on what should be done to curb the risky socio-cultural behaviours.

5.4 Sexual behaviour pattern and number of sexual partners in the past 12 months

The findings indicate that 43.3% (n=13) of respondents have had one sexual partner in the past 12 months. Of these 23.3%(n=7) and 20% (n=6) were males and females respectively. While 33.3% (n=10) have had two or more sexual partners in the past twelve months. Among those respondents who had two or more sexual partners, females were 20% (n=6) and males were 13.3% (n=4) respectively. All these were the youths in the age range of 15-24 years. This accounted for 47.6% (n=10) of all the youth (n=21) in the sample. However about 23% reported having abstained during the past twelve months.

Table: 6 number of sex partners in the past 12 months

Number of partner	Male	Female	Percentage (%)	Age group 15-19	20-24	25-29
None	3	4	23.3% (n=7)	4	2	-
1 person	7	6	43.3% (n=13)	2	3	2
2 persons	3	1	13.3% (n=4)	1	3	-
3 or more persons	1	5	20% (n=6)	4	2	-

Table 6 indicates the distribution in terms of sex partners that youth respondents had in the past 12 months.

5.4.2 What Do You talk about with your partner when having sex?

The findings indicate that 63.3% (n=19) of the participants talk about avoiding HIV/AIDS, 36.7% (n=12) talk about preventing pregnancy, 33.3% (n=10) talk about sex without intercourse, while those who talk about using Condoms were 40% (n=12). More females talk about prevention of HIV/AIDS just as good as males. However, more females 22% (n=7) about twice as much as males 12% (n=4) talk more about preventing un wanted pregnancy.

Table: 7 Shows what partners talk about when having sex

Talk about:	Males	Females	Percentage (%)	Frequency (n)
Avoid pregnancy	4	7	36.7	11
Avoid HIV/AIDS	9	10	63.3	19
Sexual pleasure without intercourse	2	8	33.3	10
Condom use	6	6	40	12

Table 7 indicates what people or couple talk about before having sex

Only 40%(n=12) talk about condom use, which reflects the percentage of respondents (40%) who know that protected sex is one component of behaviour change.

5.4.2 Frequency of condom use in the past 12 months

The study indicates that 20% (n=6) always used condom in the past 12 months when they had sex. 23.3% (n=7) sometimes they used condoms and 56.7% never used condoms in the past 12 months.

Figure: 3 Frequency of condom use

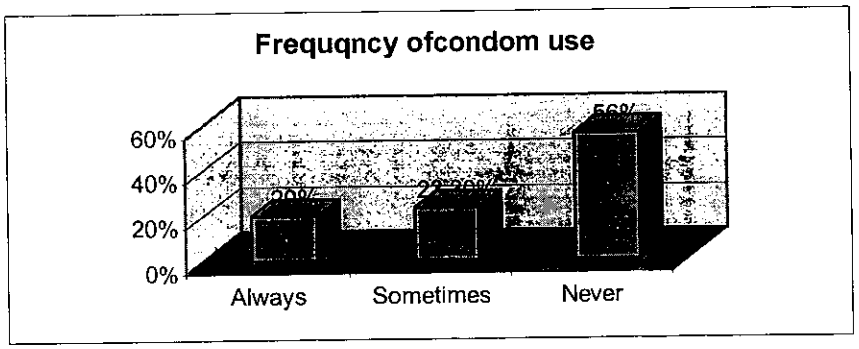

Fig 3. Shows the frequency of using condoms in the past 12 months. Majority 56.7% of participants did not use condoms in the past 12 month.

For those who do not use condoms gave various reasons for not using condoms. The majority of the respondents 40% (n=12) indicated that condom was not applicable to them, 20% (n=6) don't like it, 30% (n=9) responded that due to partner's refusal and 10% (n=3) don't know where to get them.

Table: 8 reasons for not using condoms

Reasons	Male	Female	frequency	Percentage(%)
Do not like it	5	1	6	20%
Partner's refusal	4	5	9	30%
Do not know where to get	2	1	3	10%
Not applicable	3	9	12	40%

Table 8: various reasons for not using condoms

. Most of respondents 40%(n=12) reported that condom use was not applicable possibly due to the presence of students in the sample 63.3% and respondents in the age range of 44-45 years who made up 16.75% (n=5) of the sample.

5.4.3 Do some of your friends have casual sex partner

The majority 90% (n=27) of respondents reported that they have friends who have casual sex partners while only 10% (n=3) indicated that they have no friends with casual sex partner. These findings might have been affected by partner's lack of knowledge of the sexual behaviour about their friends.

Fig.4 Shows the distribution of participants with friends who have had casual sex Partners

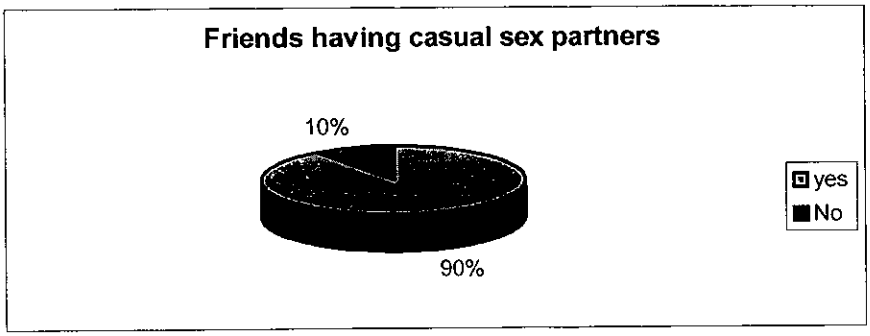

Figure 4 shows90% of respondents had friends who have had casual sex

5.4.4 what could be the contributing factors to casual sex?

Distribution of contributing factors to casual sex that emerged from the respondents. The major ones were satisfaction of sex desire 66.7% (n=20), and poverty 33.3% (n=10).

5.5.0 Perceived benefits of behaviour change

Majority of the informants 96.7% (n=29) perceived prevent contracting HIV/AIDS as the number one benefit of behaviour change. Other benefits that emerged were to lead healthier life 36.7% (n=11), to accomplish one's future plan 26.7% (n=8), finally to prevent STIs 6.7% (n=2) of the respondents perception on the benefits of behaviour change initiative.

Table: 9 Perceived benefits of behaviour change

	Percentage (%)	**Frequency**
Prevention of HIV/AIDS	96%	29
Healthier life	36	11
Accomplish future plan	26.7	8
Prevent STIs	6.7%	2

Table9. Indicates Majority 96 % of respondents perceived that BCI is mainly for prevention of HIV/AIDS

5.5.1 Benefits of knowing ones HIV status

Asked whether they know the benefits of knowing ones HIV status, all respondent 100% (n=30) indicated that they know.

Further information was solicited on the different benefits of behaviour change to them. The research study indicates that the majority 96.7% (n=29) responded that it helps in preventing contracting/spreading HIV/AIDS deliberately. While 43.3% (n=13) showed that it helps in future planning and 36.7% (n=11) responded that enables taking right precautions and actions.

5.6 Perceived ideal ways of disseminating behavioural change information

The survey assessed the perceived effects of methods through which behaviour change messages are disseminated in the area. Findings reveal that 70% (n=21) of the respondents perceive it as very effective. Only 6.7% (n=2) of the respondents observed that the method is not effective while 23% (n=7) of the respondents perceived the method to be effective.

Table:10 perception on the effectiveness of the BCI

	Percentage %	Number (n)
Very effective	70%	21
Effective	23.3	7
Not effective	6.7	2

Table10 shows Perception on the effectiveness of method of disseminating behaviour change messages.

The survey assessed perceptions and views from people towards the application of behaviour change messages in daily life. Findings point out that 66.7% (n=20) of the respondents felt that behaviour change information can be easily applied in life. Some of the respondents 26.7% (n=8) felt that it is moderately easy to apply the behaviour change information into life. Results indicate that 6.7% (n=2) of the respondents felt that it is difficult to apply behaviour change information in life.

Those results reveal that despite high knowledge level on behaviour change 100% among respondents, the majority does not practice it, because they feel it is difficult. There is danger of not changing behaviour. Probably because they just hear it through the radio 99% of respondents.

FIGURE: 5 Application of behaviour change information in life.

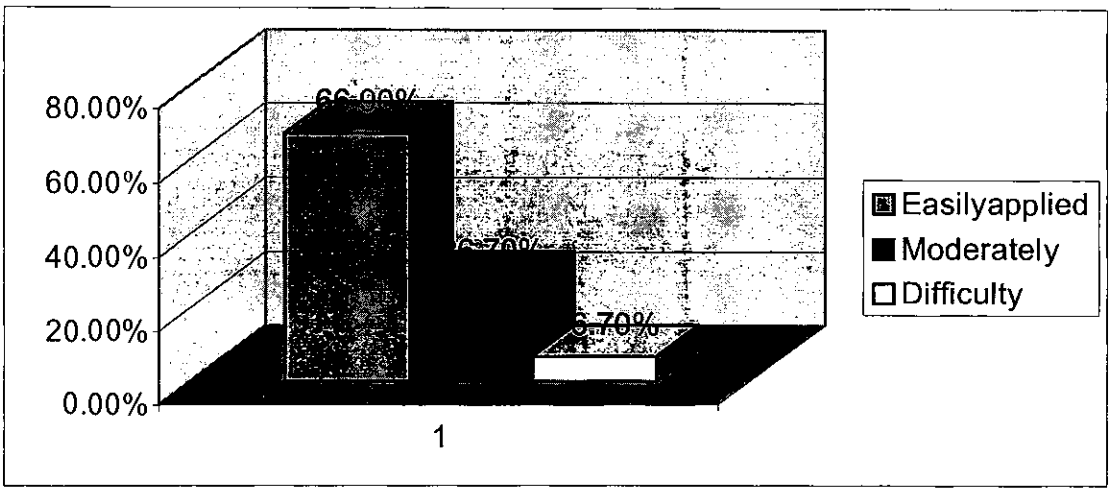

Figure 5 shows perceptions on application of behavioural change information.

The survey also solicited respondent's views on who should be involved in the giving out of behaviour change messages. The findings reveal that the majority 63.3% (n=19) of the respondents opt for the use of Anti-Aids clubs in the community. For other options, 36.7% (n=11) of the respondents indicated involvement of health personnel, 33.3% (n=10) of the respondents showered interest in the use of community leaders, 26.7% (n=8) of the respondents indicated the involvement of peers or age-mates while 23.3% (n=7) of respondents have shown interest in the use of teachers and 20% (n=6) opted the inclusion of church leaders in the dissemination of behavioural change information in Muona community.

Table:11 who should be involved in the dissemination of behaviour change messages.

Age groups (years)

	15-19	20-24	25-29	30-34	35-39	40-44	Male	Female	Frequency	Percentage
teachers	4	2	-	1	-	5	5	2	7	23.3
health personnel		2	2	2	-	5	4	7	11	36.7
Community leaders	-	1	2	2	-	5	4	6	10	33.3
Church leaders	-	2	1	1	-	2	3	5	6	20
Peers/age mates	-	1	2	-	-	5	3	5	8	26.7
Anti Aids clubs	8	6	1	1	-	5	7	12	19	63.3

Table11 shows Categories of people to be involved in the dissemination of BCI messages

Asked whether they talk to their friends about behaviour change, all respondents 100% (n=30) reported that they talk about behaviour change to their friends. However, 63.3% (n=19) of respondents do talk about preventing HIV/AIDS before sex.

Asked further on the reaction of their friends towards the behavioural change message, various responses emerged. The majority of respondents 93.3% (n=28) indicated that the reaction of their friends is that changing behaviour is difficult. Of these, females and males were 53.3%(n=16) and 40% (n=12) respectively.

Table: 12 Reaction from friends towards behaviour changes.

Reaction	Male	Female	Number	Percentage (%)
Changing behaviour is difficult	12	16	28	93.3
HIV/AIDS is spread in many ways	5	7	12	40
HIV/AIDS can not be prevented in any way	3	2	5	16.7

Table 12 shows various reactions that people make in response to behaviour change

5.7 Perceived impact of behaviour change information in Muona community

The survey assessed whether there are perceived changes in cultural practices brought about by the behaviour change information in the community. The results hold that 100%(n=30) of the respondents have perceived the changes. The results showed that 40%(n=12) of the respondents have observed decreased *fisi* ***practice*** and 60% (n=18) said that there is a decrease in practice of *kulowa kufa.*

Figure 6. Pie chart: Responses on the reduction of cultural practice

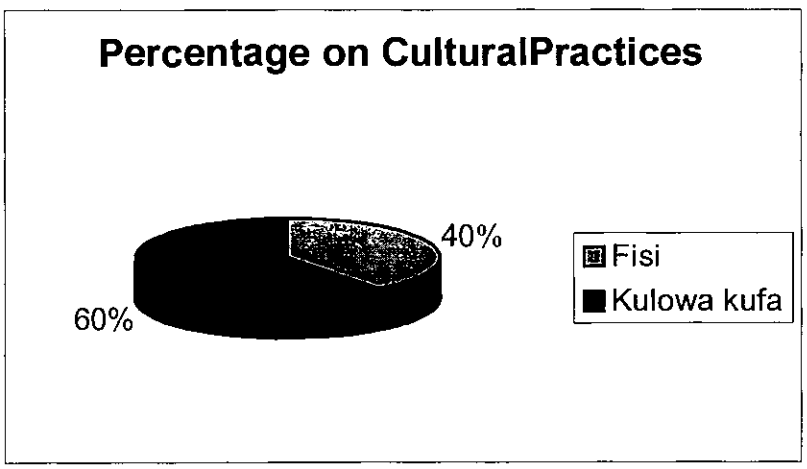

Table 6 shows percentages on reduction of some cultural practice. More respondents 60 % (n=18) had observed that kulowa kufa practice is reduced.

All respondents were asked if they have a role/involvement in the dissemination of behaviour change messages to a friend. The research has found out that that 80% (n=24) of the respondents would give advice to their friends on behaviour change. They were further asked if they could be on fore front to change the risky cultural practice if given chance. 100% (n=30) of the respondents had said yes, they would act to change the cultural practices that are deemed risky for HIV/AIDS.

The survey assessed the respondent's views on the increasing numbers of HIV/AIDS cases despite the high level of knowledge on behaviour change messages. The results revealed that 53.3% (n=16) of the respondents felt it is due to prostitution while 46.7% (n=14) reported that the fisi practice accounts for this increase in HIV/AIDS cases.

Responding to a question asking on whom would the respondents be comfortable to talk to about HIV/AIDS behaviour change, different feelings emerged. Majority, 96.7% (n=29) of the respondents mentioned the peers/age-mates, 40% (n=12) mentioned health personnel, respondents who mentioned community leaders were 33.3% (n=10) and only 6.7%(n=2) of the respondents mentioned teachers.

Table: 13 of frequency on whom to talk to about BCI

Comfortable to talk to	Male	Female	Frequency	Percentage (%)
Peers/age-mates	13	16	29	96.7
Health personnel	6	6	12	40
Community leaders	4	6	10	33.3
Teachers	1	1	2	6.7

Table13 shows thee distribution on frequency on whom respondents were comfortable to talk to

These findings hold that peer/age-mates have a big influence on behaviour change information, as the majority 96.7%(n= 29) of the respondents would be very comfortable to talk to their age-mates. Others 40%(n=12) showed that they would be comfortable to talk to teachers. This indicates that teachers are least preferred in the dissemination of

HIV/AIDS. This correlates with the respondents' views as results reveal that only 23.3% (n=7) of the respondents feel that teachers should be involved in the dissemination. Most people would not be able to learn the behaviour change messages if teachers are to be very much involved. Therefore find alternatives for the dissemination of behaviour change messages.

Chapter six

6.0 DISCUSSION

This chapter discusses the findings of the study. The discussion centres on the use of the conceptual framework in relation to the findings. it looks into the knowledge levels on HIV/AIDS behaviour change, perceived benefits of BCI., perceived ideal ways of disseminating BC messages, risky social and cultural practices that predispose people to HIV/AIDS infection and suggestions on ways to avoid these practices. Then it will discuss the implication of the study to nursing education, practice and to other healthcare providers.

6.1 Conceptual framework as applied to the findings

The conceptual framework, Health belief model (HBM) explains that individual's perception or beliefs, demographic factors, social and cultural factors may lead to increased awareness on a disease hence influence decision s to take actions to prevent it. This study has found out that there are social and cultural factors including knowledge that influence people of Muona on their sexual behaviour in relation to HIV/AIDS prevention. The knowledge level 100%(N=30) has brought awareness on HIV/AIDS behaviour change to individuals. This has brought perception and beliefs that HIV/AIDS pandemic is real. As stated by Berger & Williams (1999) it may increase the awareness that an individual stands a chance to contract HIV/AIDS. All these factors contribute to taking action on the HIV/AIDS behaviour change in order to prevent contracting it because people are able to see the advantages of following the behaviour change.

However, the findings show that there are cultural and social practices that predispose people to HIV/AIDS infection. These hinder the effectiveness of behavioural change and may compel people to perform the risky practices hence

predispose them to HIV/AIDS infection. Stanhope & Lancaster, (1995) assert that action to prevent any disease is triggered by external factors. Therefore if there were stimuli within the environment, people would be willing to take part in the HIV/AIDS behaviour change by avoiding the risky social and cultural practices. This means when people are involved in the behaviour change would enable them to feel that they are capable of performing those actions. People would be to identify and attach value or/ and benefits to the intended actions in HIV/AIDS behavioural change. The NACP, (2001:5) indicated a similar statement that Behaviour change would be achieved through instilling knowledge, attitudes and skills through participation.

SFAIDS (2002:6) also recommends participatory actions in the behaviour change. This is congruent to the research findings as 100% (n=30) showed interest to involve them peer education in order to avoid risky social and cultural practice. It is also evident in this community people prefer participatory approach because most of the respondents 63.3% (n=19) opted for the use of community based Anti-Aids clubs, (Table 11). However, 36.6% indicated that they would prefer to hear BCI from health care workers. This implies that health messages on behaviour change should be clear and enriching to clear misconceptions that people have on the HIV/AIDS.

6.2 knowledge level on behavioural change information

The results show that IEC has provided opportunity for members of Muona community to hear about the behavioural change information.

Findings indicate that all respondents 100% (n=30) have knowledge on the behavioural change. There is not difference in knowledge levels between males and females. This is encouraging that would empower women to make decisions

affecting their sexual and reproductive behaviours. This would enable women to prevent contracting HIV/AIDS.

Wyndaele et al (1995) found out that HIV/AIDS knowledge level was 98%, while NACP (2001) found knowledge level at 99% national wide. In this study the knowledge level is 100%. This is a positive fact because knowledge clarifies perceptions, beliefs, values, attitudes and skills towards an action that is deemed important to an individual. Bennet and Baker (2001) in similar sense state that knowledge is key factor for behaviour change at an individual level and community level. Knowledge influence people to take action in HIV/AIDS fight in order to avoid contracting or spreading HIV/ AIDS.

However the results have shown that people in Muona community do not know exactly what is involved in behaviour change. Although 80% (n=24) indicated that behaviour change is aimed at preventing spread of HIV/AIDS. This percentage does not correlate with the knowledge level on awareness of behaviour change information. This has an implication on people commitment to involve them selves in the behaviour change.
66.7% of the respondents know that total abstinence is is an integral component of behaviour change. This is a serious problem considering that about 40% do not know about abstinence as part of changing behaviour. This predisposes people to contract HIV/AIDS infection.

It is also found out that66.9% (n=20) feel that it is difficult to apply the behaviour change in their daily life.(figure 9) as a result people do not put in practice what they know. Perhaps this is attributed to the method of communicating the behaviour change information. They only hear it but there is no reality in its application to life events. Knowledge is only a departing stage for individuals to take action in behaviour change. However it needs to be combined with

community level factors that motivate people to act in accordingly. Bennet and Baker (2001) observe that community level factors are influences from others such as peers family members leaders and cultural practices. This conludesthat communication through radios, newspapers and health personnel without involving community level factors contribute to lack of application of behaviour change information to recipient's daily life.

6.3 Perceived benefits of behaviour change information

Majority 80%(n=24) perceive that they would benefit from behavioural change messages by preventing contracting HIV/AIDS. The results correlate with what was found Nyasulu et al (2000) that in Chikwawa and Nsanje districts 89% of 216 participants had adequate knowledge on HIV/ AIDS. However these results did not report on behavioural change messages. This is important because people have positive perception about behavioural change practices. On contrary observation, about 20% do not regard behavioural change as a means to prevent the spread of HIV/AIDS.

This may have a negative impact on communication of HIV/AIDS behaviour change as a result it might not achieve its objective.

20% is big enough to significantly contribute to the spread of HIV/AIDS

It was also found out that only 3.3% of the respondents know that through behavioural change practices, people would avoid contracting other sexually transmitted infections (STIs)(Table 9) .It has a connotation that majority of the people in this community disregard the importance of behavioural change as a preventive measure to spread of STIs including HIV/AIDS. Further evidence is the low numbers 20% (n=6) of participants who used condoms while 56% (n=17) never used condom in the past 12 months. It is a major problem that hinders the intended effects of behavioural change approach in the community.

This is an indication that people have misconceptions about the benefits of behaviour change. This results in resistance to change their behaviours positively in relation to HIV/AIDS prevention. This problem is attributed to unclear and inadequate behavioural change information. Mandalazi and Chizimba (2002) found that IEC through radios and newspapers did quite well on awareness of HIV/AIDS behaviour change. However, they lack individual and community involvement for better results in changing individual behaviour. Perceived benefits of behavioural change messages would have been facilitated if it allowed community participation for members to correct misconception (SAFAIDS, 2002:2)

6.4 **Perceived ideal ways of communicating behavioural change messages**

Results hold that people have different perceptions on how should behavioural change messages be communicated to the community members. (Table11). Different age groups have different preferences on who to be involved in the exercise of disseminating behaviour change information.63.3%(n=19) of respondents prefer the use of community based Anti -AIDS clubs but majority were youth participants78.9% (N=15).

Apart from involving health personnel 36.7%(n=11), some respondents 33.3% (n=10) opted for the use of community leaders. This gives a clear picture that people in this area have a strong drive for community participation. Twin at al (1996) support this suggestion as he asserts that dissemination of key health messages would be very effective if opinion leaders were working together with change agents. Adults in the age range between 35 – 44 years prefer the use of age mate/ peers or teachers in the dissemination of behavioural change information. However it all comes back to collective community participation.

6.5 Risky social and cultural practices in Muona that predispose people to HIV/AIDS Infection

It is clear in this study that people do practice some social and cultural practices hence become vulnerable to contract HIV/AIDS infection. There are practices such as polygamy, kupita kufa, fisi (hyena), and prostitution. (Table 11). The major reasons for indulging in casual sex are to satisfy one's sexual desire and to earn a living as a means to combat poverty. It is also revealed that culturally women are forced to indulge in these practices. This external pressure that surmount women suppress women's autonomy in making decisions as regards to when to use condom as it is evidenced that about 55% of female respondents did not use condom because the male partners refused to use it. All these problems culminate from unclear inadequate information that may empower women in making decisions on issues that affect their reproductive activities. All this calls for multi-sectoral approach and comprehensive IEC that will enlighten women on their rights so that they should not be sexually exploited. However it came out that more respondents (n=80) would be willing to offer civic education to fellow community members on negative effects of these risky social and cultural practices.

Apparently, results have shown that there are decreased levels of fisi and kulowa kufa practices. (Figure 10) The IEC did a plausible work in educating the community on relationship of these practices and the spread of HIV/AIDS. Only 40% (n=12) respondents had observed that fisi practice has decreased. This gives impression that about 60% of the respondents observed it being practiced. If women were empowered enough may be in basic human rights, they would have resisted this to be done on them.

The study results indicate that there is loss of hope among people in the prevention of HIV/AIDS as all female respondents (n=16) 53.3% of the total study sample indicate that their friends express that it is difficult to change behaviour and 16.7% (n=5) say that HIV/ AIDS can not be prevented in any way. Such sense of hopelessness among community members contributes to complacency to the social and cultural practices

hence predisposing them to HIV/AIDS infection. This is supporting the findings by Abdil and Kaunda (2001) that other populations in rural areas do not know whether they are at risk or not. Similarly people in this community may not know which social and cultural factors that may put them at risk of contracting HIV/AIDS.

6.6 Implications of the study to nursing and other health care providers workers

Nurses and other healthcare providers should be knowledgeable on behavioural change through community participation to enable them work effectively in the community. This concept should be integrated in nursing curricula and in curricula for other health workers.

Behavioural change approach should involve other sectors both public and non-governmental organizations in order to bring about total collaborative participation.

There is need for health workers responsible for this area to use peer education and community based Anti-AIDS clubs. This will fully involve the community members in the fight against HIV/AIDS. Community members should be allowed to play a major role in disseminating behaviour change messages. Health workers should take facilitative role to guide them.

Behavioural change messages should be explicit and enriching. Thus its aims and what it entails should come out clear to clarify misconception that may exist in the community.

Messages should contain content in fundamental human rights and Sex and Reproductive health in order to enlighten and empower women of this community to make decisions on their sexual behaviour. They should be able to negotiate for safe sex or they should be able to say no to the risky cultural practices such as fisi and kulowa kufa.

Empowering women on small income generating activities would also assist to curb the spread of HIV/AIDS in this community because poverty is one of the factors contributing to increased incidents of casual sex among females.

Bearing in mind that there are different feelings on behaviour change in relation to HIV/AIDS prevention, it is therefore recommended that in collaboration with traditional leaders, religious leaders teachers and health workers of this area should intensify awareness campaigns on behaviour change. These campaigns should embark on social and cultural practices that predispose people to HIV/AIDS and on the dangers of such practices.

Considering that majority of youths are indulging in casual sex, it is, therefore advantageous to establish youth centres where youth will be sharing ideas on how to express sexuality .In view of this, it is therefore recommended that youths in schools should be taught Sex and sexuality topics that include gender issues. Also condoms should be available and accessible to the youth close to there living areas so that they do not travel long distance to get access to them.

6.7 Limitations of he study

- Small study sample was used and was drawn from one community to which the findings are generalized. This occurred because of financial constraints. Secondly, it was an academic study therefore time constraint imposed some limitations to the study.
- The results are generalized only to the community from which the sample study was drawn. Therefore there is need for a large-scale study to generalize the results national wide.
- The study was done in rural community therefore findings are confined to the rural areas hence need for its replication in urban areas.

6.8 Conclusion

It is evident in these study findings that behaviour information is regarded as mere message. Apparently, more people in Muona have not changed their behaviours that predispose them to HIV/AIDS infection. Risky social and cultural practices that exist and being practiced predispose people to this deadly infection and other STIs. Emerging from the study is that people feel that it is impossible to arrest the spread of HIV/AIDS.

It is noticed that community members want to be much involved in the dissemination of behavioural change messages. This calls for total community involvement in the fight against HIV/AIDS

REFERENCES

Abdil,K. and Kaunda,C. (2002). Assessing perception and Channels of HIV/AIDS Messages in Sub – Saharan Africa. *The Malawi Case. Sixth Research Dissemination Conference. College of Medicine.* Blantyre Malawi.

Adey, O., Hacht, R., Njobvu, E. and Soucat, (2001). Aids, Poverty Reduction and Debt Relief. *UNAIDS/World Bank.* Geneva. March 2001.

Bennet, C. and Baker, K. (2001). HIV/ AIDS. An overview. *Nursing Standard* vol.15 (24): 45—52.

Berger, K.J. and Williams, M.B. (1999). *Fundamentals of Nursing. Collaboration for Optimal Health.* Stamford: U.S.A. vol. 1: 269.

Burns, W. and Grove, S.K.(2001).*The practice of Nursing Research. Conduct, Critique and utilization. Philadelphia*: W.B. Suanders.

Damison, H. and Bicego, G. (2001). *Aids and Other Sexually* Transmitted Infections. *Malawi Demographic Health Survey-MDHS National Statistical Office.* Zomba. Malawi.

Eilish, A. (1994*). AIDS. The Barriers to Behavioural* change. *University of Malawi Centre for Social* Research. UNICEF-MALAWI.

Elkan, R. and Blair, M. (2000). Evidence-based Practice and Health Visiting: The need for Theoretical Underpinning for evaluation. *Journal of Advanced Nursing* vol. 31(6).1316.

Ellis, J.R. and Nowlis, E.A. (1989). *Nursing a Human needs Approach.* Boston. Houghton. Mifflin Company.

Gillies, D.A. (1994). *Nursing Management. A Systems Approach.* Philadephia: W.B. Saunders.

Imane (2002). *International AIDS Conference xiii. Abstract Book* vol.11.: 496. July 9-14.

Jackson, H. (2002). *Aids In Africa. Continent In Crisis* Harare. Zimbabwe. Fontline electronic Publishing.

Kachingwe. S.I., Jeke, A.J., Chidalengwa, G. Chiunda G.A. Moleni, C.M. (2000). *The Impact of Sexual Reproductive Health Education Programmes for Primary Schools in Malawi; Base line survey.* Malawi institute of Education. POPED Project. Domasi.

Kadzamira, E. et – al (2001). *The impact of HIV/AIDS on Primary and Secondary Schooling in Malawi. Developing a comprehensive Strategic Response.* Centre for Educational Research and Training (CERT). Zomba.

Kasiya, A.L. (2002). The Youth In Danger. Which Way forward? *MANASO News Letter* Issue No. 1. 1st Quarter.

Kim, B. (2000). When Partners Talk, Behaviour May change. Net work: *Family Health International.* Vol. 15. p. 9-13.

Mandalazi, P & Chizimba, E. (2002). Baseline Survey And Care Project. Extending Tangible hope to those Affected by HIV/AIDS. World Vision International. Lilongwe Malawi.

Maluwa-Banda, D., Kadzamira, E.C., Kamlongera, A. and Swainson, N. (2001). *The Impact of HIV/AIDS on Primary and Secondary Schooling in Malawi*: Developing a *Comprehensive Strategic Response.* Centre for Educational Research and Training (CERT) Zomba.

National Aids Control Programme (NACP) (2001). Estimating National HIV. Prevalence in Malawi from Sentinel Surviellance Data. Lilongwe. Malawi NACP p.5.

National Aids Strategy Planning Unit (NSAPU) (1998). Capacity Building for HIV and Developing NSAPU p.11.

Nyasulu, V.Z., Maggai, D. (2000). Cultural Practice that Predispose Women to HIV infections in Nsanje and Chikwawa districts. *Sixth Research Dissemination conference.* College Research Committee. C.O.M. – Blantyre Malawi November 2002.

Polit, D.F. and Hungler, B.P. (1995). *Nursing Research. Principles and Methods. (sed.).* Philadelphia. J.B. Lippincolt.

Mendel G. (2002). How Can We Use Education To Deal With HIV? SAFAIDS Healthlinks. Issue 54 :2 December.

Smith, E.J. (2002). Life Circumstances Influence Decision. *Family Health International* vol. 21 No.4 p.24.

Stanhope, M, and Lancaster, J. (1995). *Community Health Nursing. Promoting Health of Aggregates, Families and Individuals.* St. Louis. Mosby year Book Inc.

Twins, S. Robert, B. and Andrews, S. (1996). *Community Health Care Nursing: Principles for Practice.* Oxford. Butterworth Hienemann.

Ulin, P.R., Robinson, E.T., Tolley, E.C. and Mc Neil E.T. (2002). *Qualitative Methods: A field Guide for Applied Research in Sexual and Reproductive Health. Family Health International*. North Carolina. Research triangle Park.

Wolff., L.V. Weitzel, M.H., Zarnow, R.A. and Zsoher, H. (1983). *Fundamentals of Nursing*, Philadelphia. J.B. Lippincolt company.

APPENDIX 1

RESEARCH INSTRUMENT (QUESTIONNAIRE)
STUDY ON THE IMPACT OF HIV/AIDS BEHAVIOURAL CHANGE INFORMATION ON THE MUONA COMMUNITY:

A: Personal data/ demographic data

1.Sex: M ☐ F ☐

2.Age: 15-19 ☐
20-24 ☐
25- 29 ☐
30- 34 ☐
35-39 ☐
40-44 ☐
45-49 ☐

3. Level of education.

None. ☐ Std.1-5 ☐ Std 6-8 ☐ Form 1-2 ☐

Form 3-4 ☐ University ☐

Other (s) specify: ----------

4.Marital status: Single ☐ Married ☐ Divorced ☐

Widowed ☐ Cohabiting ☐

Other(s) Specify----------

5. Occupation: Teacher ☐

Subsistent farmer ☐

Fisherman ☐

Skilled worker ☐

Other(s) specify----------

---

6. Tribe: Sena ☐

Lomwe ☐

Yao ☐

Chewa ☐

Ngoni ☐

Tumbuka ☐

Other(s) specify----------

---

7. Religion: Roman Catholic ☐

C.C.A.P. ☐

S.D.A. ☐

Salvation Army ☐

Zambezi Evangelical Mission (Z.E.M.) ☐

B. Knowledge about HIV/AIDS behavioural change information

8. Have you ever head of HIV/AIDS behavioural change messages?

Yes ☐ No ☐

If yes, how did you know about the message? Through

Radios ☐
Newspapers ☐
Community leaders ☐
Church leaders ☐
Teachers ☐
Health personnel ☐
A friend ☐
Anti-AIDS clubs ☐

9.what is the aim of behavioural change? Tick as appropriate

Prevention of HIV/AIDS

Prevent unwanted pregnancy

Prevent STIs

Improve social relationship among couples

Other(s) specify----------

---------.

Behaviour change includes the following: Tick appropriately.

Having protected sexual intercourse

Have one sexual partner always

Total abstinence from sexual intercourse

Non-penetrative sex

Knowing one's HIV status

Avoiding spreading HIV/AIDS deliberately

Avoiding risky cultural practices

C. **Cultural practices that predispose people to HIV/AIDS infection**

11.(a) What do you think are some of the practices in your community that promote the spread of HIV/AIDS:

- Polygamy
- Kupita kufa (wife inheritance)
- Fisi
- Prostitution
- Other(s) specify----------

(b).What do you think should be done to reduce the risky cultural practices?

D. **Sexual behaviours**

12 .How many partners have you had sex with in the past 12 months?

None ☐

One (1) person ☐

Two (2) people ☐

Three (3) or more people ☐

Never had sex for the past 12 months ☐

13. Last time you had sex did you and your partner talk about:

a. Avoiding pregnancy Yes ☐ No. ☐

b. Avoiding HIV/AIDS infection Yes ☐ No. ☐

c. How to get sexual pleasure without intercourse. Yes ☐ No. ☐

d. Using a condom. Yes ☐ No. ☐

14. How often did you use condoms when having sex in the past 12 months?

Always used condom ☐

Some times used condom ☐

Never used condom ☐

Did not have sex with casual partners ☐

Have never had sex ☐

Never had extra marital sex ☐

If never used condoms, what was the reason?

Do not like it ☐

Partner's refusal ☐

Do not know where to get ☐

15. Do some of your friends have casual sex partner(s)

Yes ☐ No. ☐

If yes in above (15), what could be the contributing factors?

a. ---

b. ---

c. ---

d. ---

e. ---

E. **Perceived benefits of behavioural change messages**

16. What are the benefits of changing individual's behaviour? Tick as appropriate

Prevent contracting HIV ☐

Prevent STIs ☐

Live healthier life ☐

Individual has chance to accomplish one's plans in life ☐

Other(s) specify----------

---

17. Do you know the benefits of knowing your HIV status?

Yes ☐ No. ☐

If yes what are the benefits of knowing your HIV status?

- Helps in future planning ☐
- Helps taking right precautions ☐
- Avoiding spreading HIV to others ☐

Other(s) specify----------

F. **Perceived ideal ways of disseminating behavioural change messages**

18. How do you perceive the method of disseminating behavioural change messages?

Very effective ☐

Effective ☐

Not effective ☐

19. How easy is the message applicable in your daily life?

- Easily to apply ☐

- Moderately easy to apply ☐
- Difficult to apply ☐

20. Whom do you think should be involved in the dissemination of behavioural change messages? Put a tick appropriately.

Health personnel

Community leaders

Church leaders

People of the same age (peers)

Primary and secondary school teachers

Community based Anti-AIDS clubs

Other(s) ----------

---

21. Do you talk with your friends about behaviour change?

Yes ☐ No. ☐

If yes, how do your friends react?

- Changing behaviour is difficult ☐
- HIV/AIDS is spread through many ways so behaviour change is impossible ☐
- HIV/AIDS can not be prevented in any way ☐

Other(s) specify: ----------

G. **Perceived impact of behavioural change messages**

22. Are there any noticeable changes in cultural practices due to the behavioural change messages? Yes ☐ No. ☐

If yes, list down the changes that you have observed:

----------:

How is the information assisting person in this area?----------

---

---

23. What is your role / involvement in he dissemination of behavioural change messages to your friends? ----------

---

---

24. If given chance would you be the first one to change the risky cultural practices?

Yes ☐ No ☐

If no, give reason(s)----------

---

25. Despite HIV/AIDS behavioural change messages, the number of HIV/AIDS cases is increasing. Why do you think this is so? ----------

---

25.Who would you be comfortable to talk about HIV/AIDS behavioural change?

Peer/age mates ☐

Community leaders ☐

Health personnel ☐

Teachers ☐

Other(s) specify----------

APPENDIX 2

C/o Kamuzu College of Nursing,
P/ Bag 1,
Lilongwe.
3rd June 2003.

District Education Manager,
P.O.Box 13
Nsanje

Dear sir/ madam,

ASKING FOR PERMISSION TO CONDUCT ARESEARCH STUDY AT FATIMA COMMUNITY DAY SECONDARY SCHOOL FROM 5TH TO 8TH MAY, 2003.

I write to apply for permission to conduct a research study on the impact of Behavioural change messages on Muona community.

Iam a second year student at Kamuzu college of Nursing pursuing a post-basic Bachelor of Science Nursing Education (BSc.N.Ed.). In partial fulfillment of requirements of the award, I am required to conduct this research study.

The study findings will help all health workers to assist communities in the fight against HIV/AIDS in regards to behaviour change.

Students and teachers will be requested to participate in the study by answering a questionnaire.

Yours faithfully,

C. MAGOMERO

APPENDIX 3

Careford P.N. Magomero,
Kamuzu College OF Nursing,
P/ Bag 1
Lilongwe.

3rd June 2003

The Head master,
Fatima Community Day Secondary School
P.O.Box 77
Muona.

Dear Sir / madam,

A REQUEST TO CONDUCT STUDY AT YOUR SCHOOL FROM 5TH TO 8TH MAY2003

I write to ask for permission to conduct research study at your school.

The topic of the study is The Impact of HIV/AIDS behavioural change Messages on the community of Muona- Nsanje North.

I am a second year student at Kamuzu College of Nursing pursuing a post-basic Bachelor Of Science Nursing Education (BSc.N. Ed.) As a requirement in partial fulfillment of the award, I am required to conduct this research study.

It will involve students and staff of this institution. They will be given individual questionnaire to answer under the guidance of data enumerators.

Yours faithfully,

C. MAGOMERO

APPENDIX 4

C/O Kamuzu College of Nursing,
P/Bag 1,
Lilongwe.
3rd June 2003

Kwa: Mfumu Marothi,

P.O. Box 15,

Muona

Wokondeka Mfumu Marothi

KUPEMPHA CHILOLEZO CHA KAFUKUFUKU YEMWE ADZACHITIKE PA 5 KUFIKA PA 8 MEYI CHAKA CHOMWE CHINO

Ndaima pa maso panu mfumu kupempha kuti ndizachite kafukufuku m'mudzi mwanu .

Ndine wo phunzira wa pa sukulu ya ukachenjede ya za uphunzitsi wa unamwino kuno ku Lilongwe ndipo ndiri m'chaka cha chiwiri.

Kafukufukuyi adza khuza njira zopewra matenda a edzi omwe avuta kwambiri. Adzathandiza kupeza njira zomwe anthu a m'mudzi mwanu anga pewere matenda amenewa.

Choncho ndasankha mudzi wanu kuti ndidzachitireko kafukufukuyi kuyambira pa 5 th kufikira pa 8th Meyi chaka chino.

Zikomo .

Ndine,

C. MAGOMERO

APPENDIX 5

PARTICIPANT'S CONSENT FORM

I ---------- agree to undersign this form to participate in the research study upon having fully understood its implications.

Participant's Name:

Signature:

Date :

Researcher's Name: Careford P.N. Magomero

Fatima CDSS,
P.O. Box 77,
Muona.
July 3, 2003

The Lecture,
Kamuzu School of Nursing,
Private Bag 1,
Lilongwe.

Dear Sir,

HIV/AID RESEARCH BY MR C.P.N. MACHMELO

I hereby humbly write to inform you that the abovenamed carried a thorough research on HIV/AIDS at this School.

Both teachers and students were involved and all went on smoothly. I therefore testify that the research was satisfactory. This was from 5th – 8th May 2003.

Thank you.

Most Sincere,

F. TOMMY (DH)

THE DEPUTY HEADMASTER
FATIMA CDSS
P/BAG 77, MUONA
DATE