HIV/AIDS COMMUNICATION STRATEGIES IN NORTHERN UGANDA:
DEVELOPMENT WORKERS OPINIONS ON WHAT WORKS

by

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Abstract

The country of Uganda has an HIV rate of approximately 6.3% countrywide, but in northern Uganda rates have been significantly higher (UNAIDS, 2011). In northern Uganda, a region that has faced decades of war and conflict, 1.2 million people live with HIV. The Extended Parallel Process Model (EPPM) and Social Cognitive Theory (SCT) are used as the theoretical framework in examining how on the ground development practitioners create programming that is the most beneficial in behavior change. Both theories have been used extensively in the design and implementation of HIV/AIDS prevention programs. However, there tends to be little consistency among scholars on what types of behavior change approaches are the most effective, especially in those countries that are most impacted by the AIDS epidemic. The goal of this study was to examine the views of practitioners who work directly with recipients and identify some of the most effective strategies and messages tailored for Northern Uganda based on the EPPM and SCT.

A qualitative approach was used in the study. A sample of current, or past long-term (at least two years working in the field) development practitioners from international agencies such as the United States Peace Corps, USAID, International Rescue Committee (IRC), among others. Data were gathered through in-depth interviews, which were conducted online due to geographic constraints of the interviewees, with selected participants currently scattered throughout the United States and sub-Saharan Africa.

The study reports practitioners' views on most effective communication strategies and messages based on experiences while working in northern Uganda. Some of the variables examined include the strategies for changing the belief systems of the population that curb the spread of the AIDS epidemic; self-efficacy strategies; and the nature and level of fear appeal appropriate for the Northern Ugandan situation; and their overall view. Findings of the study indicate respondents feel fear appeal messaging may be ill suited for use in Northern Uganda. Culture-centered approaches may be of best use during the transition from war to reconciliation. Results of the study will help to inform future HIV/AIDS prevention programs on best practices that are both theory and research based.

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Dedication

This study is dedicated to my wife, Sami. Without her love and support I would not have even ventured into graduate studies. She was my comfort and strength as we worked in Uganda as Peace Corps volunteers. She served as the same during the writing of this thesis.

Chapter 1 - Introduction

With more than 34.2 million people living with HIV/AIDS in 2011, HIV/AIDS remains one of the biggest global epidemics of the 21st century with sub-Saharan Africa hosting about 67 percent of all AIDS cases (UNAIDS, 2011). Political instability, which leads to war and ethnic conflicts, has been associated with the high rates of HIV infection in many developing nations (Lau, 2004) including some African countries. Elevated rates seen in war zones can be attributed to rape and other forms of sexual violence. In northern Uganda, a region that has faced decades of war and conflict, 1.2 million people live with HIV. Of those one million are 15 years or older with females accounting for 610,000. The country as a whole has an adult HIV prevalence of 6.3% (UNAIDS, 2011) but the rate is higher in northern Uganda, the epicenter of the conflict between the Lord's Resistance Army (LRA) and the Ugandan government (Edmondson, 2005).

Northern Uganda is slowly coming out of this 20-year period of war and conflict. In 1987, the renowned rebel leader, Joseph Kony of the LRA, waged war on president Yoweri Museveni and the Uganda government. Since the war broke out nearly two million northern Ugandans have been displaced by insurgency, forcing them to live in appalling conditions within Internally Displaced Persons (IDP) camps (Bongyereirwe, 2010). Over the years, the LRA has abducted over 66,000 children to fight as child soldiers or serve as sex slaves for the commanders of the rebellion. The children who have managed to escape the rebels and return to their families are often suffering from a host of mental health problems and infected by HIV (Barenbaum, Ruchkin & Schwab-Stone, 2004; Westerhaus, Finnegan, Zabulon & Mukherjee, 2007).

Since 1987, approximately 132 IDP camps have been set up in Northern Uganda because of the conflict in the region. These camps housed between 200 people to over 55,000 at any given time, depending on the situation and area. Since 1987, there has been a phenomenon known as "night commuting" by the children of the north. Children would make a pilgrimage each night from their rural villages to the town centers of northern Uganda, where they would attempt to sleep safely away from LRA capture in churches, schools and non-governmental agency (NGO) headquarters. Women who tended crops and gardens were routinely raped and

kidnapped by both roaming LRA and governmental soldiers whereas village men would be savagely beaten or murdered by these same groups of people (Westerhaus, et al., 2007).

HIV/AIDS has been one of main consequences of war and displacement in northern Uganda (Brown, Fraser & Kiruswa, 2005; Diop, 2000). In the three main districts of the north, Gulu, Kitgum, and Pader, the HIV prevalence rates reached as high as 11.9 % (Ugandan Ministry of Health, 2005), which stands at nearly double that of the country's national average of approximately 4.1% in rural areas and 6.5% in major towns (Uganda AIDS Control Council, 2010). The mass abduction of people by the LRA, the IDP camps, and the phenomenon of "night commuting" for safety are the three main reasons for the unique nature of HIV in Northern Uganda (Westerhaus, et al, 2007) and the extraordinarily high infection rates in that region.

Prevention of HIV infection is the mainstay of various responses to the epidemic as indicated in the United Nations Declaration of Commitment (Muturi & Mwangi, 2011, UNAIDS, 2008). One of the United Nations' millennium development goals is also to control and reverse the rates of HIV/AIDS globally by the year 2015 (United Nations, 2011). Other goals listed are the empowerment of women through AIDS education and increasing condom use in the richest and poorest households. In an attempt to achieve these goals, sub-Saharan African countries are collaborating with national and international NGO's to alleviate the HIV epidemic in the region. One such intervention is the United States President's Emergency Plan for AIDS Relief (PEPFAR), an initiative that has so far pledged $48 billion (PEPFER.gov) to combat the global HIV/AIDS epidemic collaboratively with the governments of impacted countries, including Uganda.

Other international development agencies, including the International Red Cross, Red Cross, International Rescue Committee (IRC), USAID, Oxfam, and the Peace Corps, to mention a few, have invested resources in HIV/AIDS preventions in war-torn regions globally. Through such interventions development workers from various agencies have implemented programs in Northern Uganda in the efforts of HIV/AIDS mitigation. Some of their efforts include identifying internal community resources, knowledge about the disease as well as skills and aptitudes, prioritizing needs of the region, and increasing capacity of community members and their role as an overall catalyst to the target groups (Donahue & Williamson, 2009). Such

formative research is important in the design and implementation of relevant interventions. However, the effectiveness of such interventions is often not systematically evaluated, particularly in Northern Uganda where war and conflict play a key role in the HIV infection.

Problem Statement

In an attempt to achieve the millennium HIV/AIDS prevention goals, several strategies have been implemented, such as, the ABC or D (abstinence, being faithful, using condoms or face death) approach (Murphy, Greene, Mihailovic, & Olupot-Olupot, 2006), antiretroviral (ARV) medication and voluntary counseling and testing (VCT) message recipients (Chamla, Olu, Wanyana, Natseri, Mukooyo, Okware, Alisalad, & George, 2007). From these components of programming the millennium goals have focused simply on improving the health status of individuals and increasing knowledge and understanding of HIV/AIDS issues while creating more positive attitudes towards the recipient's situation (Donahue & Williamson, 1999; Muturi, 2005). It is unclear how effective these strategies have been in northern Uganda where inadequate information, education, and services prevail in the context of war and conflict.

Health communication programs that focus on prevention have historically relied on a top-down information transmission-based model. This model is a one-way method of communication in which the health expert knows what is best for a passive audience. It is theorized that a more appropriate approach in development is creating programming that relies on a culture-centered approach (Dutta & Basu, 2008). A culture-centered approach relies on dialogue between the expert and the community members. This approach is to inform, influence, motivate, change behavior, empower, and increase knowledge while taking into account the unique culture components of the at-risk population (Airhihenbuwa & Obregon, 2000; Dutta & Basu, 2008). In the context of northern Uganda, it is important to understand how this culture-centered approach is applied to the development and design of HIV/AIDS prevention programs.

Similarly, the application of the ABC or D model and its success in northern Uganda, as in other regions impacted by war and conflict, has been questionable. One of the components of the PEPFAR directive is the ABC or D approach to HIV prevention. The message of the program is that abstinence is preferable but, if not possible, then people should be faithful. If people are unable to be faithful, then they should use a condom. If a condom isn't worn, then they run the risk of death (Barrett, 2007). This type of messaging may not address the culture

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issues that are unique to certain regions of Africa. It is also important to examine the extent to which the "risk of death" is perceived among communities that are highly impacted by war and conflict. According to Westerhaus and colleagues (2007) traditional forms of HIV prevention through the ABC or D model are not going to address "the unique and interconnected realities of child soldiers, night commuters, and the IDP camps" that entangle the population in physical and structural violence. Airhihenbuwa (2000) states that citizen participation needs to be present in the design and implementation of messages to insure that the people's needs are being met. From the perspectives of development practitioners in northern Uganda, this study will examine the extent to which current programs incorporate the culture approach, specifically how the local communities are involved in their design and implementation.

In spite of the resources invested in HIV/AIDS prevention through PEPFAR and other international aid organizations, there is limited or no change in HIV prevalence, particularly in Northern Uganda. This research is an examination of the effectiveness of the HIV/AIDS communication approaches used in the region from the development practitioners perspective. The study's main objective is to examine what they perceive as best practices for reaching their target audience. Additionally, the study examines their perspectives on the nature and appeal of HIV/AIDS messages that would be most effective and beneficial for Northern Uganda given the fearful environment as a result of was and conflict.

The study is informed by the Extended Parallel Process Model (EPPM) (Green & Witte, 2006) and Social Cognitive Theory (1997). The EPPM (Witte, 1992) draws from classic fear appeal theories dating back to the late 1960s. The EPPM is a health communication theory that draws on the role of fear appeal in health decision-making and on the person's response efficacy to the recommended behavior. The EPPM will be applied in analyzing the perspectives of development workers on HIV/AIDS prevention messages that are designed and disseminated in Northern Uganda, specifically to determine the level of fear appeal used and the effectiveness of the message. This will be examined from the perspectives of development practitioners. Among at risk populations such as northern Uganda, where fear levels are already high from war, it may be beneficial to explore alternative health messaging programs.

The Social Cognitive Theory (SCT) (Bandura 1997) focuses on perceived self-efficacy or the belief in one's capabilities to organize and execute the courses of action required to produce given levels of attainment. According to SCT, the acquisition of knowledge and skills should

increase one's ability to manage the demands of everyday life (Bandura, 2004). If people do not believe their behavior will change their position when faced with a threat, they will be unwilling to act. The SCT theory is applied in the study to examine contributing factors to the HIV/AIDS epidemic in northern Uganda from the perspectives of development workers. Additionally, SCT will be used to determine the level of self-efficacy among message recipients who are targets in the current interventions.

The life-skills approach, based on SCT, is one of the models used in HIV/AIDS prevention in northern Uganda as in other regions impacted by the epidemic. The approach seeks to enhance self-efficacy through economic and political participation, ameliorate gender inequalities (UNICEF, 2007; Yankah & Aggleton, 2008), enhance the quality of parenting (Olen, 1994), and reduce anti-social behavior and crime (Botvin, Griffen & Nichols, 2006; Deffenbacher, et al., 1995; Yankah & Aggleton, 2008). Life skills enable people to communicate openly and freely, indicating their preferences and what they wish to avoid. Life skills result in clear thinking, having the correct attitudes, and staying safe (Yankah & Aggleton, 2008). The life-skills approach may be particularly relevant in the context of war and conflict where the target population face a higher risk of HIV infection and where self-efficacy is critical for effective prevention. Through life-skills development, the approach has a focus on long-term goals and involvement of at-risk groups for sustainability of development programs. The examined the extent to which the life-skills model is applied in Northern Uganda as well as development workers' perspectives on its relevance in the context of war and conflict.

Overall, this study focused on the approaches to HIV/AIDS communication in Northern Uganda, specifically examining the best practices and failures and gaps in programming in the context of war and conflict. Though research has addressed the effectiveness of fear appeal in HIV/AIDS Communication in Uganda (Green & Witte, 2003), it is important to examine how the environment in Uganda affects the effectiveness of fear appeal messages from the perspectives of development practitioners who design and implement the preventative messages. The study examines the extent to which fear is incorporated in the messages and the self-efficacy development through application of the life-skills model, as well as from the culture-centered approach. The study examines how development workers engage the target publics in the design and implementation of the HIV/AIDS communication programs.

Justification and Study Significance

There is sparse research being done to assess the effectiveness of fear-based and SCT health messaging campaigns among development organizations working in developing countries where high levels of fear already exist. Some research says target groups will respond positively to these types of messages, while other limited research claims fear appeals to be counterproductive (Muthusmy, 2009). This examined the perceptions of development workers in northern Uganda regarding what communication approaches are preferred and what communication approaches they believe are most effective in creating long-term behavior change.

The study is based on the personal interest and experience of the principal researcher who spent over two years living in Kitgum, a small township in northern Uganda, living and working with a small community based organization (CBO) whose programming was HIV/AIDS education and communication. The researcher observed many other aid organizations using fear based messaging in their campaigns throughout the region with varying degrees of success. The researchers own CBO relied heavily on the life-skills approach to behavior change and modification and feels this method greater suited for reduction in HIV/AIDS related infections in populations already living in an elevated state of fear. This research could be of benefit to those that are designing, implementing or utilizing HIV/AIDS campaigns in Uganda and other high-fear areas of Sub-Saharan Africa. Development workers who are new to the area of northern Uganda may find the past experiences of those in the field useful to their own endeavors.

The results of the study added to the literature on communication techniques in areas of elevated levels of war and conflict. The study will help non-governmental organizations in developing best practices in sustained HIV/AIDS prevention strategies for working within these at risk communities. Previous research has examined the use of fear appeal from the receivers' perspective (e.g. Green & Witte, 2003). This study examines the effectiveness of the fear appeal and SCT messages from the perspectives of development workers.

Organization

Chapter Two reviews the literature on HIV/AIDS in Africa (specifically as it applies to northern Uganda), fear appeal messaging (EPPM), Social Cognitive Theory (SCT), the ABC model used under PEPFAR funding, and finally alternative methods of HIV/AIDS education such as the life skills approaches will also be explored in relation to the theoretical framework. Based on the previous literature and theories, research questions and a hypothesis are presented.

Chapter Three explains the methodology used for this study. It describes how the participants were chosen for the qualitative questionnaire administered. It describes how the questionnaire was administered as well as how the answers were coded and interpreted.

Chapter Four presents the relevant findings brought out during the anonymous online questionnaire and notes any other themes or findings that emerged.

Chapter Five discusses the findings of this study in detail and in application to the theories used. It aims to provide a detailed analysis of the research in the context of the research questions and theories used. The researcher concedes the limitations of the study and concludes with best practices.

Chapter 2 - Review of the Literature

This study is an examination of HIV/AIDS programming in northern Uganda, focusing specifically on how development organizations design and implement their health initiatives. This chapter examines a review of existing studies on the HIV/AIDS epidemic in sub-Saharan Africa and, more specifically, Uganda. The chapter will also review extant literature on the contributors to the HIV/AIDS epidemic in the region. Issues such as war, political instability, and gender inequity, among others play a significant role in the high infection rates of HIV/AIDS. This chapter also addresses the two theories used in the study, the Extended Parallel Process Model and the Social Cognitive Theory, and lists the research questions that will be drawn from each theory. Both SCT and EPPM are complementary to the understanding of current HIV/AIDS education practices in developing regions of Africa. The PEPFAR funded ABC approach uses tenants of fear appeals in message disseminations, while the life-skills approach to cognitive change leans heavily on Bandura's SCT.

Global HIVAIDS Epidemic

The HIV/AIDS epidemic has emerged as one of the global public health concerns of the 21st century with about 95% of those affected living in the less developed nations (Muturi & An, 2010). UNAIDS estimates that out of approximately 34 million people living with HIV/AIDS, about 2.5 million are adolescents (Geary, Burke, Johnson, Liku, Castelnau, Naupane, & Niang, 2006; UNAIDS, 2011) and AIDS is among the leading causes of death claiming the lives of those aged 15-49 years in sub-Saharan Africa (UNAIDS, 2011). Adult prevalence rates in many countries in the region stand at about 5%, which is statistically lower than HIV rates for the majority of countries (Kaiser Family Foundation, 2011; UNAIDS, 2011). For examples South Africa has an HIV prevalence of 10.5% (Statistics South Africa, 2010); Botswana's is 17% and Swaziland has reached as high as 25.9%. Although infraction rates in parts of sub-Saharan Africa have decreased the region still ranks number one in the world (UNAIDS, 2011).

The high rates of HIV infection in African countries are attributed to a number of factors, such as sustained political disruption, exploitation and bad government, income and gender inequalities along with a lack of social cohesion have also played major roles in these higher HIV rates (Barnett & Whiteside, 2002; Lau, 2004). Other factors that have been documented

include women's inability to say no to sex, sexual and domestic violence (Muturi, 2005), food shortages, economic conditions, societal violence, economic conditions, an overall lack of knowledge of risk factors and historical elements are also very important in the ongoing struggle with HIV. The HIV/AIDS virus also travels unchecked with human trafficking and migrant labor (Tufte, 2005) in sub-Saharan Africa, just like in other regions impacted by the epidemic.

USAID, in the EQUATE Technical brief section of their website, lists five areas to concentrate on in stemming the tide of HIV/AIDS in conflict/post conflict regions of sub-Saharan Africa, namely gender norms that provide equal and fair treatment between boys and girls education for vulnerable children, life-skills education in curricula with a strong focus on gender issues, increased parental and community involvement, and the establishment of youth clubs.

HIV/AIDS in Uganda

HIV was first identified in south west Uganda in 1982 and was one of the first countries to start reporting outbreaks of the disease. There has been a significant reduction of HIV rates since the 1991 peak of 18%. Beginning in 1991, according to surveys administered, there is evidence of an increase in age of sexual debut, an increase in overall condom use, and a decrease in the number of sexual partners (Stoneburner & Low-Beer, 2004). Today, Uganda has of about a national infection rate of about 6.3% (UNAIDS, 2011) even though some regions like northern Uganda have a higher rate, as high as 10% in certain districts (Uganda AIDS Commission, 2012). The widespread epidemic of the disease, it appeared, was not only causing death among adults, infants, and young children, but was also impoverishing and dismantling families (Uganda AIDS Commission, 2012). Uganda saw a rapid spread of HIV (1982-1999) with infection rates reaching as high as 18% (30% in some districts) nationally (Halperin & Epstein, 2008; Gusman, 2009; Iliffe, 2006). In Uganda there are over 1.2 million people who are infected with HIV (Walusimbi & Okonsky, 2004). According to the Uganda AIDS Commission (2012), the highest rates of infection are between married couples at 42%, followed by commercial sex workers who account for 21% and casual sexual encounters for 14%. The rate of infection among women is higher than that of men from childhood to mature adulthood although women aged 30-34 years are the demographic with the highest prevalence rates. This high rate of

infection is associated with the mother-to-child transmission, which accounts for 22% of the infection rates in Uganda (Uganda AIDS Commission, 2012).

There are also differences for the demographic variables in the population, with an HIV prevalence rate of 10.1% for those in urban settings as compared to 6.7% for those in rural environments (Uganda AIDS Commission, 2012). Over 2.3 million children under the age of 15 and 10 million youth between ages 15 and 24 are infected with the HIV virus, the majority of whom are female. As ICAD (2006) put it, the youth in Uganda have never known a world without HIV/AIDS and young people for the most part do not have the critical information that could help them prevent HIV infection. Although Uganda still ranks among countries hardest hit by HIV/AIDS, it has come up with several measures and responses that have not only stemmed the rise of the epidemic, but also are actually beginning to show reduction in its spread among groups within the country (Diop, 2000). The rate of infection has largely remained high because people are unable to choose a different way of life. Circumstances are such that individual opportunity and ability to change their life's situation are hard to come by. Rarely, when it comes to sex, are people in the position to freely opt for abstinence or condom use (Diop, 2000)

Even though Uganda has shown a decrease in national HIV prevalence because of the diversity of the country of Uganda HIV prevention strategies continue to be a hot topic. The country remains at the center of the debate between proponents of risk avoidance and harm reduction strategies (Westerhaus, et al., 2007). Studies have shown programs that target prevention often work in isolation from those programs that give care for persons living with HIV/AIDS (Donahue & Williamson, 1999).

Forces behind the HIV/AIDS epidemic in Uganda are behavioral, socio-culture, and economic. Individual behaviors, such as age at first sexual experience, incorrect condom or inconsistent use, multiple sex partners, alcohol and drug abuse are responsible for elevated rates of infection. Discordant couples are another factor in creating an environment where HIV can thrive (Uganda AIDS Commission, 2012). Additionally, poverty creates a sense of powerlessness and fatalism and a feeling in people that the events in their lives are beyond control. Poverty undermines people's commitment and ability to listen to prevention messages on the topic of HIV/AIDS (USAID, 2010). Work environments also lead to higher incidences of HIV infection. Fishing communities and the uniformed services all tend to have higher rates, as do commercial sex workers and alcohol brewers (Uganda AIDS Commission, 2012).

The children are also looking outside of school for other ways to support the household (USAID, 2012). The lack of testing for HIV infection in rural communities, where 80% of the population resides, is a key factor in HIV infection (Allen & Heald, 2004). In Uganda, only 10-12% of the entire population is aware of their status. This number represents the number of people who have been tested for HIV and are aware of their results. Studies have shown that 70% of the population has expressed a desire to be tested but lack the means (Uganda AIDS Commission, 2012).

It is evident that poverty eradication, education and income generation activities are essential for effective HIV prevention (Westerhaus, et al., 2007). According to the Uganda AIDS Commission (2012), efforts to mainstream gender, sexual and reproductive health rights are critical in addressing high discordance rates, vulnerability of women, and new infections being seen within marriage.

HIV/AIDS and War in Northern Uganda

Northern Uganda is a unique case within the country as a result of the LRA insurgency that has contributed to the creation of internal displacement of persons (IDP) camps. People who have been forced to live in the IDP camps are extremely vulnerable to HIV infection because of both insecurity and severely limited economic opportunity. Women historically have been attacked and raped by both Ugandan soldiers and members of the LRA. Many of these women were also frequently driven to transactional sex in order to provide for their families (Westerhaus, et al., 2007).

In northern Uganda, rebels of the LRA, led by Joseph Kony, fighting against the government forces of President Yoweri Museveni has left thousands dead and many more maimed. According to a recent count, nearly two million people in Northern Uganda had been displaced by the insurgency (Bongyereirwe, 2010). Because of this conflict many inhabitants of northern Uganda have fled their homes to live in appalling conditions within the IDP camps (Bongyereirwe, 2010). Today, the LRA have been pushed out of northern Uganda into the jungles of the Democratic Republic of Congo, and Joseph Kony has yet to be brought to justice. The wounds in northern Uganda still remain, and the millions affected by the insurgency continue to try and pick up the pieces. The situation in the region demonstrates that settings

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permeated by war and poverty obstruct the expression of personal agency (Westerhaus, et al., 2007).

In Gulu, Kitgum, and Pader (Acholi sub-region), which are the most conflict-affected districts in northern Uganda, HIV/AIDS was the second most frequently reported cause of death in 2005 (World Health Organization [WHO], 2005). The people who have been forced to live in the IDP camps are extremely vulnerable to HIV infection because of both insecurity and severely limited economic opportunity.

In northern Uganda, physical and structural violence (political repression, economic inequality, and gender-based discrimination) increase vulnerability to HIV infection. In settings of war, traditional HIV prevention that solely promotes risk avoidance and risk reduction and assumes the existence of personal choice inadequately addresses the realities of HIV transmission (Westerhaus, et al., 2007). While voluntary counseling and testing (VCT) has been scaled up over the past decade with a declaration by the WHO, little has been documented on the access to these services in this conflict affected region (Chamla, et al., 2007).

Three unique exigencies of the war in northern Uganda make traditional HIV prevention programs ineffective: the mass abduction of children into the LRA, the existence of internally displaced people's camps, and the phenomena of night commuting. These three issues have led to an HIV prevalence rate that stands at nearly double that of the rest of the country (Westerhaus, et al 2007). Since the war broke out in 1987, there have been 1.8 million people living in the camps and over 66,000 children kidnapped to fight as soldiers or serve as sex slaves. Males abducted into the LRA are coerced through physical violence to use rape as a weapon of war, and many of the girls are forced into sexual slavery as "wives" to LRA commanders (Westerhaus, et al., 2007).

Research on children affected by armed conflict and displacement indicates their increased risk for a range of mental health problems (Barenbaum, Ruchkin, & Schwab-Stone, 2004; Betancourt, Speelman, Onyango, & Bolton, 2009; Lustig et al., 2004; Stichick, 2001), creating even more difficulties in social reintegration and proper health education needs. During this period of time in northern Uganda there were 132 different IDP camps (population ranges from 200 to approximately 55,000) in the districts of Gulu, Kitgum, and Pader. In these three districts the antenatal HIV prevalence was 11.9%, 7.2%, and 11% respectively (Chamla, Olu, Wanyana, Natseri, Mukooyo, et al.; Ugandan Ministry of Health, 2005) and the number of

people infected with HIV/AIDS overall at 8.2% (Amony & Otim, 2006; Westerhaus, et al., 2007).

During the war, tens of thousands of children would travel from their village homes every night to city centers to sleep in the relative safety of schools and churches. These children became known as the night commuters, their purpose was to avoid easy capture by the LRA. In the churches, schools and other areas along the commute these children were often sexually victimized by those charged with protecting them (Diop, 2000). The unique realities of child soldiers, night commuters, and the IDP camps that entangle the population in a web of physical and structural violence (i.e., political repression, economic inequality, and gender-based discrimination) must be accounted for to design successful HIV prevention programs (Westerhaus, et al., 2007).

Prevention Strategies

As indicated in the Ugandan National HIV & AIDS Strategic Plan 2007/8 – 2011/12; "there has been no significant decline in the trends of the epidemic in the past five years (2000/1 – 2005/6) (p.14)." The report acknowledges several achievements for that time period. The commission points to improved support for orphans and vulnerable children (OVCs), with school enrolment up because of universal primary education. There has been improved national response with increased funding mobilization (just under $40 million in 2000/1 to nearly $170 million in 2006/7), advent of policy frameworks and technical guidelines, a maintained focus on community mobilization in HIV programming and activities, and scaled up ART services (48 accredited sites in 2003 to 220 sites in 2006). The government also points to improved blood screening techniques in medical procedures as an area of acknowledgement (Uganda AIDS Commission, 2012).

The design of HIV prevention strategies in Uganda must recognize how HIV transmission occurs and the factors, beliefs and attitudes that put these people at risk for infection (Westerhaus, et al., 2007). Uganda has established three areas of service in the fight against HIV/AIDS: prevention, care and treatment, and social support. They have implemented measurable goals with objectives and strategic actions for each area of service. In the service area of prevention, Uganda's goal was to reduce the incidence rate of HIV by 40% within the program. The government has implemented five objectives to try and obtain the stated goal. The

first objective is to accelerate the prevention of sexual transmission through established and new prevention strategies. Uganda looks to continue using the ABC or D approach, while implementing life-skills health interventions for high risk populations, such as commercial sex workers, those living in IDP camps, and discordant couples, among others. The second objective is to reduce transmission from mother to child by 50%, while the third objective is to maintain 100% blood transfusion safety. The fourth and fifth objectives were to control sexually transmitted infections by 70% and promote new HIV prevention technologies (Uganda AIDS Commission, 2006).

Under the service area of care and treatment, Uganda has five objectives with the goal of improving the quality of life of people living with HIV/AIDS. These are to increase the access to ARV medication by those in need, increase access to the prevention and treatment of opportunistic infections, increase HIV counseling and testing while providing universal access, integrating prevention into all care and treatment, and expanding the provision of home based care country-wide (Uganda AIDS Commission, 2006).

The third area of service is social support with the goal of mitigating social, culture and the economic effects of HIV/AIDS. In doing so, the government of Uganda will look to provide complementary support, including nutrition, to those living with HIV. They will also look to increase the quality of psychosocial support to those infected with HIV, orphans and vulnerable children and other disadvantaged groups. The promotion of sustained education, both formal and informal, vocational and life skills for these at risk groups will also be key in the effort to enhance economic livelihoods (Uganda AIDS Commission, 2006).

At government levels, many countries have been slow in recognizing the magnitude of the problem within their borders. Only within the last 6-8 years have many governments set up national HIV/AIDS committees. While governments are increasingly seeking to coordinate and take the lead in national response mechanisms, NGOs continue to hold an important role in combating the disease, tackling the most pressing issues in countries struck by government denial, low priority, corruption, or lack of funds (Tufte, 2005).

There is also indication that fear-based health campaigns are at least one of the reasons that HIV rates have dropped in the country of Uganda. The ABC approach was instilled in national HIV campaigns. Many of the initial campaigns in Uganda used a theme of 'Beware of AIDS. AIDS kills' in their messages (Green & Witte, 2006). Ugandan President Museveni says

that he has tried to boost public awareness about the disease since taking office in 1986. "When I had a chance, I would shout at them. I used to say, 'you are going to die if you don't stop this. You are going to die' (Green & Witte, 2006 p.252)." Fear in health messaging has been a part of the national program from the very beginning.

Development agencies have "become prone to exaggerate and dramatize, and this has clearly affected some of the more academic analysis too (Allen, 2006)." The African "success" has led some to wonder if Uganda provides a watermark for wider international HIV prevention programming (Green, Nantulya, Stoneburner & Stover, 2002; Low-Beer & Stoneburner, 2003; Parkhurst, 2002; Sachs, 2003). Discussion over policy and practice has been highly political, as much concerned with European and US policy, as actual HIV prevention (Low-Beer & Stoneburner, 2003). In high conflict areas, such as northern Uganda, there tends to be four groups at elevated levels for potential HIV/AIDS infection, those being children, women, armed personnel, and humanitarian workers (Spiegel, 2004; UNHCR, 2003). For the purpose of this study the researcher will not be discussing potential harm to humanitarian workers.

Theoretical Framework

This study examined health communication in northern Uganda through the lens of Kim Witte's Extended Parallel Process Model (EPPM) and Albert bandura's Social Cognitive Theory (SCT). The two theories are applied while examining the situation in the north. The two theories will be applied in assessing the communication tools used by health workers in the field and developing the research questions used.

Fear Appeal Messaging

Studies have shown that across a variety of health domains fear appeals can be powerful, persuasive devices, but only under certain conditions (Kleinot & Rogers, 1992; Maddux & Rogers, 1983; Witte, 1992). Use of fear appeal is particularly common in communication campaigns that seek to convince audiences to adopt protective and healthy behavior patterns (Hale & Dillard, 1995; Muthusamy, Levine & Weber, 2009). This is particularly effective when people believe that they are able to adopt effective responses to avert a threat (Witte, 1992; Witte & Morrison, 2000).

The Extended Parallel Process Model (EPPM), a fear appeal theory that draws from 40 years of fear appeal research (Janis, 1967; Janis & Feshbach, 1953; Leventhal, 1970; Rogers,

1983), posits that when an individual is exposed to a potential threat there will be two things that happen to that person: "First, the 'appraisal of the threat' and second, the 'appraisal of the efficacy of the message's recommended response (Green & Witte, 2006; Witte, Meyer, & Martell, 2001, p. 28)." The model offers suggestions on how individual differences influence reactions to fear appeals but offers no propositions on the issue (Witte, 1992; Witte, & Morrison, 2000).

The EPPM then suggests that when people perceive a serious threat, and it induces them to become scared, they will be motivated to take action to reduce their fear. If people do not perceive a threat to be significant (i.e., low perceived threat), then they will not in turn respond to the fear appeal (Witte & Morrison, 2000).

There are then two types of responses that can occur, one being a rejection (fear control) of the appeal message. This is when people believe that they are at-risk for a serious or significant threat, but they believe that they are unable to perform the recommended response or they believe that the recommended response will be ineffective. People will control their fear instead of addressing the perceived threat. They then are avoiding the threat, denying they are at risk, or act angrily to those attempting to help them (Witte, 1994).

The second option is what is known as the danger control. This is where a person believes, or recognizes that they are at risk for a significant threat, but feel that they are capable of avoiding said threat. When people are able to control the danger, then they will have the ability to change their attitudes, intentions and behaviors. By doing so, the individual is able to adopt behavioral recommendations of the health message (Witte, 1994).

If people do not believe they are able to make a recommended response, or they believe that the recommended response will not deter the threat, then fear appeals can fail. This can lead to adverse behavior, causing individuals to engage in even greater levels of risky behaviors (Maddux & Rogers, 1983; Witte, 1994; Witte & Morrison, 2000).

Some research suggests that fear appeal messaging may be counterproductive in development programs working in areas of high existing fear. It is said that if a fear appeal fails to produce a heighted level of perceived threat then it will fail. If a fear, in turn promotes high threat and low efficacy perceptions, people will then become overly frightened and reject message recommendations (Witte & Morrison, 2000).

There are conflicting views upon fear appeal messaging in a high-fear developing country context. In developing countries within sub-Saharan Africa, some researchers say that fear campaigns work well in an American context for HIV/AIDS, but miss the mark when implemented in developing countries (e.g., Muthusamy, et al., 2009). Other research has shown that fear campaigns in development do have their place if used correctly in overcoming inherent fear by the population (Green & Witte, 2006).

Witte and colleagues believe that there needs to be other components in campaigns in high-fear areas of Africa, as there is no question that AIDS is spreading at staggering rates throughout Kenya and the rest of sub-Saharan Africa (Witte, Cameron, Knight-Lapinski, & Nzyuko, 2010; WHO, 1995, 1996). Witte and colleagues (2010) makes the point that campaign developers should increase perceptions of self-efficacy and response efficacy in campaign materials, but should also incorporate other aspects of health promotion into their programming. They also emphasize the importance of designing health programs that focus on creating leave behinds, such as pamphlets, condoms, and images of role modeling in a successful campaign. Designing development programming with the notion of fear appeals alone may be setting a non-government organization (NGO) up for failure, but as suggested, if coupled with social cognition theories, success and goals may be achieved at a higher rate.

Muthusamy, who is not a believer in using fear appeals in development, sees little value in "scaring the already scared." He believes that maladaptive responses will occur in most cases because it is so hard for efficacy to exceed threat (Muthusamy, et al., 2009). When creating HIV/AIDS campaigns in sub-Saharan Africa, donors may want to rethink how they are targeting their audiences. Some say that the potential for negative consequences and maladaptive behavior outweigh the potential for a successful fear based initiative. When talking about HIV/AIDS interventions in developing countries, it is possible that when health programming fails, we are faced with greater and unnecessary loss of life (Muthusamy, et al., 2009).

Social Cognitive Theory

Albert Bandura developed his Social Cognitive Theory (SCT) in 1997. His theory also looks at efficacy, but from a differing standpoint than Witte and others that fall in line with EPPM. SCT examines behavior change through a series of building blocks and behavior change activities that improve and cultivate higher levels of self-efficacy. In SCT, an individual has a

certain level of belief in their ability to overcome a perceived threat or obstacle. Bandura believes with the correct cognition change that individuals will obtain the "tools" necessary to overcome the threat and achieve higher levels of efficacy for future use (Bandura, 1998).

In this theory it is recognized that setbacks are to be expected. There can and possibly will be setbacks in the cognition change process. Bandura believes successes build towards future successes, while failures can undermine the progress that has been made. That being said, SCT is a long-term behavior change model that builds upon itself as it is implemented by a successful health campaign (Bandura, 1997).

SCT has been applied widely in understanding health and disease prevention in communication campaigns. It is an approach that has its focus on the demand side of prevention. The goal is to keep recipients of the message healthy throughout their lives by giving them the tools necessary to build on knowledge and make safe choices in maintaining healthy lifestyles (Bandura, 2004).

In the 1970s a paradigm shift happened when a focus on behavior became a focus on cognitions during the adoption, initiation, and maintenance of health behaviors. In 1977 Bandura published Social Learning Theory and his article on self-efficacy, but would not fully develop his Social Cognitive Theory (SCT) of human functioning until 1986 (Luszcynska, & Schwarzer, 2005). These social cognitive approaches focus on the demand side of cognitive side rather than the supply side. They promote effective self-management of health habits that keep people healthy through their life span (Bandura, 2004). SCT deals with key constructs, such as perceived self-efficacy, outcome expectations, goals and socio-structural impediments and facilitators (Bandura, 1992, 2000; Luszcynska, & Schwarzer, 2005).

SCT is the foundation of many health interventions. One type of programming is the entertainment-education. This is defined as a systematic strategy of designing and implementing a socially beneficial message that has both an entertaining and education component in order to increase knowledge of an issue, create favorable attitudes, or change behavior over time (Brown & Singhal, 1999; Singhal & Rogers, 1999).

Self-efficacy

Self-efficacy lies in three aspects: (a) it implies an internal attribution (a person is the cause of the action, (b) it is prospective, referring to future behaviors, and (c) it is an operative

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construct, which means that this condition is proximal to the critical behavior (Bandura, 1997; Luszcynska, & Schwarzer, 2005).

It is important for people to have knowledge of health risks and benefits. This knowledge creates the precondition for change. If people lack the knowledge of how their lifestyle habits adversely affect their health then they will have little reason to change their behavior, especially if their lifestyle habits are ones which they enjoy (Bandura, 2004). In most people, additional self-influences are needed to overcome the impediments to adopting new lifestyle habits and maintaining them. Therefore, beliefs of personal efficacy play a central role in personal change (Bandura, 2004).

According to Bandura the most effective way of creating a strong sense of efficacy is through mastery experiences. Successes build personal efficacy, while failures undermine it. A second way of strengthening efficacy is seeing people similar to oneself having successes and modeling behavior after them. The third method of solidifying self-efficacy is through social persuasion, that is, strengthening people's beliefs that they have what it takes to succeed through persuasion methods (e.g. life-skills programming) within a community (Bandura, 1992, 1999). A key component of Bandura's SCT in relation to humanitarian work is that if people believe they can deal effectively with potential stressors they are not perturbed by them. But if they believe they cannot control aversive events they distress themselves and impair their level of functioning (Bandura, 1999). Physical outcome expectations, such as expectations of discomfort or disease symptoms, refer to the anticipation of what will be experienced after change takes place (Bandura, 2004). There are three dimensions to outcome expectations: area of consequences, positive or negative consequences, and short-term or long-term consequences (Luszcynska & Schwarzer, 2005).

In 2002 Bandura wrote: "To be an agent (development practitioner) is to influence intentionally one's functioning and life circumstances. Social cognitive theory distinguishes among three modes of agency: direct personal agency; proxy agency that relies on others to act on one's behest to secure desired outcomes; and collective agency exercised through group action (p. 270)." When working in the arena, wide culture diversity requires that the messages of risk reduction campaigns for HIV/AIDS be tailored to socioeconomic, racial and ethnic differences in value orientations and disseminated through multiple sources to ensure adequate exposure (Mantell, Schinke & Akabas, 1988). It is also theorized that there is a "major difference

between possessing self-regulative skills and being able to use them effectively and consistently under difficult circumstances (Bandura, 1986)."

The life-skills approach to HIV/AIDS prevention

SCT informs the life-skills approach to HIV/AIDS prevention that the United States Peace Corps applies widely in regions that are impacted most by the epidemic. The United States Peace Corps (USPC) is a government aid organization formed in 1961 by then-president John F. Kennedy. Since that time there have been over 210,000 volunteers working in 130 host countries (USPC, 2012) around the world. Of all the volunteers 43% are sent to work on HIV/AIDS related projects in sub-Saharan Africa. This life-skills approach is defined as a comprehensive behavior change approach that concentrates on the development of the skills needed for life (p.9). These skills include communication, decision-making, thinking, managing emotions, and the empowerment of women.

USPC Life Skills program is designed to be a long-term behavior change initiative. It seeks to develop the skills needed to lead a successful and productive life. Those skills include enhanced communication, decision-making, thinking, managing emotions, resisting peer pressure, and self-esteem building, among others. It also looks to empower young girls while guiding boys towards new values. The life-skills approach is a completely interactive (culture-centered) approach to addressing everyday relevant issues of the targeted youth (USPC, 2011). Entertainment-education is also incorporated as a component of the life-skills initiative (USPC, 2012).

The life skills manual that is given to the volunteers of the United States Peace Corps worldwide is a comprehensive manual for incorporating cohesive programs while working in the field (Peace Corps, 2012). The manual was compiled and adapted from materials created by WHO, United Nations Educational, Scientific and Culture Organization (UNESCO), ACTIONAID, UNICEF and others (Peace Corps, 2001).

A Culture-Centered Approach to Cognitive Change

A newer approach may be more effective in positive communication, especially when working with villages and groups in developing countries. This is the culture-centered approach to health communications. In the culture-centered approach the receiving individual or group has a say in the needs of themselves. The health communicator therefore works collaboratively with

the group in determining the needs, wants, and programs that are going to be most effective in changing the population in a positive manner (Dutta & Basu, 2008).

Although it is all members of the community that development workers are trying to reach, the key demographic is young people when implementing life-skills approaches in development. According to UNAIDS (2011) there were 330,000 new infections among youths in that same year. It is documented that youth ages 15-24 are more likely than adults to engage in risky behavior. Research has shown that adolescents globally are more likely than adults to drive recklessly, to drive while intoxicated, to use illicit substances, and to have unprotected sex (Arnett, 1992; Gardner, & Steinberg, 2005).

When dealing with HIV/AIDS issues and youth, the practitioner needs to take into account the unique social constructs in which they are working. When a population feels at risk, it may possibly lead to a state of denial and situations of elevated stress in which young people develop an attitude that they do not care (Tufte, 2005). Some of them deny that they are at risk, and most often they blame the spread of the virus on somebody else, be it the opposite sex, be it marginal groups as prostitutes, be it those in another neighborhood or be it simply 'others.' HIV/AIDS is, in that respect, is dividing societies far more than it is promoting unity or the degree of collectivism required for confronting the problem.

For nearly 20 years, life-skills education has been advocated as a key component of HIV/AIDS education for children and young people (Yankah, & Aggleton, 2008). In 2001 member states represented in the United Nations General Assembly Special Session on HIV and AIDS committed themselves to ensuring that: at least 90% and by 2010 at least 95% of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection (United Nations, 2001). Incorporating a life-skills method into programming can confront these feelings as well as others. HIV/AIDS is a problem of poverty and gender inequity. It is a pandemic, which travels with human trafficking or with migrant labor. It strikes hardest those that cannot afford treatment (Tufte, 2005). A key problem in development that development workers have treated only the symptoms in the fight against HIV/AIDS with a lack of attention towards the root causes (Panos, 2001; Tufte, 2005; UNAIDS, 1999).

Culture-Centered Approach to HIV/AIDS Prevention

Past development programs have understood HIV/AIDS as a culture problem. In this context, the focus has long been to view culture as a barrier to safe sexual behavior. Health practitioners were implementing a top-down transmission-based model of communication in which the practitioner is the all-knowing expert and the recipient a passive receptor of the message (Airhihenbuwa & Obregon, 2000; Dutta & Basu, 2008; Tufte, 2005).

This approach can be risky because the "expert" is not taking into account what may be of great importance to the message receiver. For a given message to work it is imperative that the receiver has a say in the intervention. When working in development it is important that the health practitioner understand the needs and wants of the community. The person implementing the programming can in no way assume that he or she knows what is best for an outside group and it can be counterproductive to think otherwise (Airhihenbuwa & Obregon, 2000).

There are five basic components to the culture-centered style of health communications. The first being an exchange of information, essentially a two way street in which both parties gain knowledge. The second is a messag*e*, which is either written or verbal. The third is the actual act of communication, in which a health message is projected to the individual or community. The fourth is rappor*t,* the process of gaining trust and understanding of the individual or the community. The fifth and final component to the culture-centered approach is acces*s,* this being the connecting of the recipients of the message to the connecting donors or relief organizations willing to help in the initiative (Airhihenbuwa & Obregon, 2000; Dutta & Basu, 2008).

A health practitioner must fully understand the needs and wants of a community when designing a program for a community. Every country is different, and every village within that country is unique as well. When working in a community, culture is the first and most important component of developing, implementing, and evaluating a health plan or campaign (Airhihenbuwa & Obregon, 2000).

In traditional top-down communication campaigns unique culture barriers, such as initiation rituals, sugar-daddy practices, prostitution, child abuse, negotiation of sexual practices, and gender inequality, among others have all been overlooked in disseminating HIV/AIDS messages. These traditional issues had been seen as problematic in preventing HIV and promoting safer sex (Tufte, 2005).

It has been shown that when people feel that a message is relevant to them and their situation they will be able to demonstrate more message relevant thoughts and behavior. To process a health message personal involvement is key (Geary, et. al, 2006). One of the main problems in overcoming HIV/AIDS in developing countries is the issue of stigma. The stigma associated with the virus in traditional setting is hard to overcome unless engaging the receiver of messages with a culture-centered approach (Airhihenbuwa & Obregon, 2000; Tufte, 2005).

The Life-Skills Approach to HIV/AIDS Prevention

The life-skills manual that is given to the volunteers of the United States Peace Corps worldwide is a comprehensive manual for incorporating cohesive programs while working in the field. The manual was compiled and adapted from materials created by the World Health Organization; United Nations Educational, Scientific and Culture Organization (UNESCO); ACTIONAID, UNICEF and others (Peace Corps, 2001). As described in the U.S. Peace Corps Life Skills program you can see the tenants and components of SCT throughout. Peace Corps Life Skills program is designed to be a long-term behavior change initiative. It looks to develop the skills needed to lead a successful and productive life. Those skills include enhanced communication, decision-making, thinking, managing emotions, resisting peer pressure, and self-esteem building, among others. It also looks to empower girls while guiding boys towards new values. The Life-skills approach is a completely interactive culture-centered approach to addressing everyday relevant issues of the targeted youth (U.S. Peace Corps Manual, 2011).

Gender Equity and Equality

Gender inequity and inequality are key factors in HIV infection. As ICAD (2006) indicates, issues such as gender inequality, traditional practices, coercive sex, lack of economic independence and information, and limited educational opportunities have put girls at a higher risk of HIV infection than young boys and men. Men historically control decision-making and have a higher status than women, which helps facilitate the spread of HIV. In many cultures sexual fidelity is required for women but only given lip service for men. Condom use has different implications for women and men because of this norm and yet messages about HIV prevention may be processed differently for men and women because of these gender norms (Esu, 2000).

Gender advocates and researchers have attributed the lack of education, especially among women, to the risk of HIV infection. Although women historically have not had the same access to education in Uganda, Walque (2006) found a correlation between education levels and the use of condoms and visits to voluntary counseling and testing centers. However, issues such as poverty, being orphaned, and stigma of having an infected parent or relative has led to fewer children being enrolled in school. Many children, especially girls, also drop out of the educational system to take care of family members who are sick.

Personal relevance has been shown to affect message processing through the self-referencing effect (Higgins, & Bargh, 1987; Symons, & Johnson, 1997). That is, personal relevance elicits self-schemas that increase the speed of processing and the ability to remember what we saw, heard, or read (Geary, et. al, 2006; Markus, 1977). The use of SCT components, such as life-skills, may have the desired effect of gender empowerment, thus creating a healthy environment of knowledge, power, and change.

This process of working within the community is often times referred to as the bridge model of behavior change, where the communicator builds a solid foundation of information in terms of health. In summary, it is a comprehensive program that looks at the root of the HIV/AIDS epidemic in developing countries. While it may not have all of the answers, it works within the context of the community. It looks to identify what is important to those affected and create programming relevant to their needs. In doing so, they are able to insert health messages while maintaining low levels of fear in communities that are already vulnerable.

Based on the theories, health programs and issues discussed the following research questions were created to capture the relationship to the environment of northern Uganda.

RQ1: What level of fear appeal do development workers in northern Uganda feel is appropriate in their HIV/AIDS programming?

RQ2: What level of self-efficacy components are development workers incorporating into their programming?

RQ3: To what extent are development workers collaborating with target audiences in their message design and implementation?

RQ4: To what level do development workers in northern Uganda believe that behavior change is occurring as a result of their campaign utility?

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RQ5: What are the perceptions of top-down versus culture-centered campaign designs among development workers in northern Uganda?

RQ6: What are best practices for HIV/AIDS education in northern Uganda?

Chapter 3 - Methodology

The purpose of this study was to examine the perspectives of international development practitioners on the current HIV/AIDS prevention interventions in northern Uganda where war and conflict make the population more vulnerable to HIV infection. The study had six research questions based on the Extended Parallel Process Model, the Social Cognitive Theory (SCT) and current literature on health and HIV/AIDS communication. This chapter focuses on the data collection methods that were used in the study. The chapter starts by explaining the qualitative approach that was used in the study, followed by a detailed explanation of the sample selection, instrument design, the procedure for data collection, and the technique for analyzing data collected.

Qualitative Approach

The qualitative researcher explores what is going on in a given situation with a focus on what is being accomplished and by whom while taking into account how it is being done. The research needs to identify why the information gathered is important, both to themselves but also to other communication scholars, professionals, and the general public. Most importantly, the qualitative researcher needs to identify the groups that will benefit from the proposed intervention (Lindloff & Taylor, 2002). Those groups could include current and future development practitioners, aid, and funding organizations.

In the past two decades qualitative research has gone through an explosion of new methods, new critiques, new insights, new theoretical developments, new proposals, and new highly experimental work (Denzin, Lincoln, & Giardina, 2006). Researchers have embraced sophisticated theoretical stances on critical and qualitative race and ethnic perspectives, border voices, queer, feminist, indigenous and other non-Western lenses and epistemologies (Denzin, et al., 2006; Lincoln, 2000). This study examines current programming from the perspectives of the development practitioners and how they perceive their own programming. The study offers a route to evaluating the effectiveness of HIV/AIDS interventions and a route to recommending best practices in the field, specifically in regions that face the challenges of war and conflict.

Qualitative researchers seek to preserve and analyze the situated form, content, and experience of social action, rather than subject it to mathematical or other formal transformations

(Chesebro, & Borisoff, 2007; Lindloff, & Taylor, 2002). Many communication scholars consider qualitative research to be the broadest and most inclusive term for social action (Chesebro, & Borisoff, 2007; Lindloff, & Taylor, 2002; Lincoln, & Denzin, 2003). However, this approach does not always immerse the researcher in the scene for a prolonged period, adopt a holistic view of social practices, or broadly consider a population's culture and historical context (Chesebro, & Borisoff, 2007; Lindloff, & Taylor, 2002).

The qualitative approach has been frequently used in the social science fields, and qualitative research methods can be "an umbrella term covering an array of interpretive techniques which seek to describe, decode, translate, and otherwise come to terms with the meaning, not the frequency, of certain more or less naturally occurring phenomena in the social world" (Frey, Anderson, & Friedman, 2009; Lindloff, & Taylor, 2002; Van Maanen, 1983). Studies employing qualitative methods, such as participant observation, in-depth interviewing, textual analysis (e.g., conversation analysis), historical methods, and visual methods appear regularly in communication journals (Frey, et al., 2009). The current study used unstructured open-ended questions that were administered online among respondents who have been involved in health communication activities in northern Uganda.

Data Collection

A questionnaire with open-ended questions was administered as the data collection method for this study. Since the subjects were spread across the U.S. and northern Uganda, this online data collection method was deemed the most efficient and cost effective. The goal of the survey method is to improve the understanding of social and culture phenomena and processes rather than to produce objective facts about reality (Fidel, 1993; Meho, 2006; Pettigrew, Fidel, & Bruce, 2001, Wang, 1999).

Challenges for the survey method include cost, time, and limited access to research participants (Denzin, & Lincoln, 2005). With these challenges, researchers have started exploring the Internet for carrying out qualitative research (Meho, 2006). Research comparing Internet data collection methods with traditional paper and pencil methods had found that the Internet findings were not adversely affected by non-serious or repeat responders (Hunt, & Mchale, 2007).

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An anonymous online survey has a number of similarities to the face-to-face interview. It involves a single interviewer and a single participant, but the interviewer can be reaching out to more than one person at a time (Hunt, & Mchale, 2007). According to Evans and Mathur (2005) there are many benefits to using a survey through online methods. It is fast; once you have your survey completed, checked and edited you can send it to a very large sample almost instantly. The online survey allows respondents ample time to reflect on their answers. If you were to give a survey in person a respondent may feel the need to rush their responses, giving you half thought out answers that may not be as beneficial (Evans & Mathur, 2005).

Research administered online is inexpensive and cost effective. In relation to printing questionnaires for in-person research, the savings are evident. A researcher can also reach a very large and specific sample while using email, giving them much faster turn-around then when trying to reach a specific demographic in person. Also, respondents may feel more at ease with an online survey, and in turn give more thoughtful answers (Evans & Mathur, 2005; Lindloff & Taylor, 2010). The online questionnaire worked well with this survey, as the sample is health and development practitioners that are currently living worldwide.

Sample

The sample used in this study was drawn from development and health practitioners that are, or have in the recent past, been stationed and working in northern Uganda. The sample was drawn from a pool of 60 health care practitioners that are non-Ugandan, from all parts of the U.S. and Europe. These participants were asked to take part in the open-ended response questionnaire. The participants all have served at least two years in northern Uganda. The principal researcher was interested in respondents from USAID, International Rescue Committee (IRC), The International Red Cross, and Oxfam because of their presence in northern Uganda. These organizations represent the major players in health communication programming in the country and were targeted while recruiting volunteers for the survey. These organizations have major influence among local NGOs and health agencies, so their involvement and guidance set the tone for development programing nationwide.

Sixty participants were recruited for the interviews through social media networks. An email message was sent out to the development networks, including Facebook and LinkedIn, explaining the purpose of the study and recruiting them to voluntarily participate. Those willing to participate were asked to send a private message to the researcher giving the researcher their

personal email address. From there, participants were sent a link to the online survey questionnaire.

A snowball method was used to contact others who might not be on the networks. The snowball method is defined as a method of locating and recruiting participants in a qualitative study with controlling bias and obtaining a representative sample. The researcher contacts potential participants asking them to participate, and to recruit participants who they know that may also be willing to participate. The method repeats itself until a sample is reached and it allows the researcher to find representative individuals who have the characteristics that are vital for the research (Arcury & Quandt, 1999). In the current study, those who agreed to participate were asked to assist in recruiting others in their networks that had done HIV/AIDS related work in northern Uganda. A request was sent asking them to participate in the research and a link to the survey sent following their response in the affirmative. Anonymity is of upmost importance and was stressed during each stage of the recruiting process.

 In-depth online interviews were conducted among development practitioners and volunteers who are affiliated with agencies, such as the United States Peace Corps, USAID, International Rescue Committee (IRC), The International Red Cross, and Oxfam, among others. The specific characteristics were that participants were at least 18 years of age and had spent at least two years working in northern Uganda in a HIV/AIDS development capacity.

Data Collection Procedure

After ethics approval by the Institutional Review Board (IRB) committee for research involving human subjects at Kansas State University was gained, data collection began. After this approval was granted, a letter of invitation was sent to each of the qualified participants. The respondents were informed about the purpose of the study in which they were invited to participate. The invitation was sent via online questionnaire to the email addresses of all participants. For the participant's convenience, the first question of the survey was an opt-in as consent, requesting permission to use participant's responses. Upon this agreement, an interview guide containing ten closed-ended and seventeen open ended questions was sent to the participants, with a link to the questionnaire. Each of the participants were given approximately two weeks to finish the interview questions, and when they were finished their responses were collected by the online program for later, anonymous review by the researcher. Reminder emails were sent to the participants every third day for the duration of the two-week period to maximize

participation. After receiving the interview guide from the participants, a thank you letter was sent to all involved.

Data Analysis

In qualitative research, the activities in data analysis should include making comparisons, developing categories, and engaging in theoretical sampling while integrating an analysis. The comparative technique allows researchers to draw the major ideas out of the subject's answers. The researcher is then able to seek specific data while evaluating and measuring the emerging conceptual categories (Denzin & Lincoln, 2005). As Kreps (2008) points out, great care should be taken to make sure that health care research generates valid, reliable and relevant data that would inform administrators, providers, consumers as well as development practitioners (Kreps, 2008). It is important that research methods effectively address the research questions in a manner that provide the researcher with in depth analysis that allows meaningful conclusions to be drawn that will guide future interventions (Glasgow et al., 2002; Kreps, 2008).

The technique of constant comparison was used. This technique was constantly comparing and contrasting themes and concepts that emerge from the email questionnaire (Dutta & Basu, 2007). Constant comparison allowed the researcher to identify discrete concepts and then easily label and sort them. Themes were built from tangible examples pulled from the text. These discrete concepts were then placed into similar categories for further review (Dutta & Basu, 2007). This constant comparison produced relationships out of the information under each category. Selective coding method was used to review the transcripts, which helped theoretical integration (Dutta & Basu, 2007; Strauss & Corbin, 1990). Direct quotes were also used in the examination as supporting content. The purpose was to minimize subjective bias during analysis and interpretation.

Chapter 4 - Findings

The purpose of this study was to examine what respondents deemed as best approaches to HIV/AIDS communication. The study specifically examined best practices, failures and gaps in programming in an area transitioning out of war and conflict. The study examined the respondents' perspectives on the unique environment that exists in northern Uganda and what types of HIV/AIDS messages are most effective and beneficial. Specifically, the study examined the practitioners' views on the level of fear that is appropriate in HIV/AIDS communication in the context or war and conflict in northern Uganda. This chapter presents the key findings based on the information gathered from the respondents through an online questionnaire. The findings were categorized based on the research questions and emerging themes identified in each category. Each theme is supported by statements and direct quotes made by the respondents as they relate to the survey questions.

Participating Organizations

Numerous international development agencies have implemented HIV/AIDS prevention in northern Uganda. For the purpose of this study, only those agencies based in the United States were targeted for recruitment. These organizations are American Refugee, Aid Africa, GOAL Uganda, International Lifeline Fund, International Rescue Committee, Mango Tree, The United States Peace Corps and War Child Holland. The roles of the respondents that participated in the study included but are not limited to: teaching at an all-girls school, leading an HIV-positive women's group, leading a village soap business, designing and co-directing a youth camp, peace groups, beekeeping initiatives for returned soldiers, and the building fuel-efficient stoves. Counselors of commercial sex workers, school-aged children and parents and grandparents are also represented. Others indicate that they have helped provide services such as groups for victims of gender based violence (GBV), child protection, education and psychosocial support.

The respondents for this research are broad and varied in their work, but all share the unique experience of working in northern Uganda and the underlying presence of war and reconciliation. All respondents, and the organizations that they work for, supply positive health messages in the programs they are involved in. Many of them indicated that HIV/AIDS education was part of their work in post-war northern Uganda. Some were mentors, football

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coaches and grant writers, while others played leadership roles. Many workers wore many hats, all while incorporating a positive health message. One respondent explained his/her role as follows:

> I worked with an organization that provided a wide range of services that were aimed at easing the transition from IDP camps to traditional homes. This included distributing energy efficient cooking stoves, raising a nursery of trees, providing services aimed at improving water treatment and availability, as well as other (health) services.

Another respondent summed up their role as running a community outreach for HIV/AIDS testing, running the local health center with local health organizations, and distributing basic care packages for HIV-positive individuals. Working with village saving and loans for HIV-positive groups, initiating youth groups for returned child soldiers among other programs. This respondent helped empower youth in leadership skills, education and empowerment in the realm of HIV/AIDS health, and conflict resolution. In doing this, the respondent tried to curb the prevalence of drugs and alcohol, domestic violence and PTSD symptoms culminating from the years of war and conflict within the region.

Use of Fear in HIV/AIDS Programming

The first research question examined participants' perception of how development workers in northern Uganda felt about using fear as a motivator for positive change in sexual health. Respondents were asked a series of questions about the overall environment that the LRA conflict had created. Emerging themes from the research question included the effects of the fearful environment the north has created in its community members and the contribution the war and conflict has had in the risk of contracting HIV/AIDS. Respondents discussed the levels of fear they observed that was inherent in the region. Respondents were also able to discuss what they saw as contributors to the current situation in which they lived and worked.

Fear as a motivator for behavior change

Workers interviewed had varying opinions on using fear as a motivator in health education and behavior change. Most expressed that fear programming tended not to be as effective as other forms of communication techniques in northern Uganda. Some of their comments that demonstrate their perception on use of fear appeal included:

"I personally do not necessarily agree with using a fear campaign, but feel instead that other forms of motivation can be more productive."

"Fear campaigns have never motivated people to change themselves or their personal decisions. Fear doesn't prevent people from taking drugs or drinking, but rather it's personal exposure to their consequences that generate behavior change."

"While I feel that a more 'positive' approach to behavior change is best, I do think that it is necessary to ensure people get the message of what HIV is and the negative consequences."

It appears that respondents feel better approaches for behavior change exist in development. Some felt that fear was a good motivator but fell flat in long-term behavior change. Fear programming may elicit a response of wanting to change behavior, but without additional education or motivation, the original fear-based message may indeed fail. According to another respondent getting people to adopt healthy HIV habits some fear may be needed:

I do not think that focusing on the fears associated with HIV is as empowering to people to adopt practices to protect themselves, however, without fearing HIV (or any disease for that matter) to some degree, people will not have the motivation to change their behaviors to avoid it.

Fear messages may be too arbitrary for the environment and culture of northern Uganda. Because of war and conflict, scaring people into behavior change may be counter-productive and difficult to make sense of for the community. One respondent said,

"I think that the use of fear to change sexual behavior is effective in the short term but lead to confusion and mixed-messages."

The researcher examined whether or not development workers in northern Uganda felt that fear-based health campaigns met the needs of the people of the region. The researcher attempted to capture whether respondents felt that fear campaigns could be a motivator for positive behavior change within the target audience. One response suggested that interventions may accomplish very short-term modification of behavior but because of issues such as poverty, war, conflict, and insecurity the people of the north are making decisions based on their needs of today, not the future. For example:

"So, people generally have poorer health seeking behavior when it comes to things like HIV. This (HIV) is dangerous but it is something that has more of an effect on you five to ten years from now."

Respondents thought that there is a place for fear-based messages in this environment, but that it needs to be in conjunction with other interventions. One respondent stated, "I tried not to use fear campaigns alone. Instead, I tried to target groups with information pertaining to aspects of health that they had control over."

Some respondents felt that a more 'positive' approach would work best for the situation in northern Uganda while others felt that using fear-based messaging could have potentially adverse consequences. It seems that in the north the stigma of HIV, according to survey respondents, is so strong that community members have a hard time talking about the issue at hand with both their sexual partners and community leaders/development workers.

Fear campaigns have never motivated people to change themselves or their personal decisions. Fear doesn't prevent people from taking drugs or drinking, but rather it's personal exposure to their consequences that generate behavior change.

Workers also discussed the fact that fear campaigns may backfire because the people running the programming in northern Uganda may be delivering inconsistent messages about HIV/AIDS and other health issues. Misinformation may lead to a rejection of a fear message that may have otherwise been successful. ARVs delay and mask the physical symptoms of HIV/AIDS and so people don't necessarily see the reality of the associated fear campaign.

I don't have a problem with fear campaigns as long as they are run correctly and the right information is going out. The problem with this particular campaign is that administrators of the information are inconsistent and often too embarrassed to talk about the content or they themselves are not fully educated about it.

Effects of the fearful environment

Northern Ugandans have been dealing with an environment that is counterproductive to individual growth and maturation. The years of war, conflict, and food insecurity, along with

elevated rates of HIV infection, have led to an unstable region with people having the inability to overcome potential threats.

> "Years of living in IDP camps, along with the conflict and war that was occurring throughout the region had adverse effects on the psyche of the people of the North."
> "Years in the camps robbed Northern Uganda of its role models that would otherwise have inspired the youth to value their lives and futures and too make smart decisions about having sex."

Northern Uganda is also unique in the fact that it is currently transitioning out of IDP camps and back into their traditional villages and ways of life.

> Related to what I saw in Northern Uganda, it was a transitional time. When I first got there, there was still significant numbers of people living in IDP camps, which automatically it is like an artificial way of living and so it absolutely effects people's decision making in the short term.

Levels of inherent fear

War has created an environment that is unlike the rest of Uganda, and much of the rest of Africa. Children are forced into harsh realities at a young age, as this respondent pointed out:

> The exchange of sex for other goods such as money and gifts has occurred so much during the war that the youth who were born and grew up during the war have trouble seeing that it is not a safe exchange. Northern Ugandans are resilient and are used to accept hardships as a regular occurrence so living with HIV/AIDs is an unfortunate situation, but not the end of the world.

It was also noted that there is an inherent fear to report rape due to the fear of revenge by perpetrators or stigma from family and the community. Respondents have noted that it seems many people in the north have a mindset of "life happens to me."

> "The war and fearful environment has had terrible effects. People have little sense of control over anything, including AIDS. I still think the overall approach for preventing HIV/AIDS would be the same with or without the war. "

> "It seemed to me that the fearful environment had convinced many people that their future was not in their own hands. They were either at the mercy or foreign aid, miracles, or if things worsened, their former tormentors.

Effects of war and conflict on HIV/AIDS rates

Northern Uganda has faced unique factors that contribute to its elevated HIV/AIDS that sets it apart from the rest of the country. The unique environment lends itself perfectly to putting people at risk for infection.

The war in Northern Uganda has not only left a number of people HIV positive from incidences of rape and defilement in the IDP camps and rebel raids, but also left an apathetic culture that lends to the spread of HIV. In the camps, families would give their daughters to the Government soldiers in exchange for extra food and older men often defiled young girls as the result of boredom and alcoholism.

Participants pointed out that the war and conflict has played a crucial role in the risk of HIV/AIDS. One of the statements made in that regard included:

"Conflict and war has upset the social fabric of Northern Uganda. Families were split apart, and children forced into behaviors that directly and indirectly increased the spread of HIV."

Respondents talked about preexisting factors that exacerbate HIV transmission in the region. Poor education systems, sexual promiscuity, a lack of access to health care were all discussed as variables that created an even bigger epidemic when war broke out.

The war has also effectively set back previous efforts by disrupting an entire generation - taking them out of school, wreaking a very serious emotional toll that will have long lasting effects.

During the war in, I believe that the biggest cause of the HIV/AIDS epidemic were the raids of villages. During these raids soldiers raped many women as they went from village to village having sex with several different women.

Some aspects include the spread of the virus through rape in the conflict areas; the breakdown of social security systems that help in creating a safe environment that protects women, girls, and boys; the culture of impunity among perpetrators due to the break down or weakening in justice and policing systems; the lack of medical and health facilities; and the weak educational systems that can spread more information about HIV and AIDS, women's rights, etc.

It is important to note that northern Uganda is now a post-conflict environment, but that being said, the problems and after effects of the conflict are still readily apparent, according to this respondent:

> I think that this post-conflict environment potentially compounds people's vulnerability to HIV infection. Weak health infrastructure and infant community health systems in the Northern region make it more difficult for communities to access health care, and to test and treat HIV infection. Higher levels of untreated infection in the community mean that the virus is more easily spread. Increased vulnerability of women during the conflict period meant increased domestic violence, increased instance of rape and other exposure to potential HIV infection. Weak health infrastructure and health seeking behavior also contributes to continued mother to child transmission, which is contributing to new infections.

Through all of the above-mentioned threats and fears that are rampant in northern Uganda there is also negative stigma surrounding HIV/AIDS. With all of the other negative factors the people of the north are facing, "people don't want to get tested because they don't want to know their status."

Use of the ABC or D Model

The ABC or D model refers to Abstinence, Be faithful to your partner, always use Condoms or suffer the consequences of Death. It is commonly used in PEPFAR-funded programming. Respondents were asked their opinions were on this type of programming specifically to the region of northern Uganda. It appears that the model is not being taught correctly or completely under PEPFAR programming, according to respondents to the questionnaire. Some respondents were not aware of all components of the program, making it less likely to be successful in northern Uganda. Some were surprised to hear that there was a D (death) component to the message structure.

> "During my first year of Peace Corps, under the Bush administration, we were only allowed to discuss A&B. During the second year, we were allowed to use PEPFAR funding to also promote C."

"I was not familiar with the "or D" portion of the model, as stated above. My organization did not specifically promote any educational model regarding health promotion."

"I am not familiar with the D portion of the model, just the ABC portion. The ABC model was incorporated into programming as both abstinence and being faithful were highlighted in behavioral change"

Development practitioners may have been taught to implement a program that was neglecting the fear component of the initiative. Whether or not this was intentional was not clear from the responses given. If the initiative was part of a PEPFAR-sponsored program and the D was omitted, then it was by mistake, but if it was being taught as part of a school curriculum the omission may be intentional. Apart from the lack of the "D" component in the programming, it seems that there was not clarity on how to effectively disseminate the program correctly:

"Condoms were never talked about. It's too taboo here still and female condoms are very hard to find."

I don't have a problem with fear campaigns as long as they are run correctly and the right information is going out. The problem with this particular campaign (ABC or D) is that administrators of the information are inconsistent and often too embarrassed to talk about the content or they themselves are not fully educated about it.

And a third said, "The ABC model is not bad and has potential, but it is not taught in full, which means it is ineffective." Respondents seem to think the teachings of ABC or D are inconsistent which can lead to confusion and missed opportunities in HIV education.

Traditional beliefs and value systems may undermine the potential for ABC or D methods of health education. HIV infection is often associated with other factors other than the individual risk-taking behavior. The use or misuse of the ABC or D method of HIV education may also be lacking in northern Uganda specifically because of the 20-year war and reconstruction that the region has seen.

When asked to rank how effective they believed the ABC or D model was in an

environment like Northern Uganda15.79% of respondents thought this type or intervention was neither ineffective nor effective, 15.79% thought it was ineffective, 5.26% thought it was very ineffective for a total of 36.84% of respondents having neutral or negative views on the model. Of the respondents, 10.53% felt the intervention was positive while the rest of the respondents gave no response to the question.

Based on their responses, practitioners appear to believe that the use of fear in HIV/AIDS in northern Uganda may be ineffective or counterproductive because of the unique nature of the region, particularly because of the possibility of misunderstanding of the role fear plays in behavior change or the lack of supporting structures needed for success if it is incorporated in the HIV/AIDS programming. Levels of inherent fear because of the war and instability in the region may also be responsible for the potential rejection of fear messaging by the people of northern Uganda.

Self-efficacy In HIV/AIDS Programming

Building self-efficacy among target groups is a strategy of HIV/AIDS prevention programming in development. Because of the uniqueness of northern Uganda, the current study examined northern Ugandans' self-efficacy level in regard to HIV/AIDS prevention and the health campaigns that are implemented to enhance it. The study sought to examine current levels of self-efficacy among Northern Ugandans. Respondents were also asked what methods they have used in trying to build Northern Ugandans' self-efficacy in the HIV/AIDS interventions they are implementing. Gender specific self-efficacy is another theme that was drawn from the questionnaire. The idea of life-skills specific programming is also discussed.

Current outlook of respondents on Northern Ugandan's self-efficacy

Respondents tend to feel that those in the north are lagging behind in terms of their self-efficacy. Because of the war there are hosts of contributing factors that have led to lower perceived levels of self-efficacy. War has had a strong effect on the Northerners' belief systems, health, and outlook, as one respondent sums up:

> The social fabric has been broken down, and the sense of community amongst village residents is weaker than previous, and that has affected the system of social norms and values that might bolster an HIV prevention strategy. I think the post-conflict

environment has also led people to have less faith in the Government and government systems, which undermines HIV prevention work. A lasting effect of the war in the north is the level of alcohol consumption in the area, which has a massive impact on HIV prevention efforts.

It was also stated that, "it seemed that the continued war gave the people very little sense of control and this lack of control extended to all aspects of life. HIV, it seemed, was just something that happened to you, not something that you had control over."

Bandura (1998) suggests that for long-term behavior change to occur a health practitioner needs to equip his or her target audience with the tools necessary to make better health decisions. In the case of northern Uganda, however, the war and conflict prevents people from accessing HIV/AIDS information leading to lower knowledge about the disease and preventive measures. As pointed out by respondents:

My stance is that more thorough education would be the most effective method. Teaching the principles of sexually transmitted diseases (and specifically why culture norms such as polygamy or interconnected sexual networks greatly increase the transmission of HIV and other STDs) would help dispel many of the erroneous beliefs could encourage greater decision making. Of course the other side of that story is improved education in general, so that students learn how to employ critical thinking, and can more easily discern the cause and effect relationship of their actions.

Because of the war, "information that would have been disseminated and dispersed earlier to the North is just now taking place, so there is still a generation of attitude change that needs to happen." The war in northern Uganda seems to have fueled this sentiment, according to some respondents:

People didn't have work or school to keep them busy. I believe that because of the stress of war and the fact that many people had a lot of time on their hands, they would participate in a lot of sexual activities.

IDP camps increased the rate of transmission of HIV/AIDS. Many now turn to alcohol, resulting in risky behavior and multiple partners. Mother to child transmission is still a

huge problem in rural Uganda.

Certain populations felt vulnerable but other populations knew that if they were careful they would be ok. Many women, however, got the virus from their partner and many infants got it through their mothers. Infants had no choice or knowledge of the matter at hand.

From the respondents' perspectives, it seems that many northern Ugandans feel that they are destined for the life they live. These factors are all integral in the feelings of despair that have arisen in the population, and "this inability to embrace ambition and hope is the apathy that further fuels the spread of HIV in northern Uganda." With the atrocities during the war and the bleak outlook towards the future that it created, northern Ugandans have been left with a sense of hopelessness that may take generations to overcome with the aid of successful interventions.

Methods used for building self-efficacy

The factors that have led to feelings of vulnerability, apathy and a sense of inability to change one's situation are difficult to overcome, but is being attempted through a host of efficacy building initiatives. Some of the programs have purposively focused skills-development as part of self-efficacy building among northern Ugandans. For example one respondent said, "I promote abstinence with the youth, but also give them the resources they need to make good decisions (self-esteem building seminars, access to free condoms, and where to get tested)." Other programs have focused on increasing knowledge and understanding about the risks of HIV/AIDS and on preventive measures. For example, one participant stated:

Our program's main contribution to building self-efficacy focused on building an understanding of what the risks are in order to avoid them. Understanding how HIV is contracted (what are the risks) is a prerequisite to changing your behavior to avoid those risks. The main message of avoiding risks was condom use, not drinking and engaging in sex, faithfulness to your partners etc. The program provided the condoms and tried to create an environment for individuals to build their confidence in using these strategies (through Stepping Stones and peer youth groups).

Peer leadership, decision-making, self-esteem building, goal-setting and youth discussion

groups were all mentioned in creating programming that could have long term effects on behavior change and health in the target groups. The main objective through these programs is creating a change in individuals and villages feeling of efficacy, slowly creating change and hope.

> I taught eight secondary schools. We discussed life-skills topics such as decision-making, choosing good friendships, being assertive (as opposed to being passive or aggressive). Rather than using a lecture style, I taught the girls how to perform skits and play games.

These skits and games would have health components and through fun, the girls were learning valuable skills.

> "Empowering children by helping them understand how individual actions affect them and the world around them. Building self-awareness through a cause and affect approach was important."

> "The education to build skills, to broaden worldview, to motivate aspirations beyond risky behaviors, and to increase the number of years before the onset of sexual activity seemed to be the most effective method."

Another important aspect of actualizing the realities of HIV/AIDS in the region was to show that the actions of today have consequences when it comes to risky behaviors. A respondent stated, "we brought in a panel of speakers who were HIV positive to talk with the youth, which seemed really effective." Helping individuals recognize the importance of ones actions today, through programming and education, give them the tools necessary to make better decisions when difficult situations arise.

Gender specific self-efficacy

Women and girls are more impacted by the HIV/AIDS epidemic in Northern Uganda due to their vulnerability caused by gender inequality and transactional sex. The war has made them more vulnerable to infection. Targeting young girls in northern Uganda with gender specific empowerment messages is also a talked about theme when it comes to the respondents discussion of efficacy among the people of the north.

With the programming with CARE, they worked hard to give disadvantaged women opportunities other than marriage or prostitution to create economic security which in most cases stops risky behavior. They also communicated the need and benefits for women in decision-making positions as well as the need to enforce laws to protect women.

A respondent said, "By teaching income generating activities to encourage independence and promoting self-esteem among my students and campers, I helped these girls realize the promise of their future and, therefore, discourage them from compromising their future by making risky behavior choices."

Reaching young girls with positive, efficacy building health messages is a very important part of the programming in northern Uganda. It is important to reach girls in their teenage years when they start becoming exposed to the underlying pressures and expectations of the environment around them.

During my first 2 years in Uganda, I was a teacher at an all girls' school in Kitgum. This school had been a safe haven during the war and most of the girls grew up in the IDP camps (although a few were abducted as well). There was a lack of ambition among the girls and encouragement for them among the community that prevented the school from achieving the status it desired. About 5 girls were forced to drop out of school each term because of pregnancy and more had to drop out either when their sponsoring NGO stopped paying for them or else their family could not afford their school fees anymore.

Incorporating the life-skills approach in northern Uganda

While examining programming in regards to self-efficacy building within target groups, the current study asked questions about using a life-skills method as a part of creating behavior change. With the definition of life-skills programming being "a behavior change model that builds on an individual's belief in their ability to create positive change in their lives. The model, through a series of successes and failures builds on an individual's perceived self-efficacy and in theory will create better health choices." Respondents were asked how effective this type of intervention was in northern Uganda.

I taught income generating activities and organized events to promote self-esteem, leadership and teamwork. This helped the targeted community later in absorbing the more serious information about HIV, reproductive health and domestic violence and applies that information to their lives.

The respondents had mixed thoughts on the effectiveness of this type of long-term model being used in northern Uganda because there are concerns as to whether it is being used effectively and appropriately. The respondents were asked their thoughts on how effective they thought life-skills programming was in enhancing individuals' ability to adopt positive health practices. They were asked to rank from very ineffective, ineffective, neither ineffective nor effective, effective, very effective or no response. Responses indicate that no one found life-skills to be very ineffective or ineffective. Of the respondents 10.53% indicated that they believed it was neither ineffective nor effective. While 31.58% found this type of programming to be effective and 5.26% indicated that it was very effective. 52.63% had no response to the question.

Responses seem to indicate that a life-skills approach may be beneficial in theory, or in other parts of the country but may not be best suited for the north because of the unique nature and inherent vulnerability of the population. One respondent had this to say:

It's an excellent approach when done well. It's dependent on many factors from quality of the package, selection and training of the facilitators, mobilization of the group etc. A process to, over time, move through a series of sessions based on active participation that have the goal of increasing knowledge, reflecting on practice, and building skills. Life-skills should increase options for those engaged.

Others said that in conjunction with the population having no particular stake in the game, often the Ugandan employees of the NGO they worked with also weren't invested in this type of program:

On a very simple level, my organization provided education about improved technologies and tree species that may be beneficial in Northern Uganda, how these things could benefit a person living in Northern Uganda, and the actual tree seedlings/seeds and stoves. I suppose that superficially, these things taken together could have been enough to

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enact behavior change, but no one within my organization seriously asked the question "Why wouldn't people change their behavior?"

Others simply stated that they themselves were only vaguely familiar with the concept of life-skills programming and how it worked in HIV/AIDS development.

"I am vaguely familiar with the idea that it takes multiple pieces to be in place (knowledge, empowerment, etc.) In order to initiate behavior change, and that in many cases, it is not simply a lack of knowledge that causes risky behaviors to be continued."

The fact that Uganda is transitioning from a war zone to an area of rebuilding and rehabilitation, the use of life-skills may not be commonplace or needed at this point of development. The needs of the population may be shifting and not fully recognized by the NGO agencies at this time.

When I first got to northern Uganda we were doing a lot of emergency programing, which tends to be larger available funding and more heavily oriented to service delivery. So there was less emphasis on getting people to actualize and change behavior. That's not so much the emphasis during the actual war. It started to shift in 2011. There wasn't so much emergency funding because the war had left Uganda. So at this point we were implementing programs, so you don't have as much money to provide actual health services.

Some respondents were not sure that northern Uganda is ready for this type of long-term intervention. The money for programming in the north may still be aimed more at helping the transition from a war zone back into normalcy.

Involvement of Target Audience

Engaging the audience in message design and program development is one of the key elements in the culture-centered approach. Research question three sought to examine how respondents in northern Uganda were engaging communities in HIV/AIDS communication. The current study examined how respondents look to collaborate with the communities in which they are trying to establish programs. In creating initiatives that are important to the community and incorporating HIV and health components the theory is that the community will be more invested

in the long term.

Community involvement in HIV/AIDS programming

It appears that many respondents feel that the community needs to be engaged, informed and have a sense of responsibility in the programming that is developed for them. One respondent stated:

[The target group] decided what income generating activity they wanted to do and how they wanted to sell their merchandise and divide up the profits. The activities I taught were tailored to the targeted community so that they would be able to continue the activity even after I left for long lasting effects. The HIV testing at the camp was voluntary.

Another respondent was a little more specific on the process. At each stage of the initiative, the groups were asked their opinions on what was being done and what they wanted to see happen:

The life-skills packages were developed with the community that they targeted at the initial development stage. Then in each cycle or intake there was the option to select preferred topics/sessions/modules- whilst some of them were core there was flexibility after the core ones based on the interests of the group.

In a process of monitoring and evaluating, respondents were on top of the changing needs of their community groups.

"We conduct needs assessments and conduct surveys and interviews to get an idea of what the community needs and wants."

Working with groups to make sure that they were engaged and getting the support that they needed appeared to be a common theme in the work respondents are doing in the communities. One respondent summed it up as follows:

The groups I worked with decided the types of programming they received. If they were not comfortable with a concept or felt that it was not going to be effective or they were

not confident in an approach to implement it the program was not used.

With a culture-centered approach there seems to be an ownership developed by the community members, with an overall feeling of a positive response to the concept of culture-centered programming.

I am a strong proponent of development programs coming from the ground up. I believe that when a community creates a program or has significant input in the program, there is an ownership in that intervention that gives it a better opportunity to be successful.

Culture barriers

The study examined the culture barriers and the respondents were asked to, in as much detail as possible, give their perceptions of the culture barriers that they faced in their programing in northern Uganda. The most telling of the culture barriers was that of the difference of the western development worker and the people of the north.

There are culture barriers that development workers face no matter what country they work in. It's an inherent part of being an outsider. One of the strongest faced by respondents is that of being a white Westerner (*Munu* in the local language) who is perceived to be rich and powerful.

"This label of being a rich Westerner can be hard to overcome while working in the villages. No matter what you do, you are noticed and scrutinized."

"A difficulty I have had was the way I was perceived. Because I am a Munu, they think I was there to give them money. If I didn't give them money, then they were disappointed."

"Culture speaking, people with money are supposed to give what they can. They call those people Ladit. So I would get many people asking and expecting money from me because they see Munus as Ladits."

"People are always watching me and sometimes it seems like they want to see me fail."

The thought that a development practitioner will fit in right or ever in the society they are working seems to be an almost impossibility. The development worker will always be viewed as

someone who does not belong, and his or her thoughts and opinions heavily scrutinized. It seems that a good method for being successful is having a local counterpart or community leader to work in tandem with while implementing programs in northern Uganda.

> Culture barriers exist for foreign workers no matter how long they live and work in a place. The key to being effective in spite of them is to be flexible about adhering to your own culture and to partner with members of the community in all initiatives.

Desperation and resignation of target groups

Another theme that was brought out is the fact that the people of northern Uganda have been through so much war and terror that they are now resigned to their existence and meager lives, HIV is viewed as just another thing that happens.

> Northern Ugandans are resilient and are used to accept hardships as a regular occurrence so living with HIV/AIDS is an unfortunate situation, but not the end of the world. These people have experienced so much hardship that it is hard for them to see a brighter future and moreover the way to obtain that future.

Another respondent noted:

> I felt that attempts by me or other staff members to encourage more community-based interventions that might actually be able to encourage positive behavior change, were written off as being too difficult. I felt that this barrier existed in two different ways. The internal staff felt that long-term change and the associated actions of the organization would be too difficult to enact and would require too much work. Furthermore, the organization and its leadership often felt that community members were incapable of sharing in the responsibility of an intervention.

With that, respondents have stated that there have been breakdowns of social structures and norms, increases in violent behaviors and negative coping strategies to their environment. One of these detrimental strategies according to some respondents has been commercial sex work by women both during and after the war in the IDP camps.

In northern Uganda, it is common for a man to have multiple wives, as is the arranged marriage of teen and pre-teen girls. Because of the war and conflict, the commercial sex trade

has also flourished in the region. Development workers tend to feel that gender relations are hard to navigate and power structures with women make communication difficult. Girls in society have a lack of control and female youth empowerment is important. One respondent stated:

> The main culture barrier I faced was my understanding of sex and intimacy. For example, I might think kissing my partners would be a nice way to show affection without engaging in sex, but in northern Uganda, kissing is an act that is inextricably linked to sex.

Perceptions of Behavior change

One of the goals of health communication is to influence behavior change and promote healthy behavior and lifestyles. The study sought respondents' views on whether behavior change was occurring based on the programs they have implemented. They were asked to reflect on the interventions that they were a part of and discuss how effective those interventions were in creating behavior change among the target audiences.

Amount of change occurring

The respondents, for the most part, seemed to think that true behavior change among their target groups was not occurring the way that they would really like to see. Because of the war and rehabilitation in the north it seems that respondents were not clear on the actual effect that their interventions were really having.

> [The programming is] marginally effective overall, but in reality, it is really very difficult to know. Among groups that were part of the program on a sustained and prolonged basis, there were noticeable changes but behavior change depends on many other factors, not just the program itself.

> Several intoned that small changes needed to take place before real change in the region could take place, "There needs to be broader behavior change adapted before the small efforts will evoke real change." It is possible that because of the previous mentioned shift from wartime aid to post-war interventions, that programs creating positive change were not really established and readily available as this respondent points out:

> I personally feel that the interventions my organization and I were a part of our projects

were based on distribution of materials, with only minor attention paid to behavior change as an afterthought. The priorities (and to a real degree, the only measurable goals) of my organization were numbers of stoves or trees given away, wells drilled or repaired, and people taken to the hospital.

Also, there appears that some respondents felt that even within the region of northern Uganda there were certain areas and villages that had been more affected by the war and the related issues and complications. Respondents felt that interventions needed to be created that fit each individual group needs. The statement evidences this:

I felt that pockets of the population felt more vulnerable than others to HIV infection (women more so). This mixed level of vulnerability makes the intervention more difficult to apply in a uniform way. The intervention needs to be able to be adapted to fit the groups' perceived level of vulnerability or messages are not received as intended.

Building motivation and confidence

Some respondents believe that motivation and confidence within a community came from creating skills and teaching accurate concise information. These could come from income generating activities or camps created for the empowerment of young women.

"The best that one can do to encourage behavior change is to impart new skills and spread accurate information."

"My interventions focused on generating confidence and hope and diminishing their fear of testing and condoms."

"I believe that the camp was effective because the effort for behavior change was a weeklong affair in a safe environment in which there were no distractions."

It seems that in northern Uganda, an area that is still recovering from a twenty-year war, the evidence of behavior change may be happening at a slow pace, if at all. The respondents all seemed to take a middle of the road approach when questioned about the effectiveness of their programs.

They all knew [HIV] was there. It was like a dark cloud in the sky that no one talked about, but everyone knew what it was. It would loom over the people and they all felt the ominous implications, but people still behaved as if they had no control over [HIV], or as if it "only happens to other people, not me."

Top-down versus Culture-centered Campaign

In past interventions health practitioners have used a top-down transmission-based model of communication in HIV/AIDS programs. This type of message views HIV/AIDS as a culture problem and takes the role of "all-knowing expert" and the beneficiary as a passive recipient of the messages (Airhihenbuwa & Obregon, 2000). Dutta & Basu (2008) say that the health communicator is better served working in collaboration with the target groups in determining their specific needs, wants and programs while figuring out how those factors are going to be of benefit in changing health practices in a positive manner. Respondents were asked about their views on the most appropriate approach for disseminating health information in northern Uganda.

Respondents discussed whether top-down approach of health information or a culture-centered design were best in working with target groups of the people of northern Uganda. Respondents had a strong leaning to a culture-centered approach, while relying on local leaders to help coordinate and disseminate the campaign.

Culture-centered approach to improved HIV/AIDS health

When working in the communities of northern Uganda, development workers stress that it is vital to know and understand the culture. Work your interventions through local channels while understanding the important constructs of northern Uganda. Being cognizant of culture relevant issues was also strongly talked about:

Bringing local leaders, religious leaders, teachers etc. on board with safe sex practice promotion including testing, condom use and faithfulness. The messages need to be practiced and promoted by people that matter, and not just NGO types or outsiders. I also believe these messages need to start with children when they are much younger, which the current educational curriculum does not allow for. If sexual debut is approximately 12, children need to know safe sex practices before this age!

Respondents reported that getting the people talking was important, not just giving them information.

> "Generate a discussion among the community instead of 'telling' them. Ignite their curiosity to learn more, mobilize community catalysts rather than using a top-down approach."

> "[Try to] create many different ways of reaching to the community including non-literacy based materials, make sure the materials are culture relevant and appropriate."

The respondents also felt that getting people involved from the outset of a proposed campaign was important in creating a successful environment in the intervention. One respondent said that their organization,

> "Followed a community-based approach, where by communities lead in mapping and identifying their needs and the organization then supports the community to fill in the needs and gaps."

Group "ownership" of the intervention

By giving the groups a sense of ownership of the project they tended to be more in involved and engaged. One respondent even said that in some of the interventions of his NGO he charged a fee for workshop participation:

> "In some of the projects I included a fee so that they would be invested in the workshops. So they were also learning something they really wanted to learn that others were not offering."

It is also important to note that respondents felt that if the groups felt a sense of ownership they would not neglect the tools or implements that they received. This is in contrast to interventions where a population is just given items like ox-plows, wells, and stoves. Many of these items, when they are just given, tend to be misused, neglected, and eventually end up broken or in disrepair.

It is crucial that the project is something that the community is interested and invested in.

I recreated a project that had given stoves away to schools for free into a self-sustaining program in which the schools paid in full for their stoves so that they felt a sense of ownership over the project. The stoves from before I made this change were mainly in disrepair because no one cared to maintain them vs. now, the schools and their administrations have poured their energy and time in partnership with us to make sure that they maintain and continue to use the stoves for as long as possible. People are fine with accepting free things, information and skills, but they won't take care to maintain those items or to incorporate the information and skills into their lives unless it's something they already invested themselves in.

Many participants shared the sentiment that it is important to get the youth involved when it comes to HIV/AIDS intervention in the communities.

I started a life skills club to teach the girls, focusing on Income Generating Activities. Additionally, I worked with a number of groups (one group was HIV positive) to start a liquid soap business and designed and co-directed a youth camp for girls that focused on building community leaders and also organized for HIV counseling and voluntary testing for each of the campers.

One person said that, "getting the youth to promote safe sex or abstinence would change the future of HIV/AIDS in northern Uganda." The campaigning needs to be heavily directed at the boys and men:

"They often have the power in the sexual relationship and it is not uncommon for men to take more than one wife."

Another respondent said that as western development workers should be aware of how being there could possibly affect interventions and opinions of the target group. This person said to identify a counterpart that you can use as an intermediary in the work being done in the community. This response leads us into culture barriers faced in northern Uganda:

As far as I am concerned, this is the ONLY way to engage communities. Take the time to find the right people first, which have ideas and drive, earn their trust and earn each other's respect, and make a plan for community engagement. Always be in the backseat,

because if you are a white person (or foreigner) trying to lead a project, you will never know if people are showing up, or pretending to be engaged because they are truly interested, or because they're just there for the 'show.'

Best Practices for HIV/AIDS Programming

The researcher asked respondents to discuss their successes and greatest achievements, as well as to identify projects they were a part of that failed. Reflection is key in creating successful initiatives in the future, and it is beneficial to see what is actually working on the ground in northern Uganda. A theme that developed in evaluating the data is that the success stories are ones that are culture-centered in nature with evident buy-in from the target audiences. In the failures, the stories seem to indicate a top-down project where the recipients had little to no say in the project.

Examples of successful programs in northern Uganda

Development workers were asked to describe their most successful initiative. They were asked to elaborate on why the initiative was successful. The question resulted in unique stories in what respondents thought were successful campaigns. All were varied in nature, but all successes had at least some hint to involvement and engagement by the community. One such story sums up there approach to engagement:

> The Stepping Stones (Life skills) model was most successful because the model brings community members together to discuss issues above and beyond HIV. The model allows time and space for gendered-age groups to communicate with one another, but then to share their insight with the other gender-age groups. This opens a dialogue within the community and begins to mend and health the fractured social fabric, and ultimately creates a more positive social environment and norms, many of which support positive behavior change for HIV prevention.

Respondents talked about having dialogue and connecting with the people that they work with. Open communication seems to be a key aspect of HIV/AIDS education programming. These successes were often as a result of working through the school system or camps designed for youth. Two good examples are:

The girl's empowerment camp was the most successful. We were able to organize a week full of activities that were carefully planned to develop the campers into leaders and educators for their communities. Self-esteem, leadership and teamwork activities took up most of the beginning of the week in preparation for daylong sessions on HIV/reproductive health (including counseling and voluntary HIV testing) and domestic violence.

And this:

I organized a workshop for girl's empowerment that included dancing, girl empowerment and HIV/AIDS information. Most of the girls went to the one-week workshop every day because they really wanted to learn dancing. Each day they practiced a routine and learned new things about girl empowerment and HIV/AIDS.

Respondents also talked about lessons they taught in business skills and local income generating activities, using women guest speakers who could be role models for girls. Respondents also discussed how HIV/AIDS education was taught through clubs and camps. These clubs and camps created supportive atmospheres for children to tackle serious topics in a relaxed secure environment. One example:

The camp had simple goals, which each activity contributed to, building upon the last activity and preparing the girls for the next activity. Additionally, the girl's camp worked with a boy's camp that focused on the same material. The camps met to work on gender equality and discussing domestic violence and encouraged the boys and girls to work together in shared communities upon returning home.

Respondents spoke about the turnout in initiatives where buy-in was evident in the communities:

They kept coming every day because they wanted to learn the routine and perform at the end of the week when we gave out certificates. I believe that by integrating Life-skills with other activities like sports or arts, it brings a better turnout. If the lessons are good enough, the beneficiaries will learn from it as well.

As one respondent pointed out, these interventions may have great successes on the front end but the outcomes may be hard to see:

"I helped with Peace Camp. The students really did feel empowered for those few days. But how lasting the effects are, I don't know."

A respondent who was in charge of a beekeeping project said that the things that made his initiative successful were that it was community-imagined, driven, funded, and led. He said that the idea came from within his community, using local knowledge. Most noticeably, elephants fear bees, so in addition to gathering honey for market they would be keeping elephants out of their gardens. He also said that having a local champion, or counterpart, as an active participant drove the project. He said that, whenever possible, a development worker should look to incorporate existing strengths and resources. In his case, they built hives out of local material, utilized local labor, and sold the honey to local cooperatives. He said that although the project took a long time to get off the ground, the community engagement is what made it sustainable. During the beekeeping project, HIV/AIDS education was incorporated into the weekly meetings of the group.

Respondents can be looked at as the managers of a project, but it is up to the beneficiaries to be invested and involved. It appears that no matter what the project is, it has to be important to the community and they have to feel that they have ownership in it. Being a steward of the program and incorporating positive messages is the true role of the development worker. One respondent stated that a successful development worker should be "a true local entrepreneur with love for his neighbors in his heart, not expecting to get anything out of it."

Examples of programs that failed in northern Uganda

While examining program failures, the common theme was that the program recipients had little to no involvement with the intervention, or the respondents just implemented the project under the assumption that it would be good for the group they were working with.

One respondent talked about a primary school soccer camp that she set up. She said that she was new to northern Uganda and just trying to get a program started. The respondent did not consult the local school about what was already being taught about HIV/AIDS or what was appropriate for the age of the students she was working with. She recognized after the failure of

the soccer club that she should have spent more time in the planning stages talking with the teachers and local leaders about what was already occurring with the children. She would have recognized the redundancy in her effort by taking time to ask questions and listen.

Trying to initiate programs without understanding the audience seems to be a common pitfall for many of the respondents who have worked in northern Uganda.

> "Teaching income generating activities to girls in school was not very successful because the students had limited time and energy to devote to a small business and did not have a strong sense of the importance of making and saving money."

> "I tried to use bamboo for irrigation, thinking that this would be a good way to increase the local income as people could grow all year round. It failed for many reasons. It was a lot of work for me and people didn't seem that interested."

Some initiatives may seem significant to the development worker, but if it's not important to the community, it will eventually fail. Knowing the audience when teaching and trying to be involved in the community is also important but not being culturally aware can lead to an otherwise good idea backfiring:

> "Peer youth centers were created as a place for youth to come and play games, and received HIV prevention messages. These centers were built but ultimately failed as there was no buy in from the community for their placement, and continued functionality."

> I tried to start a "story-time" club during lunch where I would read to those interested as they ate. This lost momentum as many of the students preferred to socialize amongst themselves and because the book I initially chose was too difficult to relate to.

Direct education programs need to be nurtured and developed over the long term. Development workers cannot just cobble a program together and expect that people will show up. One respondent said, "Life-skills initiatives need an extended period of time (like a full week) that is fully devoted to developing the program so that shorter follow up activities can be meaningful and still fit within the person's schedule."

Another program failed when a development worker assumed he knew what was needed or wanted as far as infrastructure for his given community. Ask questions, become involved and take your time when determining the goals of the community:

My organization occasionally attempted to repair or install drinking water wells. The most abject failure was a well that went dry within a few weeks of being installed, in addition to being contaminated. In this instance, the intervention was carried out in isolation from the community, without their direct buy-in or support, and without any education about what practices they could take to adequately protect their water source from damage. In addition, my organization did not have well-trained or responsible staff in charge of the project. This ultimately led to bonds between the community and the organization being broken, such that future efforts in this particular community were less likely to receive support.

It is possible to have successful programs while incorporating HIV/AIDS education in northern Uganda. It is important, according to respondents, that a development worker engages the community groups and leaders as they create and plan programming. One should not take for granted the ideas, input or resources that are available to them from the local groups. A worker should get people involved and excited whenever possible when creating programs that have the best chances of being successful. Working in a top-down manner, while assuming you know what is best for the community may possibly lead to apathy, disengagement, and project failure.

Advice for new practitioners in northern Uganda

This study examined development workers who are living, or who have lived, in northern Uganda for a minimum of two years. Respondents were asked to relay the three biggest pieces of advice that they would give to a new development worker that was moving to northern Uganda for the first time. The following are a representative sample of the advice that was given to this hypothetical new volunteer. They are not listed in any particular order, but rather are representative of the themes that emerged from the responses:

"All activities have to involve the community in their development, implementation and follow-up monitoring and must require the investment of the community's time and energy."

"Help people make a plan on their role with HIV/ AIDS prevention and follow up."

"Have key stakeholder buy in- whether it be churches, hospitals, schools, etc. Have

consistency in messaging. Be working on overcoming stigma to promote positive living."

"Listen first, then listen some more, you are NOT the expert, they know their own conditions better. Respect their dignity and do not impose your program."

"All barriers to behavior change need to be known before the intervention to ensure that the intervention doesn't create demand for something that isn't there (i.e. don't increase demand for HIV testing if you know health facilities don't have test kits.)

Don't let your culture superiority get in the way of an informed approach. Try to think about who makes decisions and how best to inform them of relevant public health knowledge. Don't try to take on the culture (especially with gender issues) in a combative manner. Instead try to work with people of different genders to reach healthy solutions.

Chapter 5 - Discussion, Conclusion and Recommendations

The aim of this study was to examine best practices for HIV/AIDS communication by practitioners working in the field to curb the epidemic in northern Uganda. The study examines the best ways of disseminating positive health messages throughout the unique environment found in the region. This study examined the perspectives of those practitioners. Because of the war and conflict that has occupied the region for more than 20 years, there are elevated rates of HIV/AIDS infection. This chapter discusses the results of the study in relation to the research questions and provides some implications based on the EPPM and SCT. In addition, the chapter provides conclusions drawn from the study and recommendations for future development practitioners interested in HIV/AIDS education programming in northern Uganda. Study limitations will also be addressed at the end of this chapter.

Discussion

RQ 1: What level of fear appeal do development workers in Northern Uganda feel is appropriate in their HIV/AIDS programming?

This research question addresses how, and to what amount of success, respondents are using fear as a motivator for positive behavior change in their sexual health. Respondents feel that the war has created an environment that is unlike any other part of Uganda. This environment has forced children into harsh realities at a young age and eradicated many would-be positive role models. Because of inherent violence, rape, abduction, and food insecurity, an environment has been created where the population may respond negatively to fear-based health campaigns. Poor education systems, sexual promiscuity (transactional sex, among others), and a lack of access to health care have created an environment of high risk and low efficacy. Northern Ugandans are currently in an environment that is counterproductive to individual growth and maturation.

Respondents have suggested that fear messaging may be too arbitrary for the current environment and culture of northern Uganda. Fear messaging may have some positive benefit if used in conjunction with other interventions. Although some respondents indicated that these types of programs might have a positive effect in the short term, on their ability to create lasting

change or behavior modification, the respondents indicated that these interventions would most likely fail.

In terms of the ABC or D model, respondents indicate that there may be too many inconsistencies for the programs to be successful. Respondents discussed gaps in programming, lack of structure and commitment by group leaders. Many times the "D" component (the fear component) of the program was omitted or forgotten about completely.

Though Green and Witte (2006) indicate that the ABC or D campaign can be used successfully in Uganda, because of the unique factors to northern Uganda, this may be one region where fear messaging may potentially backfire. Research suggests that in areas of high existing fear, where added fear fails to produce a heightened level of perceived threat, the message will be rejected (Witte & Morrison, 2000). Northern Uganda may indeed be an area where message rejection is possible.

RQ 2: What level of self-efficacy components are development workers incorporating into their programming?

Results from this study show that northern Uganda may be lagging behind the rest of the country when it comes to people's self-efficacy. It was stated that because of the war social fabrics had been broken down and people had very little sense of self-control. Children have been out of school for entire generations and cognition is at very low levels. There is very little work to be had and this exacerbates an already bleak existence for many in northern Uganda. One respondent sums it up very well, "this inability to embrace ambition and hope is the apathy that further fuels the spread of HIV in northern Uganda."

Programs are focusing on giving the people of northern Uganda the tools needed for increasing knowledge and understanding about the risks of HIV/AIDS. These programs attempt to improve peer leadership, decision making, and goal setting, while actualizing the effects of HIV infection. However, a common thread in the responses is that northern Uganda may not be ready for this type of long-term behavior change intervention. With the idea of life-skills, respondents in northern Uganda did not seem to have fully embraced this specific type of intervention as having a benefit to the people. Some described using components of life-skills, but being unable to see long-term positive change at this time as a result of the intervention.

According to Bandura (2004) it is important for people to have knowledge of health risks and benefits. This knowledge will create the precondition for behavior change. If people lack the requisite knowledge of how their lifestyle habits adversely affect their health, they will have little reason or motivation to change. In the case of northern Uganda it is important that development programs focus more on providing adequate knowledge about HIV/AIDS as a key component of current behavior change interventions.

RQ 3: To what extent are development workers collaborating with target audiences in their message design and implementation?

Albert Bandura wrote, "to be an agent (development practitioner) is to influence one's functioning and life circumstances. Social Cognitive Theory distinguishes among three modes of agency: direct personal agency; proxy agency that relies on others to act on one's behest to secure desired outcomes; and collective agency exercises through group action (2000, p. 270)" So, in the context of northern Uganda, the questionnaire examined if respondents were fulfilling these components in their message design.

From their responses, it appears that respondents find it important to check in with the populations on a regular basis when designing and implementing an intervention. From the initial development stages to the final evaluation of the successes of a given project, it was found to be important to be gathering the opinions, thoughts, and suggestions of the community. Buy-in and understanding of the initiative by the community is critical to the success of the intervention.

Understanding culture barriers is another important component in the eventual collaboration with target groups in HIV/AIDS programming. During the war, there were many donor organizations flooding the region with money, goods, and services. Now, during the transition into peace and stability, the people still view westerners as a means to quick money. People are always watching the every move of development practitioners; so one must be on their best behavior while living and working in the region.

Respondents need to be especially aware of the culture ideas of sexuality and intimacy. It is easy to view northern Uganda through a western lens, but in doing so it may very well be transposing viewpoints that are counterintuitive to the people of northern Uganda. Gender inequalities and the hierarchal society are two other culture barriers and potential pitfalls for the

respondents in northern Uganda. Again, it is important to get accustomed to not viewing belief systems through traditional lenses.

While creating and implementing successful programs it is important to be aware of the breakdown in social structures and norms. The development practitioner should also be cognizant of potential negative coping strategies inherent to those living in the north before attempting campaigns that may be counterproductive.

RQ 4: To what level do development workers in northern Uganda believe that behavior change is occurring as a result of their campaign utility?

Research suggests that when working in a sector of development, the wide culture diversity requires that the messages of risk reduction for HIV/AIDS be tailored to the socioeconomic, racial and ethnic differences that are inherent (Mantell, et al., 1988). Bandura states that there is a "major difference between possessing self-regulative skills and being able to use them effectively and consistently under difficult circumstances (1986)."

Because of the drawn out war in northern Uganda, it is possible that positive effects of interventions are not yet being seen in HIV/AIDS behavior. Because of the complexities of the war, respondents have said that real behavior change may be happening at a slower than expected pace, if at all. The respondents all seemed to avoid making any profound statements on whether or not positive change was actually occurring from their interventions. As northern Uganda continues to transition from war to a place of peace and stability, it may be too early to tell the effect that behavior change interventions are having on the beneficiaries of the programming. It should be noted that motivation and confidence within the community need to be built along with hope, before any amount of positive behavior change can take place.

RQ 5: What are the perceptions of top-down versus culture-centered campaign designs among development workers in northern Uganda?

A top-down transmission-based model of communication is when the practitioner is the all-knowing expert and the recipient is a passive receptor of the message. This type of message can be risky because the "expert" is not taking into account what may be of great importance to the message receiver (Airhihenbuwa & Obregon, 2000). A culture-centered approach to health communication is when a practitioner fully understands the needs and wants of the community. The person implementing the programming can in no way assume that he or she knows what is

best for an outside group and it can be counterproductive to think otherwise (Airhihenbuwa & Obregon, 2000).

The respondents had a very strong opinion that working with a culture-centered approach was a very viable method of working with people in northern Uganda. The respondents were all in agreement that being in touch with local leaders, religious leaders and teachers is an important place to start in message design. It is important to get people talking and it may be hard to do at first. An outside development practitioner must gain the trust of the population before any work can begin. Creating a sense of ownership by the beneficiaries was key if respondents wanted any chance of having a successful program, or creating positive behavior change in terms of health practices. It is also critical in getting the youth involved in the discussion as their voices matter in the way a project runs.

RQ 6: What are best practices for HIV/AIDS education in northern Uganda?

The successful interventions, according to the respondents, all included levels of involvement and engagement by the community. To foster success it is important that communicators are seeking the opinions of the locals. Working through local organizations, such as churches and schools, will not only ingratiate communicators into the community but also give them strong allies when implementing new programming.

On the other side, it appears that most respondents' initiative failed because of a lack of engagement or buy-in from the local community. What may seem important to the respondents may not matter to the stakeholders. Development practitioners should have their eyes and ears open and be prepared to ask a lot of questions as they transition into their health initiatives.

Conclusion and Implications

The EPPM and SCT guided this study and the creation of research questions used. Based on the EPPM, perceptions of fear appeal in HIV/AIDS prevention campaigns were that it might be beneficial in the short term but ineffective in the long term. The fear component of the EPPM may not be appropriate in an area transitioning out of a war environment. Respondents felt this type of campaign would end without creating any lasting behavior change. Because of the added stresses of violence, rape, abduction, and food security issues associated with the war and instability in northern Uganda, all of which contribute to the risk of HIV infection, message recipients may deem the initiative as unimportant and reject the health message. The researcher

acknowledges that EPPM has proven to be successful and productive in other parts of Uganda and regions of development.

In terms of self-efficacy messaging, respondents felt that the region may be too fresh out of the war environment for recipients of messages to respond positively. The bleak existence that the population has been exposed to is still a hindrance for any type of long-term involved programming at this point. This includes life-skills based messaging techniques. Respondents seem to indicate that life-skills methods may work in other parts of Uganda, but that it may be premature for them to be implemented successfully in the north. The infrastructure and support may not yet be in place for successful campaigns using a life-skills method. Because of conflict, the social structures and infrastructures of the region have been severally damaged. The region is now in post-war rehabilitation, but the scars are still evident.

The responses to this survey indicate that respondents believe it is critical in getting recipients and village members involved from the very beginning of an intervention. In doing so, a development practitioner is engaging the community and building trust among the very people he or she is there to help. A culture-centered approach will work best in message design and delivery.

Northern Uganda is healing slowly from a conflict that affected many people. It is possible that positive behavior change is going to be slower than other regions of Uganda. To have the best possible successes in health communications in the region, the practitioner must be cognizant of the specific needs of the population without making assumptions of what is best for them based on western ideology or current methodologies that are successful in other parts of Uganda.

Recommendations

This study provides valuable information for anyone considering working in health communication in northern Uganda. The uniqueness of the region may require a different type of intervention than what are successful for other regions of Uganda or sub-Saharan Africa. Because of war and conflict that has consumed the region for such a long period of time, traditional health communication techniques may be of little value at this time in northern Uganda.

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The use of fear in northern Uganda may at this time be counterproductive in HIV/AIDS programming. It is the opinion of the respondents that fear-based programming may be too arbitrary in this environment. Programming that incorporates self-efficacy, which is used in current programming, are possibly not getting to the community as effectively as hoped. Respondents feel that, at the current time, being culture-centered and aware of the inherent needs of the population is most important during this transition period.

The results of this study indicate that a health practitioner should enter northern Uganda with no pre-conceived notions of how the population should be treated, or what is going to be best for them. Respondents indicate that culture-centered interventions combined with self-efficacy building components may work best for the current environment of northern Uganda. The people of northern Uganda have faced many hardships over the years, and though they are rebuilding, it may be at a slower pace than may be otherwise expected. A development practitioner should not assume that they know what is best for northern Ugandans. Practitioners should be compassionate, involved consultants who are willing to be involved over the long term.

Practitioners should be willing to commit years to the service of northern Uganda. Change takes time and according to the respondents in this survey, "lasting change occurs in generations, not in years. If you and your organization aren't in it for the long haul, then don't come, don't build schools, don't hand out pamphlets, and don't give money. Live with them, learn their life, live their culture, speak their language and let go of your assumptions about how to do things."

Further Research

This study is the basis for further research testing EPPM and SCT in northern Uganda. Further research into best practices for communicating in northern Uganda would be beneficial to potential development practitioners, NGOs and non-profit organizations. This exploratory, qualitative study lays the groundwork for more exploration. Research where a team traveled to northern Uganda and spent time in the field interacting with development practitioners and the target groups would be ideal. Examining how programs are being run on the ground would benefit the donor organizations and how they distribute funding. Knowledge gained from

firsthand observation and interaction would be of benefit in better understanding HIV/AIDS messages best suited for post-war areas, such as northern Uganda.

Further research examining the recipients' perspective of HIV/AIDS messaging could be an important aspect of further research. Examining what is important to the people of northern Uganda would be of value in creating future HIV/AIDS campaigns. Hearing what their opinions are on the kinds of interventions most valuable to them would add extensively to the literature.

Further research from the funding agencies perspectives would also add to a complete study of HIV/AIDS messaging in northern Uganda. Examining how these agencies select and implement the models in use would be of great value. Researching their opinions on what works best in terms of effectiveness in the region would add an aspect to the overall communication techniques.

Limitations

This study was not without its limitations. The researcher acknowledges that in-person or telephone interviews may have drawn out more in-depth responses. Because many of the respondents are currently living in Uganda or dispersed throughout the United States, there were several financial and coordination constraints. Respondents that were currently living in northern Uganda may not have the resources or time to participate in more than an online questionnaire. Because of their location, the time difference could also be considered a limitation in reaching participants in the study. Internet access is costly and intermittent in Uganda; it is the researcher's opinion that the questionnaire may have become too time consuming and laborious for all respondents to complete in full. This study was exploratory and the findings cannot be generalized to the rest of Uganda.

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Appendix A - IRB

KANSAS STATE | University Research Compliance Office
UNIVERSITY

TO: Nancy Mururi   Proposal Number: 6607
         Journalism
         105 Kedzie

FROM: Rick Scheidt, Chair
         Committee on Research Involving Human Subjects

DATE: 03/11/2013

RE: Proposal Entitled, "HIV/AIDS Communication Strategies in Developing Countries: Behavior
        Change ina high Fear Environment"

The Committee on Research Involving Human Subjects / Institutional Review Board (IRB) for Kansas State
University has reviewed the proposal identified above and has determined that it is EXEMPT from further
IRB review. This exemption applies only to the proposal - as written – and currently on file with the IRB.
Any change potentially affecting human subjects must be approved by the IRB prior to implementation and
may disqualify the proposal from exemption.

Based upon information provided to the IRB, this activity is exempt under the criteria set forth in the
Federal Policy for the Protection of Human Subjects, **45 CFR §46.101, paragraph b, category: 2,
subsection: ii.**

Certain research is exempt from the requirements of HHS/OHRP regulations. A determination that
research is exempt does not imply that investigators have no ethical responsibilities to subjects in such
research; it means only that the regulatory requirements related to IRB review, informed consent, and
assurance of compliance do not apply to the research.

Any unanticipated problems involving risk to subjects or to others must be reported immediately to the
Chair of the Committee on Research Involving Human Subjects, the University Research Compliance
Office, and if the subjects are KSU students, to the Director of the Student Health Center.

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