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**ADDIS ABABA UNIVERSITY**  
**SCHOOL OF GRADUATE STUDIES**

**THE EFFECT OF INTEGRATING MASS MEDIA  
WITH INTERPERSONAL COMMUNICATION  
EFFORTS: A CASE OF YICHALAL RADIO**

**BY**  
**SILESHIE SEMAHAGNE**

**ADDIS ABABA**  
**MARCH 2011**

**THE EFFECT OF INTEGRATING MASS MEDIA WITH  
INTERPERSONAL COMMUNICATION EFFORTS: A CASE  
OF *YICHALAL* RADIO**

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**BY  
SILESHIE SEMAHAGNE**

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## **Acronyms**

ABECs	Alternative Basic Education for Children out of school
AIDS	Acquired Immuno Deficiency Syndrome
ART	Antiretroviral Therapy
BCC	Behavioural Change Communication
CHGA	Commission on HIV/AIDS and Governance in Africa
FHI	Family Health International
FSW	Female Sex Workers
GEMC	Gondar Educational Media Center
HAPCO	HIV/AIDS Prevention and Control Office
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
HTPs	Harmful Traditional Practices
IPU	Inter-Parliamentary Union
JHUCCP	Johns Hopkins University Health Communication Partnership
KAP	Knowledge, Attitude and Practice
OVC	Orphans and Vulnerable Children
PENNSSTATE	Pennsylvania State University
PLHA	People Living with HIV/AIDS
SCNE	Save the Children Norway Ethiopia
SCOPE OVC	Strengthening Community Partnerships for the Empowerment of Orphans and Vulnerable Children
SIDA	Swedish International Development Cooperation Agency
TPB	Theory of Planned Behavior

TRA	Theory of Reasoned Action
UNAIDS	Joint United Nations Program on HIV/AIDS/UNAIDS
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific and Cultural Organization
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

## **Abstract**

*The developing world has become home to multi-faceted socio-economic problems. Previous research findings witness that the prevalence of debilitating pandemics like HIV/AIDS have been placing life and development at the worst. Unless immediate measures are taken, the severity of the pandemic, as research predict, will proceed to take life with an alarming rate. The absence of cure or vaccine for HIV/AIDS has restricted professionals to concentrate on mass education about the concept, prevention and spread of the epidemic. To this end, the mass media, particularly radio, have been used as essential tools of combating the pandemic. Yet, the effect of radio with the presence of its top-down nature which let the audiences to be passive recipients of what comes from stations is being repeatedly questioned. Integrating radio stations with interpersonal communication efforts has been recommended for better results. In such countries as India, Philippines, Ghana, the integration of radio with interpersonal communication was proved to be effective. Accordingly, this research is conducted to analyze whether integrating radio with interpersonal communication is effective in terms of developing the knowledge of the listeners by taking Yichalal Radio into consideration. Yichalal Radio is targeted at four districts of North Gondar, Ethiopia, to teach about HIV/AIDS, harmful traditional practices (HTPs) and child right to the youth and children of the area. The station is trying to redress the shortcomings of radio by establishing groups of listening students, 21 students at each school, in most of the elementary and junior schools of the districts. These students undergo formal follow-up discussions every Saturday after Yichalal radio is over. This research is, thus, a quasi-experimental study that measured the knowledge of the listening groups and matched up to the non-listening ones who regularly listen to Yichalal Radio at home or somewhere else but do not have listening groups of Yichalal Radio at their school, hence do not undergo formal follow-up discussions. By using convenience sampling, all members of the listening groups were chosen from the two nearby elementary and junior schools that had listening groups in the year 2010/11. By using the same sampling method and by purposefully matching the age, grade level and gender of the samples with the listening students, the same number of non-listener students were chosen from other elementary and junior schools where listening group members of the radio did not exist. The study revealed that while students in both groups did not show significant knowledge disparity about HIV/AIDS between students of age group 10-13 and 14-17 and 7<sup>th</sup> and 8<sup>th</sup> graders, the females of both listeners were found to be less knowledgeable than their male counterparts. While the listening group students of Yichalal Radio were found to have a very good knowledge of the concept, spread and prevention of HIV/AIDS, the non-listeners fairly knew these issues. Yet, the non-listeners failed to understand the concept HIV and AIDS well. When the knowledge about HIV/AIDS of the two groups of Yichalal Radio listeners was measured, the listener group members had in many ways significantly outdone the non-listeners. Given the attempt made to match both groups of listeners in access to HIV/AIDS information, grade level, academic performance, age and gender, it might be safe to say that the exposure of the listening group members to the formal follow-up discussions after listening to the radio programs significantly improved their knowledge about the epidemic. The follow-up discussion was found to contribute a lot to the listening group students in that it gave them a chance to search information for their discussion, better understand the broadcast messages, develop their knowledge of HIV/AIDS, pass their knowledge to people around them, internalize what they listen and discuss and see many angles of a story/an idea.*

# **CHAPTER ONE**

## **INTRODUCTION**

### **1.1. Background of the Study**

It is apparent that developing countries have for long been suffering from multi-faceted socio-economic problems, of which the prevalence of severe pandemics like HIV/AIDS is becoming a harsh threat for life and development. According to Misra (2006) the overwhelming majority of people with HIV, some 95% of the global total, live in the developing world. As to the Joint United Nations Program on HIV/AIDS/UNAIDS & World Health Organization/WHO (2006), among the estimated 2.1 million AIDS-related deaths in 2006, 72% of them were in Africa. UNAIDS & Pennsylvania State University /PENNSYLVANIA STATE (1999) also accentuated that the Sub-Saharan Africa takes the lion's share with 150 million people, one quarter of the population, victims with the pandemic.

Ethiopia, as part of the Sub-Saharan Africa, is also experiencing the grief with the cumulative number of AIDS deaths of 1,267,000 by 2005. The death was also projected to reach 1.9 million by 2010 if the then trends continue and, in the same year, a total of 128, 922 new HIV infections (353 a day), including 30,338 births with the virus (mother-to-child infections) were estimated (HIV/AIDS Prevention and Control Office/ HAPCO 2005).

The absence of a cure or vaccine for HIV/AIDS and the pressing call for contacting people on the impact of the disease and for preventing it have resulted in the emphasis on mass education of populations. As to the Global Media AIDS Initiative (2004) it is often said that education is the vaccine against HIV/AIDS. To halt the challenges of HIV/AIDS, thus, various developing countries have been responding through a variety of awareness campaigns to sensitize their nationals on meaning, mode of spread as well as prevention of the infection.

With this regard, radio has played a pivotal role. By its very nature, radio disseminates various programs for large anonymous audience. Since its invention, it has been used to address various intended goals in a variety of areas throughout the world. As Tufte and Mefalopulos stated, in 1927 the German author Bertolt Brecht formulated a “radio theory” in which he envisioned the new technology, the radio, as a dialogical instrument for change. However, the radio lost its dialogic potential and developed into a mass mediated broadcasting instrument in the years that followed his early vision.

Though it is a mass medium which is broadcast top-down with minimal immediate feedback from the audience, radio has several comparative advantages over the other mass media. According to Dagrón (2001: 15-16) radio as a tool for social change and participatory communication has the following advantages:

- *it is cost-efficient in terms of investment — both for those that run the station and for the audience;*
- *it is pertinent in terms of language and content —ideal for the huge illiterate population that still remains marginalized especially in rural areas of the Third World;*
- *it is relevant to local practices, traditions and culture;*
- *once the initial investment in equipment is made, sustainability is feasible, though dependent on the level of community participation;*
- *in terms of outreach and geographic coverage, radio has a strong advantage over other media.*

Its comparative advantages enable radio to be the dominant medium within the disadvantaged communities. McLeish (2005) underlines that radio is particularly well suited to meet the needs of the poor and disadvantaged as it can fill the economic, social and educational gaps of the communities in the effort of empowering them. Therefore, radio, using its comparative advantages, is rising to the challenge by promoting awareness about HIV/AIDS and educating the general public on its control.

Even though most scholars agree that radio is a crucial mass medium in the fight against HIV/AIDS in most rural parts of Africa (Kuponiyi 2000), the very limitations it has, however, may hinder the role it can play. Mefalopulos (2008) pointed out that although radio is often the preferred medium in rural settings, it has many limitations and is better if it is used in a more participatory way for development-oriented purposes. According to Crisell (1994), the risks of ambiguity or complete communication failure are high, and so, in all kinds of radio much effort is expended on overcoming the limitations of the medium on establishing the different kinds of context which we would generally be able to see for ourselves.

Servaes (2008) also stated that radio was seen as top-down processes whereby it could bring about widespread change. As Rogers & Steinfatt (1999) it was realized, however, that the role of the media in such a manner was mainly limited to creating awareness-knowledge of new ideas and perhaps stimulating interpersonal communication about a new idea. They argue that both of these impacts increase the likelihood of changed behavior, but they are generally insufficient to effect a change without additional communication efforts. Hence, scholars are arguing that in line with the role of radio in the fight against HIV/AIDS in the developing world, the complimentary combination of interpersonal communication efforts is very essential. Yet, these arguments need to be proved in areas where the combination of mass media with interpersonal communication is being practiced. This research is an attempt to prove or disprove the issue at hand.

## **1.2. Statement of the problem**

HIV/AIDS is the greatest challenge that has faced the African continent in recent decades. WHO (2004) points out that although Africa has only 11% of the World's population, it has 75% of people living with AIDS in the world with an estimated 29 million people living with HIV/AIDS, most of who are in Sub-Saharan Africa.

As stated in the background, Sub-Saharan Africa remains the most affected region in the global AIDS epidemic. More than two thirds (68%) of all HIV-positive people live in this region where more than three quarters (76%) of all AIDS deaths in 2007 occurred. It is estimated that 1.7 million people were newly infected with HIV in 2007, bringing to 22.5 million the total number of people living with the virus (UNAIDS & WHO 2007).

Ethiopia is also one of the most HIV/AIDS debilitated countries of the Sub-Saharan Africa. Ethiopia's population reached an estimated 73 million in mid-2005. As to HAPCO (2005), by 2005, the cumulative number of AIDS deaths was 1,267,000 and it was projected to reach 1.9 million by 2010. In the same year, a total of 128, 922 new HIV infections (353 a day), including 30,338 births with the virus (mother-to-child infections) were estimated.

To halt the expansion and debilitating effect of HIV/AIDS, various projects and methods of restricting the pandemic's effect are being undertaken. One of the methods that Ethiopia has been extensively utilizing is the use of some awareness creating and behavior changing radio programs, as eighty-four percent of the population live in the rural areas, most of whom illiterate (ibid.), with no access to other mass media like newspapers and television.

One of such attempts is being practiced in the rural parts of North Gondar (Chilga, Alefa, Takussa and Lay Armachiho), Ethiopia, under a radio station called *Yichalal* Radio. *Yichalal*, which literally means '*It is possible*', is a youth focused weekly program on HIV/AIDS, child rights and harmful traditional practices (HTPs). *Yichalal* Radio is operating under the Gondar Educational Media Center (GEMC) which is one of the educational media centers in Ethiopia focusing at teaching the youth. The radio station is attempting to support its messages with interpersonal communication.

In fact, integrating radio with interpersonal communication is not a new phenomenon. According to Farm Radio International (2008), the practice of integrating mass media with interpersonal communication has been repeatedly proved effective in countries like Canada, India, Philippines, Tanzania, Malawi, Mali, Mozambique, Ghana and South Africa. In the rural parts of these countries, listening groups were established for follow-up discussions that come in combination with the radio programs. In most of the circumstances, the listener members' knowledge, attitude and practices were found to be positively changed.

Even though the program contents are different from what was witnessed from the above countries' experiences, *Yichalal* Radio is also integrating radio programs with interpersonal communications. As to the Gondar Educational Media Center/GEMC (2009), *Yichalal* Radio project is based on the hypothesis that interaction between the audience and the radio program will establish a relevant and effective approach to engage youth in AIDS prevention and community development.

For the radio program, there are two kinds (groups) of listeners in its target area. These are: the listener groups and the non-listener groups. The listener groups are those elementary and junior school students in the reach of the radio, Chilga, Alefa, Takussa and Lay Armachiho, and who listen and undertake a sort of formal follow-up discussions after the transmission of the radio programs on Saturdays in their school. They are also expected to pass the knowledge acquired to the rest of the society. Every elementary and junior school, which is part of the radio project, is required to recruit 21 students on the commencement of the program (in January each year) to make a listener group that will stay for a year term. Upon finishing a year of listening and discussion, the students will be graduated by *Yichalal* Radio. Dropouts may exist. But, those who graduate will be awarded radio sets.

The non-listener groups are those people who are in the reach of the radio station but are not formally embraced in the listening groups of *Yichalal* Radio project. In this research, however, the non-listener groups refer the elementary and junior school students within the reach of the radio station whose school do not have *Yichalal* Radio listener groups and thus do not undertake formal interpersonal communication (discussion) under the radio project in combination with the transmitted radio programs. They, however, regularly listen to *Yichalal* Radio in either their home or anywhere else and use *Yichalal* Radio as a dominant source of their knowledge about HIV/AIDS.

The previous research works conducted on the radio station tried to assess the appropriateness of the communication strategies that were being applied (Tigist 2009) and the behavioral changes witnessed from the programs (Shitaye and Yohanis 2003); (FocasLich 2006) by targeting the listener groups who are assumed to diffuse the knowledge, attitude and skills grasped from the programs, through active listening and discussion, to the community at large.

In the aforementioned research works, the effect of *Yichalal* Radio program in its target listeners has not been well studied. Indicating a research gap that considers both the listening and the non listening groups and compares the knowledge differences to indicate the effect of combining the radio program with interpersonal communication efforts, therefore, this research targeted to analyze the effect/s of integrating the radio programs with interpersonal communication efforts by taking samples from the two types of listeners and by comparing the impacts of the program on their knowledge.

### **1.3. Hypothesis**

It is quite relevant to note that radio has many limitations due to its top-down nature and has to be combined with interpersonal communication efforts if it is meant to have an elevated impact (Rogers & Steinfatt 1999). Particularly, Rogers who used to argue that the top-down approach could bring behavior change among the people in the Third World later conceded that the potential of the

mass media is great if they are used in a complementary combination with interpersonal channels. This research is, therefore, framed under this theoretical underpinning. Drawing on this theoretical benchmark, the researcher has formulated the following hypotheses:

1. The impact/s of *Yichalal* Radio program on the HIV/AIDS knowledge of the listening groups can be paramount as they complimentarily undergo formal follow-up discussion after listening to the radio program every Saturday.
2. The impacts of *Yichalal* Radio program on the HIV/AIDS knowledge of the non listening groups can be minimal for they do not undergo formal discussions after the radio program is over every week.
3. A significant knowledge difference, about HIV/AIDS, can exist between the two groups of listeners as the formal follow-up discussion is believed to significantly develop the HIV/AIDS knowledge of the listening groups.
4. The complimentary use of *Yichalal* Radio program with interpersonal communication efforts can have a lot of advantages for the empowerment of the listening groups.

#### **1.4. Objectives of the Study**

##### **1.4.1. General Objectives**

This study is a quasi-experimental study mainly intended to analyze the effect/s of combining mass media with interpersonal communication efforts in the Gondar Educational Media Center. The research will, therefore, compare the impacts of *Yichalal* Radio program on the knowledge of the two groups of listeners about HIV/AIDS by taking samples from both groups and by measuring the impacts of the programs on their knowledge. Thereby the research will find out the advantage/s (if any) of combining radio with interpersonal communication efforts in the case of GEMC's *Yichalal* Radio Program.

##### **1.4.2. Specific Objectives**

The research will try to:

- gauge the impact/s of *Yichalal* Radio program on the knowledge of the listening groups on HIV/AIDS.
- measure the impacts of *Yichalal* Radio program on the knowledge of the non listening groups on HIV/AIDS.
- find out whether there exist a significant knowledge difference about HIV/AIDS between the two groups of listeners.
- analyze the advantage/s (if any) of combining *Yichalal* Radio program with interpersonal communication efforts.

### **1.5. Scope of the Study**

The purview of the research is bounded to analyze the advantages of combining *Yichalal* Radio with interpersonal communication efforts by measuring the knowledge about HIV/AIDS of the two groups of *Yichalal* Radio listeners. This research does not look in to the overall effects of the radio program. The research is mainly focused on Chilga District which can represent the rest of the embraced districts with in the radio project.

### **1.6. Applications of the Results**

The researcher believes that the findings of this study have enormous advantages for people who are specifically engaged in research and practical arenas of media in the fight against HIV/AIDS in particular and of mass communication for development in general. These days, the power of mass media, which once was thought as ‘magic multipliers’ of ‘modernity’, is being questioned. Some influential scholars like Paulo Friere and Evertt Rogers are contending that the mass media alone have played insignificant, if not disappointing, role in empowering the poor. Hence, combining mass media with other forms of communication for better effect is being a contemporary issue. In such a moment, the researcher found that testing the theoretical implications in the practical world is worth studying.

Thus, this research analyzed whether integrating radio with other communication efforts, particularly interpersonal communication, is immensely helpful in empowering listeners with knowledge about HIV/AIDS. The research can, therefore, help communication strategists and researchers at all levels of development to find out the possible advantages of integrating different communication efforts.

This research can also help the GEMC's *Yichalal* Radio producers and owners to evaluate their work as per the objectives of the station.

This research work can also be a spot from which other research works begin.

### **1.7. Definition of Terms**

**Listening Groups of Yichalal Radio:** are the elementary and junior school students, in Chilga, Alefa, Takussa and Lay Armachiho Woredas, who listen and undertake a sort of formal follow-up discussions after the transmission of *Yichalal* Radio programs on Saturdays in their school and use the radio program as their dominant source of HIV/AIDS knowledge.

**Non-Listening Groups of Yichalal Radio:** refer the elementary and junior school students whose school do not have *Yichalal* Radio listener groups and thus do not undertake formal interpersonal communication (discussion) under the radio project's reach in combination with the transmitted radio programs, but they regularly listen to *Yichalal* Radio in either their home or anywhere else and use the radio as a dominant source of their HIV/AIDS knowledge.

## **CHAPTER TWO**

### **REVIEW OF RELATED LITERATURE**

#### **2.1. HIV/AIDS and Radio**

##### **2.1.1. Introduction**

This chapter incorporates a review of theoretical ideals in relation to the objectives of the research. In this part of the research, the role of radio in the fight against HIV/AIDS in the developing world and the extensively used strategies and models in HIV/AIDS communication campaigns are widely assessed. The experiences of some countries that became effective by integrating mass media with interpersonal communication efforts are also reviewed. The theoretical points are presented in the context of the research so as to justify the integration effects of mass media with interpersonal communication efforts.

##### **2.1.2. The Prevalence of HIV/AIDS in the Developing World**

Since 1981, when HIV/AIDS was first diagnosed in United States of America, the virus has spread throughout the world affecting children and adults, the rich and the poor, the urban and the rural people alike. As the 20th century draws to a close, HIV and AIDS continue to inflict mess on an escalating number of persons, couples, families, and communities. Gakahu (2010) emphasizes that HIV/AIDS pandemic has even become the greatest challenge in the 21st Century.

Global Media AIDS Initiative (2004) reported that 8,000 people will lose their lives to HIV/AIDS and another 14,000—10 people every single minute—will become newly infected. The realities of the day's global epidemic are graver than even the worst-case predictions of 10 years ago. AIDS killed more than 3 million people in 2003 and an estimated 5 million more became infected—bringing to some 40 million the number currently living with the virus. More than 20 million have already died since the first clinical evidence of the disease was reported in 1981 (Global Media AIDS Initiative 2004). As Pollard and Walters (2006) state,

about one-third of those living with HIV/AIDS are between 15 and 24 years old and, in 2005, 2.3 million children under the age of 15 were living with HIV/AIDS.

The most tragically affected areas by the pandemic are found within the developing world. Joint United Nations Program on HIV/AIDS /UNAIDS & Inter-Parliamentary Union/IPU (1999) reported that, more than 90 percent of the 33.6 million people living with HIV/AIDS at the end of 1999 were in the developing world. In many developing countries, the epidemic has come to represent a threat to human security itself. Sparing neither children nor parents, neither teachers, health workers, farmers nor other active members of society, AIDS is wiping out gains in social and economic development (UNAIDS & IPU 1999).

Africa takes the lion's share of the debilitating effect of the epidemic. Although Africa has only 11% of the World's population (WHO 2004), it seized 72% of the estimated 2.1 million AIDS-related deaths in 2006 (UNAIDS & WHO 2006). And Sub-Saharan Africa remains by far the hardest hit region. With only 10 percent of the world's population, it accounts for more than 70% of the estimated 40 million people infected with HIV/AIDS at the end of 2005 (Pollard & Walters 2006; Development Management Associates 2005; UNAIDS report 2006).

This statistics indicates that apart from being a health challenge, HIV/AIDS is a human development issue. It affects virtually all strata of any society, be it the military, education, commerce or other sectors and specifically the young working force.

### **2.1.3. The Social, Economic and Political Impacts of HIV/AIDS**

AIDS is not just a disease; it is also a plagued sign in the contemporary world's social, economic and political scenario. According to UNAIDS (1999), many

developing countries are experiencing exponential growth of HIV/AIDS cases as they only receive about 12% of the world's HIV/AIDS care, research and prevention resources despite having 95% of HIV/AIDS cases. The socioeconomic factors contributing to the spread of HIV/AIDS which disproportionately impact on developing countries include: poverty; illiteracy; gender inequality; increased mobility of populations within and between countries; and rapid industrialization involving the movement of workers from villages to cities, and consequent breakdown of traditional values (UNAIDS 1999).

Because HIV/AIDS usually hits adults who are usually at the age of their economic productivity and are often heads of families, it has a huge impact on life expectancy, exacerbates inequality (e.g. surviving orphans), and increases the burden on health systems. Governance, development and human rights are increasingly being recognized as interdependent, as HIV/AIDS undermines recent development achievements. In a few years of rampant spread, AIDS has become the leading cause of adult death in some developing countries, and may be the most important macroeconomic and social determinant of human welfare and poverty (ibid).

#### **2.1.4. Radio in the Fight Against HIV/AIDS**

To stop the challenges of HIV/AIDS, different world countries have been responding through various awareness campaigns to sensitize their nationals on meaning, mode of spread as well as prevention of the infection. With this regard, the media have played a pivotal role in the fight against HIV/AIDS. According to Global Media AIDS Initiative (2004), it is often said that education is the vaccine against HIV/AIDS. Hence, many media organizations are rising to the challenge by promoting awareness of HIV/AIDS and educating the general public on its control.

The strength of the media in influencing people's perception as well as making society to change their behavior may be an essential tool for fighting medical and social problems such as HIV/AIDS (Omoera et al. 2010).

Health communicators have laid emphasis on the pivotal role of the media in the fast spread of scientific information related to the pandemic and viewed the vehicle of the media, especially, as to Idu and Obinne (2003), the radio as necessary in curtailing the disease . In developing countries, radio and to some extent television are the most effective tools of communication since they cut across literacy boundaries. Kuponiyi (2000) argues that radio is one broadcast medium that almost all experts agree is the most appropriate for rural and urban emancipation programme. Moemeka (1993) as cited in Kamla-Raj (2005) points out that radio beats distance and thus has immediate effect. Radio is also cheap to obtain and widely owned by people due to the advent of the battery – operated transistorized sets.

Report of the Commission on HIV/AIDS and Governance in Africa/CHGA (2008) recommended that prevention programmes should ensure that people receive the basic facts about HIV/AIDS in a language and medium that they can understand and relate to, including intensified mass media campaigns that use radio, television and print media and involve government institutions, civil society groups and the private sector.

In Africa, access to HIV/AIDS information is mainly through radio, health personnel, local leaders, peers, family members, NGOs, and schools (University of Namibia 2000). Mchombu and Mchombu (2007) underscore that among these channels, radio is the dominant one because of affordability, especially for those who live in rural areas.

However, it does not mean that radio is a perfect medium. Although radio is often the preferred medium in rural settings, it has many limitations and is

better if it is used in a more participatory way for development-oriented purposes (Mefalopulos 2008). Even though most scholars agree that radio is a crucial mass medium in the fight against HIV/AIDS in most rural parts of Africa, the very limitations it has may, therefore, hinder the role it can play. According to Crisell (1994), the risks of ambiguity or complete communication failure are high, and so in all kinds of radio much effort is expended on overcoming the limitations of the medium, on establishing the different kinds of context which we would generally be able to see for ourselves.

Experience clearly shows that information alone is not enough: campaigns must also provide emotional and social motivation for change (Family Health International/FHI and Strengthening Community Partnerships for the Empowerment of Orphans and Vulnerable Children/ SCOPE OVC 2002). As to Stoneburner and Low-Beer (2004), this requires going beyond imparting basic facts to promoting discussion of sexuality, gender and relationships. Although the mass media can have a role here too, community campaigns are often more effective in turning awareness into action (Commission on HIV/AIDS and Governance in Africa /CHGA Report 2008).

Accordingly, beyond the role of radio in the fight against HIV/AIDS in the developing world, interpersonal communication efforts too should play a crucial role. Rogers (1974), who used to argue that the top-down nature of mass media plays a palpable role in development, later conceded that mass media alone have played a disappointing role in diffusing technological innovations in less developed nations. He rather argued that the potential of the media is great, if they are used in a complementary combination with interpersonal channels.

#### **2.1.5. Participatory Radio Programs Against HIV/AIDS in Ethiopia**

The AIDS epidemic in Ethiopia is of particular interest because it is the second largest populous country in sub-Saharan Africa, one of the largest HIV-infected

populations in the world (an estimated 1.32 million in 2005), and has some of the lowest socioeconomic and health indicators (World Bank 2005).

Ethiopia is one of the prime examples whereby the severity of the pandemic is also worsened due to medical problems. Given the diverse situations in sub-Saharan Africa, it seems likely that the scarcity of health professionals will not be felt uniformly across countries. Some may be well endowed with medical staff while facing a low-level epidemic. Others may confront a severe epidemic but also have enough doctors. A few may confront a severe epidemic and have a shortage of medical staff. To distinguish these cases, CHGA classified countries by the ratio of people living with HIV/AIDS divided by the number of doctors—and by the severity of the epidemic. CHGA (2004) grouped Ethiopia in the last row of the Sub-Saharan countries group who are facing a severe HIV/AIDS epidemic plus a shortage of doctors as well (CHGA 2008).

Given the largest proportion of the rural society and lack of infrastructures and communication strategies in the rural parts of Ethiopia, it is not surprising if these fractions of the country are given priority in every aspect of HIV/AIDS communication campaigns. In fact, the adult HIV prevalence rate for 2005 is estimated at 2.1% (7.8% urban, 1% rural) (Alemtsehai and Tsegazeab 2008). Though the rural rate is low, when it is seen vis-à-vis its population size, its effect is very high. While there is a growing literature on HIV/AIDS in the rural parts of Ethiopia, the focus has, however, been on the epidemiology side and on urban areas.

The trend of combining radio which is widely accessible and other mass media with interpersonal communication efforts for a better result in combating HIV/AIDS and HTPs is, thus, becoming a useful trend in Ethiopia. The country is striving to improve the exacerbated situation of HIV/AIDS by employing participatory radio program approaches in complement with interpersonal activities in different parts of the country. As Engelbrecht (2007:49) puts it:

“Outside the school environment, one of the few opportunities for Ethiopian children and adolescents to learn about HIV/AIDS risk and prevention are recently developed radio programs.”

A Swedish International Development Cooperation Agency (SIDA) sponsored study in HIV/AIDS communication in a few selected African countries in 2007 by Parker, Rau and Peppia incorporated Ethiopia as part of the study and singled out the basic radio programs that are exclusively devoted to HIV/AIDS prevention and awareness efforts. According to the study, the following radio programs are the fully operating ones in the campaign against the epidemic:

- *Betengna* is a radio series broadcast through Sheger FM 102.1, Amhara Radio, FM 96.9 (Bahir Dar), Southern Nations Nationalities and Peoples/SNNP Radio, and Dimtse Woyane Radio that showcases the diaries of ordinary people living with HIV; it was launched in Ethiopia in October 2006. The series aims to decrease stigma against People Living with HIV/AIDS (PLHA) and promote discussion.
- Since 2000, a radio programme, *Yibekal*, through Ethiopian Radio provides information on HIV/AIDS, promotes discussion around gender inequality and harmful traditions, among other topics. ActionAid also funds a dating service, whereby HIV-positive listeners search partners through the radio station, with a view to promoting stigma reduction.
- A three-year project launched in 2002 to create radio dramas in Addis Ababa which addresses reproductive health, marriage by abduction, spousal communication, and HIV/AIDS. Two dramas are broadcast nationwide on Radio Ethiopia and Harrar Radio regularly.
- A youth-focused talk radio and serialized drama, entitled *Menta Menged* (‘Crossroads’), through Ethiopian Radio, to inform young people about HIV/AIDS, reproductive health and related social issues.
- In 2002, the Johns Hopkins University Health Communication Partnership (JHUCCP) with support from USAID provided technical

assistance to the National Office of Population in Ethiopia in developing a 26-episode weekly radio drama, *Journey of Life*. The drama's objectives included educating urban youth on HIV prevention (p 35-38).

As stated in Parker, Rau & Peppia (2007) the above radio programs were successful in many instances as several reviews of interventions carried out in Ethiopia found increases in awareness and behavioural response, increased Voluntary Counseling and Testing (VCT) demand, increased condom uptake, and stigma reduction, among other successes (ibid).

#### **2.1.6. The GEMC's *Yichalal* Radio Program**

The radio program was established in 2003 as a project targeted in four districts, Chilga, Alefa, Takussa and Lay Armachiho, with current population of 2,957,228 in north Gondar by Save the Children Norway Ethiopia (SCNE) in collaboration with GEMC. At the commencement of the project, in 2003, a KAP (Knowledge, Attitude and Practice) survey was held as a pilot by Shitaye and Yohanis and the GEMC together with the SCNE. The KAP (knowledge, attitude and practice) survey which was conducted in Chilga and Lay Armachiho Woredas about HIV/AIDS identified radio and peer-educators to be the major sources of HIV/AIDS information. It also proved the existence of various misconceptions about the ways of HIV/AIDS transmission in the Woredas.

Taking a lesson from the survey, the GEMC, by complementing the broadcast radio programs with interpersonal communication efforts, established *Yichalal* Radio as an attempt to let the youth to develop knowledge about HIV/AIDS, HTPs, and children's rights and to teach them about how to care of the elderly and the environment.

Primarily, the program embraced 19 in-school and 2 out-of-school listening groups as a pilot project in Lay Armachiho and Chilga Woredas. During the

project years, 2004-2006, and extension period, 2007-2009, the number of listener groups had increased in the 4 Woredas and the project was able to reach 100 formal primary schools and 97 ABECs (Alternative Basic Education for Children out of school), where new radio listening groups were organized to attend a series of broadcast every year.

In 2010, the radio station has members of listening groups in 54 elementary and junior schools. Each listener group is provided a radio set and the group members meet in their school every Saturday from 11:30AM to 1:00 PM to listen to the program and discuss. After attending a year of listening and discussion, the member students who successfully attended the program graduate. Upon graduation, each graduating group is awarded a radio set. The member students discuss the issues they listened and diffuse the information they have for the society and send reports to the radio station. The club members are expected to be active participants in fundraising and supporting OVC (Orphans and Vulnerable Children), bed ridden patients and old aged people. They are expected to disseminate the message they got from the broadcast to their school mates and to the community at large (GEMC 2009).

According to FocasLich (2006) *Yichalal* could empower its listeners due to, what she called “key elements”: the introduction of children’s rights, the listening group structure and the emphasis on community service (p. 29).

Other research works in the area also tried to analyze the appropriateness of the communication strategies and the use of radio to reach remote audiences. Tigist (2009: 54) found out that even though the radio station was applying some participatory communication strategies and was trying to empower students through social/environmental activities, the role or actions of listener groups in the program was more guided by already set criteria rather than emphasizing target listeners’ needs and interests. In the aforementioned researches, the effect of *Yichalal* radio program in its target listeners is, therefore, blurred.

## **2.1.7. The Role of Radio in Combating HIV/AIDS**

### **2.1.7.1. Media Effects and Audience Cognitive Development on HIV/AIDS**

One of the primary focuses of the study of mass communication has been the social, cultural, and psychological effects of media content and use. Despite Berelson's (1959) warning that the field was "withering away," the study of effects has remained active and robust. Much of the empirical research published in the major mass communication journals concerns the effects of the mass media, like radio. There is no longer discussion in that literature about whether the media have effects or not; nor is the field as interested in identifying the different effects that media do have. Instead, most current research attempts to improve the understanding of media effects by refining the theoretical explanations of the processes by which media effects occur (Perse 2001:1).

In general, media effects are usually described as cognitive, affective, or behavioral and are the changes in an individual's knowledge, attitudes, and overt behavior due to exposure to a communication message (Rogers & Steinfatt 1999:116).

According to Perse (2001), cognitive effects are those that concern the acquisition of information—what people learn, how beliefs are structured (or restructured) in the mind, how needs for information are satisfied or not. These effects include concerns about what is learned as well as how much is learned (Perse 2001).

Harries (2004) stated that the media are not only the magic windows through which we view the world, but also the doors through which ideas enter our minds. He further stated that our experience with media is a major way that we acquire knowledge about the world; this knowledge then has consequences in terms of attitudes and behavior. We may call this a cognitive approach to mass communication because the emphasis is on the way that our minds create knowledge— indeed, even a mental reality—about the world based on our

experience with the media. This mental reality then becomes the basis for various attitudes and behaviors, which have a great impact on our lives (ibid).

When it comes to HIV/AIDS, the current focus on education as a primary tool in lessening the spread of the pandemic highlights the need for estimating HIV-related knowledge levels in the general population, and for understanding the factors that affect the diffusion of HIV-related information (LeBlanc 1993:23).

The mass media are very useful tools in the fight against HIV/AIDS scourge. As stated in the aforementioned sub topics, despite access to HIV/AIDS information is mainly through radio, health personnel, local leaders, peers, family members, NGOs and schools, radio remains the dominant channel of communication because of affordability, especially for those who live in rural areas of Africa (Mchombu & Mchombu 2007).

United Nations Development Program /UNDP (2006) underscores the particular importance of radio in creating knowledge about HIV/AIDS campaigns because of its reach to people of high illiteracy rates, particularly in rural areas and among women, accessibility to the poor and increasingly interactive character. Forman (2005) also stated that the relative prevalence of radio in Africa makes the medium key for disseminating information on reducing vulnerability to AIDS.

#### **2.1.7.2. Radio's Educating Role on HIV/AIDS**

The radio has immense reach in the developing world and radio listening still remains an important source of information for a large number of listeners particularly in rural arenas. Considering this aspect, strategies can be adopted to provide HIV/AIDS education through radio.

The absence of a cure or vaccine for HIV/AIDS and the urgent need to reach people on the impact of the disease as well as the need to prevent it have

resulted in the emphasis on mass education of populations. This inevitably means that effective communication approaches and strategies should be identified and applied to reach people in a way that affects them emotionally and motivates them to change their behavior. Changing human behavior is a concept and goal that has long eluded researchers and program/ project officers, since human beings are individually affected by different factors in terms of changing attitude and their behavior.

In the Family Health International /FHI (1997) experience, an effective educational communication model which affects behavior change involves five steps:

- awareness of the problem;
- gathering of knowledge and skills by the target audience;
- motivation to take action;
- preparation for trial of the new behavior; and
- the sustenance of the new behavior

As Kiai (1994) stated the primary aim of current mass education on HIV/AIDS is to reach those whose HIV status is negative to encourage them to retain this status; to support those whose status is positive to urge them to be careful so as not to spread the virus and to maintain hope through positive living; and generally to educate society as a whole to develop sustainable structures that will contribute to the prevention and effective management of HIV/AIDS. He also stated that ways in which the mass media can support educational efforts on HIV/AIDS prevention present a vital question in these educational efforts.

### **2.1.7.3. Radio's Advocacy Role**

Family Health International/FHI (2005) defined advocacy as an organized effort to change governmental, public or organizational policies; to redefine norms and procedures; and/or to support protocols for the ultimate benefit of groups such

as people living with HIV/AIDS (PLHA), female sex workers (FSW), orphans and vulnerable children (OVC) and populations affected by existing legislation, norms and procedures. Advocacy also includes getting important people to speak up, drawing attention to important issues, defending new ideas or policies before those needing to hear about them and directing decision makers toward solutions (FHI 2005).

Effective advocacy contributes to the creation of an enabling environment for cumulative change of policies, norms and regulations affecting the behavior of individuals and communities (ibid). Servaes (2000) also stated that the primary aim of advocacy is fostering public policies that support the solution of an issue or problem.

Advocacy role is better played by radio which seems to be the most appropriate medium for development (Sposato & Smith 2005). With the proliferation of community radios in most parts of the Third World, it is possible to use these as local concertizing agents. Besides providing much needed information to the local audiences, it can focus on local problems with a certain commitment. Local radio can transform communities by giving a voice to the people, increasing the free flow of accurate information, and celebrating local culture in music, songs, and story-telling (Srampickal 2006:10).

## **2.2. Extensively Used Strategies and Models in HIV/AIDS Communication Campaigns**

### **2.2.1. Communication Strategies on HIV/AIDS**

This part of the literature review incorporates the widely used ways in which health communicators try to address issues of the pandemic. Participatory communication, behavioural change communication (BCC), the integration of mass media with interpersonal communication and diffusion of innovation are presented and discussed by considering various literatures written previously.

### **2.2.1.1. Participatory Communication**

According to Tufte and Mefalopulos (2009), participatory communication is an approach based on dialogue, which allows the sharing of information, perceptions and opinions among the various stakeholders and thereby facilitates their empowerment, especially for those who are most vulnerable and marginalized. They also reckoned that participatory communication is not just the exchange of information and experiences but also “the exploration and generation of new knowledge aimed at addressing situations that need to be improved” (Tufte and Mefalopulos 2009).

During the 1950s, experiences with participatory communication first appeared when the Brazilian adult educator Paulo Freire worked with adult literacy campaigns among the poor peasants in North-Eastern Brazil to empower landless peasants to formulate their own demands and to liberate themselves from oppressive conditions for a better life. From this experience, he grew into one of the most influential proponents for participatory communication theory and practice. Central to this line of thinking was the emphasis on letting the stakeholders get involved in the development process and determine the outcome, rather than imposing a pre-established (i.e. already decided by external actors) outcome (Tufte and Mefalopulos 2009).

There are two major approaches to participatory communication that should be fulfilled by every communication project which calls itself participatory: the dialogical pedagogy of Paulo Freire, and; the ideas of access, participation and self-management articulated in the United Nations Educational, Scientific and Cultural Organization/UNESCO debates of the 1970s (Serveas 2008).

The Freirian argument works by a dual theoretical strategy. He insists that subjugated peoples must be treated as fully human subjects in any political process. This implies dialogical communication. Individual opportunity, Freire stresses, is no solution to general situations of poverty and cultural subjugation.

One problem with Freire is, however, that his theory of dialogical communication is based on group dialogue rather than such amplifying media as radio, print and television. Freire also gives little attention to the language or form of communication, devoting most of his discussion to the intentions of communication actions (Serveas 2008: 170-171).

The second discourse about participatory communication is the UNESCO language about *self management*, *access* and *participation* from the 1977 meeting in Belgrade, the former Yugoslavia. *Access* was defined as the use of media for public service. It may be defined in terms of the opportunities available to the public to choose varied and relevant programs and to have a means of feedback to transmit its reactions and demands to production organizations. *Participation* also implied a higher level of public involvement in communication systems. It includes the involvement of the public in the production process, and also in the management and planning of communication systems. On the other hand, *self-management* is the most advanced form of participation as the public exercises the power of decision-making within communication enterprises and is also fully involved in the formulation of communication policies and plans (ibid).

According to Tufte and Mefalopulos (2009), what is often not made explicit in participatory communication approaches, however, is the important role of media access, which is increasingly crucial considering the rapid changes in media tools, coverage and worldwide use. Thus, participatory communication is also about visibility and voice in the mediated public sphere.

#### **2.2.1.2. Behavior Change Communication (BCC)**

According to Family Health International (2002), behavior change communication (BCC) is an interactive process with communities (as integrated with an overall program) to develop tailored messages and approaches using a variety of communication channels to develop positive behaviors; promote and

sustain individual, community and societal behavior change; and maintain appropriate behaviors.

In the context of the AIDS epidemic, BCC is part of a comprehensive program that includes both services (medical, social, psychological and spiritual) and commodities (e.g., condoms, needles and syringes). Before individuals and communities can reduce their level of risk or change their behaviors, they must first understand basic facts about HIV and AIDS, adopt key attitudes, learn a set of skills and have access to appropriate products and services. They must also perceive their environment as supporting behavior change and the maintenance of safe behaviors, as well as supportive of seeking appropriate treatment for prevention, care and support (ibid).

BCC is an integral component of a comprehensive HIV/AIDS prevention, care and support program. It has a number of different but interrelated roles. They include increase knowledge, stimulate community dialogue, promote essential attitude change, reduce stigma and discrimination, create a demand for information and services, advocate and promote services for prevention, care and support (ibid).

### **2.2.1.3. Integrating Mass Media with Interpersonal Communication**

Interpersonal channels are those which involve a face to face message transfer between two or more individuals. According to Hanan (2009) interpersonal communication is the most effective component for behavior change especially in HIV/AIDS prevention campaign because message is delivered by a person who belongs to a particular group to whom message is constructed; content of message is more harmonized with local culture, tradition, norms and values; interpersonal communication has been considered a successful way in addressing the sensitive issues of sexual behavior; and the mass media campaigns are typically of limited duration. For sustained promotions among

individuals and groups, it requires an interpersonal communication. As Rogers (1974), research evidences in less developed countries generally indicate that interpersonal channels are of much greater importance than mass media channels. However, interpersonal communication reaches fewer people than mass media and it results in behavior change that cannot be evaluated as easily as creating and maintaining awareness through the mass media (Hanan 2009). Therefore, to overcome the weaknesses in interpersonal communication, the combined use of radio with interpersonal communication strategies can play a significant role in behavior change for effective communication campaign for HIV/AIDS prevention (Rogers 1974; Serveas 2008).

Generally, mass media campaigns and interpersonal communication complement each other in the development of communication interventions for HIV/AIDS prevention and care. Mass media can convey information effectively and thereby provide effective support for face-to-face communication. The combination of radio with interpersonal communication allows for addressing diverse individual and group concern while honoring the delicate, private nature of human sexuality. In addition, Simons et.al (1997) point out that a one dimensional approach to health promotion, such as reliance on radio campaigns or other single-component communication activities, has been shown to be insufficient to achieve program goals (Hanan 2009).

### **Effective Experiences of Integrating Mass Media with Interpersonal Communication**

Integrating mass media with interpersonal communication is not a new communication approach in different fields. It has rather been experienced in various countries and became effective in some circumstances. Farm Radio International (2008: 19-59) has presented findings from selected rural radio effectiveness evaluations which were using mass media in a complimentary combination with interpersonal communication. These effective experiences are presented under.

India is an example. India is known for its radio based development programs in integration with group discussions in its rural parts since 1933 when “rural radio listening communities” were formed in Bhiwandi to listen to rural broadcasts in the Marathi, Gujarati and Kannada languages. In the 1950s the Indian government in collaboration with the United Nations Educational, Scientific and Cultural Organization (UNESCO) introduced a carefully designed network of rural radio forums, small listening and discussion groups that meet regularly to receive a special radio programme and then discuss. These groups were known as the *Charcha Mandals* that were first implemented in the Poona region. India’s radio forums provided a top-down component of important rural development information, especially on agriculture, that was transformed into horizontal communications through participatory discussions. Rogers, Braun and Vermilion (1977: 371) also stated that by 1959, the Indian government had attempted to introduce the rural radio forum project nationally, with one forum in each community development block of 200 square miles and a population range of 60,000 to 80,000. Consisting between 12 and 20 members, India’s forums were dominated by men, farmers and elders. Each forum had a chairperson—usually a village elder or school teacher—as well as a secretary and regular members.

Rogers, Braun and Vermilion (1977) pointed out that organized group listening and discussion improves knowledge gain and that the radio forums involving peasants in participatory learning and action led them to improvements in the quality of their lives. They also added that on the basis of the program and discussion, community members of a radio forum were able to decide on what relevant action to take. The Indian radio forums also assured that multi-channel communication than single channel communication.

The Philippines has also been undertaking discussion in integration with a rural radio station called DZLB. Radio DZLB was established in 1962 by the College of

Agriculture (University of the Philippines) to assist the College's research on effective ways to disseminate agricultural knowledge and to serve as an instrument of extension. The radio program involved the rural youth (students) and farmers for discussion and sharing of knowledge after the broadcast programs. It was then apparent that the use of radio schools alongside dialogical and interpersonal communications facilitates higher knowledge gain among school participants. A recommendation was also offered saying if the effort was meant to sustain, subsequent actions, follow-up activities should be done.

Tanzania has also been experiencing the rural broadcasting together with follow-up discussions since the 1960's. By 1973, a larger, cheap but effective radio-based study group campaign, *Mtu ni Afya* (Man is Health), was organized and implemented, reaching two million aiming at increasing public awareness of healthy living; providing simple information on medical symptoms and the prevention of specific diseases; and empowering literacy campaign participants to continue improving their reading skills (Hall 1978; Hall and Dodds 1977). Adapting China's and Cuba's health and literacy campaigns, Tanzania's forum project was a multi-media approach supplemented by visual aids in the form of films, pictures, posters, charts, and fortnightly listening guides for the farm forum programs (Rogers, Braun and Vermilion 1977).

In the group discussions of the Tanzania's forum project, the convener, who was also the secretary, was vital in organizing meetings and venues and ensuring radio sets (Rogers, Braun and Vermilion, 1977). The secretary convener was likely to be the secretary of the village council, the village level extension worker or the teacher of the village. Listenership centered on weekly or biweekly half-hour programmes on national radio focusing on rural development, "intended to stimulate discussion and action among the participants" (Rogers, Braun and Vermilion 1977: 371).

Finally, it was found out that the *Mtu ni Afya* health education campaign improved people's knowledge of, and practices in relation to, health issues by providing simple information on symptoms, prevention and diseases. Rogers et al (1977: 375) also observe that due to increased awareness of general health and development among rural people, "an atmosphere has been created in which people in rural areas have been able to take control of their own development, politics."

Farm Radio International (2008) also incorporated the rural parts of Malawi, Mali, Mozambique, Ghana and South Africa to be areas where the practice of integrating radio with interpersonal communication became effective.

#### **2.2.1.4. Diffusion of Innovations Approach**

According to Rogers (1983), diffusion is the process by which an innovation is communicated through certain channels over time among the members of a social system. He further elaborated it as a kind of social change by which alteration occurs when new ideas are invented, diffused, and are adopted or rejected, leading to certain consequences in the structure and function of a social system.

In the diffusion of innovations, Rogers (1983) identified four elements: the innovation, communication channels, time and the social system. The innovation refers to "an idea, practice, or object that is perceived as new to an individual". The "newness" of an innovation is expressed in terms of knowledge, persuasion, or a decision to adopt. A communication channel is the way through which messages get from one individual to another. The nature of the information-exchange relationship between the pair of individuals determines the conditions under which a source will or will not transmit the innovation to the receiver, and the effect of the transfer. Time is an integral part of every activity in the diffusion of innovations. A social system is defined as a set of

interrelated units that are engaged in joint problem solving to accomplish a common goal. All members of a social system cooperate at least to the extent of seeking to solve a common problem in order to reach a mutual goal. This sharing of a common objective binds the system together (Rogers 1983: 11-24).

When it comes to HIV/AIDS, diffusion of innovations theory provides useful insight into the difficulty of achieving the behavior change necessary to control the HIV/AIDS epidemic in developing countries. The diffusion of innovations literature is full of examples of successful innovations like hybrid corn, modern math, new prescription drugs, and family planning. However, the changes in behavior needed to halt the HIV/AIDS epidemic constitute what Rogers has marked a “preventive innovation,” defined as “an idea that an individual adopts at one point in time in order to lower the probability that some future unwanted event may occur” (Rogers 2003). In countries where HIV transmission occurs primarily through sexual relations, the specific behaviors include abstinence, being faithful (to an uninfected partner), or condom use—known as the “ABCs.” In countries with a high level of injection drug use, the behavior change intervention includes both needle exchange for injection drug users and adherence to the ABCs (Bertrand 2004: 114).

### **2.2.2. Theories and Models Used in HIV/AIDS Prevention**

#### **The Health Belief Model (HBM)**

UNAIDS & Pennsylvania State University (PENNSTATE) (1999) state that the Health Belief Model (HBM) focuses on individuals’ perceptions of the threat posed by a health problem, the benefits of avoiding the threat, and factors influencing the decision to act.

HBM was developed in the 1950’s to predict individual response to, and use of, screening and other preventive health services. Since the 1950s the HBM was adapted to explore a variety of health related behaviors, including sexual risk

behaviors and the transmission of HIV/AIDS. As to Rosenstock et.al (1994), the model consists of six key variables. These are:

1. **Perceived Susceptibility:** refers to an individual's perception of susceptibility to the health condition. Applications of this concept include a) defining populations at risk and their risk levels; b) personalizing risk based on a person's traits or behaviours and c) heightening perceived susceptibility if it is too low.
2. **Perceived Severity:** refers to believed serious consequences or threats that the condition has. It includes evaluations of medical, clinical, and possible social consequences. It also involves specifying and describing consequences of the risk and the condition.
3. **Perceived Benefits:** are the believed effectiveness of personal strategies that would reduce susceptibility to the condition or its severity to the threat of illness. Applications include, a) defining the action to be taken [how, when & where]; b) clarifying the positive effects to be expected and c) describing evidence of effectiveness.
4. **Perceived Barriers:** are the potential negative consequences that may result from taking particular health actions, including physical, psychological, and financial demands. Those seeking to bring about behavior change would need to identify and reduce barriers through reassurance, incentives and assistance.
5. **Cues to Action:** factors either bodily (e.g. physical symptoms of a health condition) or environmental (e.g. medical publicity) that prompt action. Applications for this concept include a) providing how-to information, b) promoting awareness and c) providing reminders.
6. **Self-Efficacy:** The belief in ability to successfully perform an action required to produce the desired outcomes. This concept was introduced by Albert Bandura in 1977 and when applied it includes providing training, guidance and positive reinforcement (Media 2008:4-5).

As stated in the U.S. Department of Health and Human Services National Institute of Health (2005) since health motivation is its central focus, the HBM is a good fit for addressing problem behaviors that evoke health concerns (e.g., high-risk sexual behavior and the possibility of contracting HIV). Together, the six constructs of the HBM provide a useful framework for designing both short-term and long-term behavior change strategies.

The model has perhaps some limitations that may restrict its effects. The most important limitation is that the model does not incorporate the influence of social norms and peer influences on people's decisions regarding their health behaviors (Media 2008) and the other limitations, according to Rosenstock et.al (1994) include it does not take into consideration environmental or economic factors that may influence health behaviors (Media 2008) .

When applying the HBM to planning health programs, the U.S. Department of Health and Human Services National Institute of Health (2005) advised that, practitioners should ground their efforts in an understanding of how susceptible the target population thinks to the health problem, whether they believe it is serious, and whether they believe action can reduce the threat at an acceptable cost.

### **Theory of Planned Behavior (TPB) and Theory of Reasoned Action (TRA)**

The Theory of Planned Behavior (TPB) and the associated Theory of Reasoned Action (TRA) explore the relationship between behavior and beliefs, attitudes, and intentions.

Both the TPB and the TRA assume *behavioral intention* as the most important determinant of behavior. According to these models, behavioral intention is influenced by a person's *attitude* toward performing a behavior, and by beliefs about whether individuals who are important to the person approve or

disapprove of the behavior (*subjective norm*). The TPB and TRA assume all other factors (e.g., culture, the environment) operate through the models' constructs, and do not independently explain the likelihood that a person will behave a certain way (U.S. Department of Health and Human Services National Institute of Health 2005: 16).

The TPB differs from the TRA in that it includes one additional construct, *perceived behavioral control*; this construct has to do with people's beliefs that they can control a particular behavior. Azjen and Driver (1991) added this construct to account for situations in which people's behavior, or behavioral intention, is influenced by factors beyond their control. They argued that people might try harder to perform a behavior if they feel they have a high degree of control over it. It has application beyond these limited situations, however. People's perceptions about controllability may have an important influence on behavior (*ibid*).

The Theory of Reasoned Action (TRA), on the other hand, has been used to predict a variety of human behaviours since 1967 by examining attitudes, beliefs, behavioral intentions, and observed, expressed acts. TRA is based on the premise that humans are rational and that the behaviours being explored are under volitional control (Media 2008).

As to Media (2008) the limitation of the individualistic approach of the Theory of Reasoned Action is that it does not or cannot consider the role of the environmental and structural issues.

### **Social Learning Theory**

According to UNAIDS/ PENNSTATE (1999) social learning theory is based on the assumption that individual behavior is the result of interaction among cognition, behavior, environment and physiology. The Social Learning theory, according to Media (2008), most frequently borrowed from the Caribbean Bandura's Social

Cognitive Theory also referred to as the Social Learning Theory (which is an earlier version).

According to the Social Learning theory providing information alone is not enough to change behavior. Sustained behaviour change requires the skills to engage in behaviour change and the ability to use these skills consistently. The theory suggests that people learn from each other through observation, imitation and modeling. According to Bandura (1973) four components are required for behaviour change. These are:

- **Awareness:** The first component is to raise awareness and the knowledge of health risk. This stage is to convince people that they can change their behaviour. In the case of HIV, this component is where you educate people about the virus and show them that they can change.

- **Self-Control:** This component is used to develop the self-control and risk-reduction skills needed to prevent the behaviour. Within this component, you show people what makes their behaviour risky and how they can change it.

- **Self-Efficacy:** This component is used to increase an individual's self-efficacy in implementing the necessary or safe behaviours or habits. This may include specific efforts to show people how to use condoms, how to negotiate safer sex and how to say "no".

- **Social Support:** A component to build social support for the individual as s/he engages in new behaviours. This could be in the form of support groups or appropriate peer groups (Media 2008: 12).

There are however some limitations to this theory. Behavior was found to be more consistent than is argued by Bandura's theory, which focuses a great deal on the situation. Some researchers have argued that the theory lacks attention to biological or hormonal processes (ibid).

### **The AIDS Risk Reduction Model**

The model is based on the belief that one has to label a behavior as risky before as change can be effected. Once the behavior is considered risky, a commitment is made to reduce the behavior before action to perform the behavior is expected. Fear and anxiety or social norms are considered factors that influence moving from one stage to the next (U.S. Department of Health and Human Services National Institute of Health 2005: 16).

## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **3.1. Introduction**

This research is a quasi-experimental study that assessed and analyzed the knowledge differences, about HIV/AIDS, of the two groups of *Yichalal* Radio program listeners, i.e. the listener groups (students) who undergo a sort of follow-up discussion in each week in their school after the program, and those listeners who are parts of the radio program's target area but have no *Yichalal* Radio listener group in their school for discussion and other interpersonal communication activities at the end of the program.

As to Vanderstoep & Johnston (2009) quasi- experiment is a study that takes place in a real - life setting as opposed to a laboratory. Accordingly, the method will help to assess knowledge towards HIV/AIDS of the listener groups in the natural setting.

The research also pondered the advantage/s of supporting the radio program with interpersonal communication activities. To that end, it explored the effects of the interpersonal communication efforts that are combined with the radio program.

#### **3.2. Research Approach**

The research dominantly employed a quantitative approach to measure, and find out whether there exists a significant knowledge differences between the levels of the research subjects' understanding/knowledge of HIV/AIDS. However, in order to see the potential integration effects of the radio program with interpersonal communication and to triangulate the quantitative data, some qualitative aspects were used. Subsequently, the questionnaire which tested the listening groups' knowledge of HIV/AIDS was used in supplement with four Focus Group Discussions/FGDs and a semi-structured, in-depth interview to triangulate the research results and to find out the integration effect of the two aforesaid communication forms respectively. Bryman (1988) underlines that when

quantitative and qualitative research are jointly pursued, much more complete accounts of social reality can be realized. Thus, by mixing both quantitative and qualitative approaches, the research tried to encompass the whole scene behind the research objectives.

### **3.3. Population and Setting of the Study**

*Yichalal* Radio project is targeted at four districts (woredas)- Chilga, Alefa, Takussa and Lay Armachiho- with current population of 2,957,228 in north Gondar. In some of the elementary & junior schools of these Woredas, the project has set up groups of listening students. These students listen and undergo follow-up discussions after attending *Yichalal* Radio, which broadcasts such issues as HIV/AIDS, HTPs and child right, each Saturday. Upon completing a year of listening and discussion, each member of the listening group student is awarded a certificate of graduation and a radio set. At the commencement (January each year), a school which is part of the project contains twenty one students for the listening group. But, through time, dropouts may exist. When students quit listening and discussion anytime after the program began, they are not substituted by other students for the substituent doesn't attend the program from the outset and may hamper the discussion process. Rather, the leftovers proceed to listen and discuss the program in their school and finish the year (Personal Interview with Ato Getnet, Coordinator of Gondar Educational Media center/GEMC).

According to Ato Getnet, the amount of schools the project embraces each year varies in accordance with the amount of funds the radio station gets. Last year (2009/10) for example, it had listener groups in 100 schools. But in 2010/11, the number of schools with listener groups is 54 within the target area.

In this research there were two groups of research subjects: in operational terms, the experimental group and the control group. The listener groups, students who were found in the 54 target areas' elementary & junior schools to make *Yichalal* Radio Listening Groups, and undertook sorts of discussion after

*Yichalal* Radio program, each Saturday from 11:30AM to 1 PM, were the experimental group. In number they were 1134. The rest elementary & junior school students of the four Woredas, whose school had no *Yichalal* Radio listener group and had no formal interpersonal communication engagements but regularly listen the radio program at their home are the control group.

The research tested and then pointed out the differences between the knowledge of the two listener groups about HIV/AIDS. Hence, the knowledge, about HIV/AIDS, of the two listener groups is the dependent variable whose outcome is reliant on the impact of the independent variable, which is in this case, listening to the broadcast radio programs and the formal follow-up discussions (in case of the listening groups) pertaining to HIV/AIDS.

### **3.4. Samples and Sampling Techniques of the Study**

By using convenience sampling, samples were taken out of both groups of listeners from the target area. Since the radio program was disseminated to the four target districts likewise and due to the similarities of facilities and interpersonal communication activities, choosing the nearby district was believed to have no significant repercussion on the findings of the research. Thus, convenience sampling was used to choose the more suitable districts.

Above all, when samples are chosen, as quasi-experimental researchers agree, the question of internal validity is decisive and can affect the findings of a given research in the field. As to Ahfad University for Women (2008), internal validity refers to the degree to which the conclusions of an investigation are in fact based solely on the effect of the experimental variable.

According to Crano & Brewer (2008), the purpose of the design of experiments is oriented toward eliminating possible alternative explanations of research results (i.e., variations in scores on the dependent variable) that are unrelated to the effects of the treatment (independent variable) of interest. In this case, quasi –

experiments are particularly susceptible to these problems (Vanderstoep & Johnston 2009).

The researcher, therefore, considered the possible threats to internal validity before the actual data gathering began. This research was, thus, based on the pilot conducted before the data was gathered. In the pilot, the researcher went to the research area and identified the non-listening research subjects that could match in every aspect of background information about HIV/AIDS except the integrated interpersonal communication the listener group members experience after listening to *Yichalal* Radio. This stage was, thus, decisive in trying to avoid the possible causes (extraneous variables) that affect the research results. The exposure of the listener groups to other additional media outlets, than the radio program, that transmit information about HIV/AIDS, and other knowledge acquiring methods about the epidemic had been found out and those listeners who have regular exposure to other knowledge giving outlets about HIV/AIDS were disregarded as they may affect the research outcomes. Listeners, in either way, who dominantly subscribe to *Yichalal* Radio program for their consumption, regarding the epidemic, had been chosen. Hence, both listener groups who dominantly subscribe to *Yichalal* Radio program for their HIV/AIDS knowledge consumption were purposefully chosen. Luckily, the whole listening member students of the two nearby schools who had listener group students were found to use *Yichalal* Radio dominantly for their HIV/AIDS knowledge consumption. Accordingly, all of the listening member students of the two schools were used for the research.

Age, sex, class level and previous semester average (academic performance) of students were also considered to be other extraneous variables. As stated in Ahfad University for Women (2008), *precision matching* is one means of resolving the threat of internal validity by making sure that each subject in one group is matched in terms of some already set variables that are deemed to affect the research result, with a subject in the other group. Hence, the researcher also matched the age, class level, and academic performance of the listener groups

with the non-listener ones for that reduces, if not resolves, the possible causes of history and maturation. Generally, subjects that have more or less similar social/media exposure, educational background, academic performance, age and sex were regarded from both sides of the experimental and control groups.

Purposeful sampling was, therefore, the other sampling technique employed to choose the research subjects. This sampling technique was used to match the non-listening group research subjects of the other convenient schools in age, grade level, sex and academic performance with the listening ones who were wholly taken primarily from the two convenient schools

Since *contamination*, which refers to the possible spillover effects from the experimental to the controlled group (Ahfad University for Women 2008), may affect the result, subjects were chosen from different schools/vicinities/kebeles. This is because the possibility of interaction between the experimental and control groups minimizes the effect on the research outcome.

As far as the sample size is concerned, for the questionnaire, two convenient schools- Aykel Elementary and Junior School and Seraba Junior Secondary School- that had listener groups were chosen. In these schools, 23 students (13 from Aykel and 10 from Seraba) were found attending the program regularly. All students who make listener groups in both schools were taken for the study and each was examined in a classroom in the presence of the researcher and a facilitator. From the non-listener groups, in the same way, two convenient schools- Negadie Bahir elementary and junior school (10 students) and Serako elementary and junior school (13 students) were chosen and the same number of students who were matched in every aspect of the aforementioned elements were also taken from schools that have no *Yichalal* Radio listening groups. The following tables show how the listening groups' samples demographic and academic profiles (Aykel and Seraba Elementary and Junior School students) were matched with the non-listening groups' samples demographic and

academic profiles (Serako and Negadie Bahir Elementary and Junior School students) for the questionnaire.

*Table1: Questionnaire samples that were taken from the listening (Aykel& Seraba) and non-listening (Serako& Negadie Bahir) groups of Yichalal Radio*

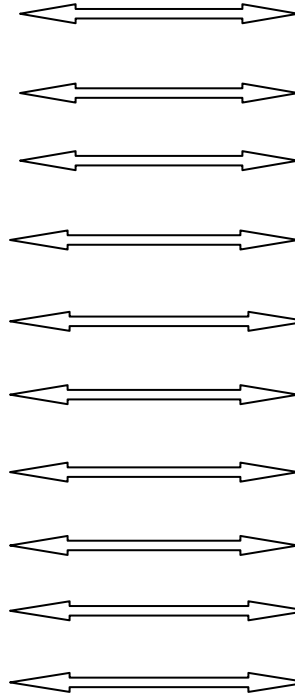
Aykel

Serako

Student	Sex	Age	Grade	Previous Year Average		Student	Sex	Age	Grade	Previous Year Average
1	F	13	8	55.5	↔	1	F	13	8	55.5
2	F	14	8	55.3	↔	2	F	15	8	55.5
3	F	15	8	79.1	↔	3	F	14	8	78.5
4	F	15	8	63.3	↔	4	F	14	8	66.6
5	F	15	8	62.8	↔	5	F	14	8	60.5
6	M	12	7	93.3	↔	6	M	13	7	95
7	M	13	8	89.5	↔	7	M	13	8	89
8	M	13	8	73.7	↔	8	M	13	8	71
9	M	15	8	54.7	↔	9	M	14	8	54
10	M	15	8	77	↔	10	M	16	8	79
11	M	15	8	92	↔	11	M	15	8	93
12	M	16	8	82.3	↔	12	M	17	8	87
13	M	16	8	74.1	↔	13	M	14	8	79

Student	Sex	Age	Grade	Previous Year
1	F	13	7	67
2	F	14	7	75
3	F	14	7	72.3
4	F	14	8	61
5	F	14	8	61.4
6	F	15	8	60.8
7	F	15	8	61
8	M	13	7	90.8
9	M	15	7	94.8
10	M	16	7	85.7

Seraba



N/Bahir

Student	Sex	Age	Grade	Previous Year
1	F	13	7	68
2	F	14	7	75
3	F	15	7	75
4	F	14	8	63.5
5	F	15	8	63
6	F	15	8	61
7	F	15	8	65.3
8	M	13	7	91
9	M	15	7	93.8
10	M	16	7	87.2

School	Students' Age		Students' Sex		Students' Previous Year Average (in %)					Grade		Total No. of Sts
	10-13	14-17	M	F	50-60	61-70	71-80	81-90	>90	7 <sup>th</sup>	8 <sup>th</sup>	
Aykel& Seraba	6	17	11	12	3	7	6	3	4	7	16	23
Serako& Negadie Bahir	6	17	11	12	3	7	6	3	4	7	16	23
Total No. of Sts	12	34	22	24	6	14	12	6	8	14	32	46

For each of the four focus group discussions, seven students were taken from each representative school. In schools which have listening groups, each focus group members were randomly chosen out of the students who filled in the questionnaire. On the other hand, the focus groups of the non-listener groups were chosen by matching the age, class level, academic performance and sex of the focus group members of the listening groups. The following tables show how the listening groups' samples demographic and academic profiles (Aykel and Seraba Elementary and Junior School students) were matched with the non-listening groups' samples demographic and academic profiles (Serako and Negadie Bahir Elementary and Junior School students) for the FGDs.

*Table 2: Focus group discussant samples that were taken from the listening (Aykel& Seraba) and non-listening (Serako& Negadie Bahir) groups of Yichalal Radio*

Aykel

Serako

Student	Sex	Age	Grade	Previous Year Average		Student	Sex	Age	Grade	Previous Year Average
1	F	15	8	79.1	↔	1	F	14	8	78.5
2	F	15	8	63.3	↔	2	F	14	8	66.6
3	F	15	8	62.8	↔	3	F	14	8	60.5
4	M	12	7	93.3	↔	4	M	13	7	95
5	M	13	8	89.5	↔	5	M	13	8	89
6	M	15	8	77	↔	6	M	16	8	79
7	M	16	8	74.1	↔	7	M	14	8	79

*Seraba                      N/Bahir*

Student	Sex	Age	Grade	Previous Year Average		Student	Sex	Age	Grade	Previous Year Average
1	F	13	7	67	↔	1	F	13	7	68
2	F	14	7	72.3	↔	2	F	15	7	75
3	F	14	8	61	↔	3	F	14	8	63.5
4	F	15	8	60.8	↔	4	F	15	8	61
5	F	15	8	61	↔	5	F	15	8	65.3
6	M	15	7	94.8	↔	6	M	15	7	93.8
7	M	16	7	85.7	↔	7	M	16	7	87.2

School	Students' Age		Students' Sex		Students' Previous Year Average (in %)					Grade		Total No. of Sts
	10-13	14-17	M	F	50-60	61-70	71-80	81-90	>90	7 <sup>th</sup>	8 <sup>th</sup>	
Aykel& Seraba	3	11	6	8	0	6	4	2	2	5	9	14
Serako& Negadie Bahir	3	11	6	8	0	6	4	2	2	5	9	14
Total No. of Sts	6	22	12	16	0	12	8	4	4	10	18	28

Moreover, a semi-structured in-depth interview was undertaken with the coordinator of GEMC's *Yichalal* Radio.

### 3.5. Data Gathering Tools

The data were gathered by using questionnaire (test), FGDs and in-depth interview. The test about HIV/AIDS knowledge was adapted from other

HIV/AIDS knowledge measures and previously broadcast contents of *Yichalal* Radio programs, the researcher tested the knowledge of the two groups of listeners about HIV/AIDS. Items in the questionnaire (test) were adapted from the broadcast messages of *Yichalal* Radio and from the research works of Zimet (1992), Koopman et al. (1990) and Carey & Schroder (2002). These scholars employed some of the items in the Sub-Saharan regions previously to measure people's knowledge of HIV/AIDS and they assured the reliability and validity of the items.

Before the actual data gathering, the questionnaire including the test was piloted twice for ten elementary and junior school students for the sake of checking reliability. Accordingly, some blurred statements were rectified and the other two statements were cancelled for they were found to be irrelevant to the research. The Cronbach's Alpha test for items' internal reliability was found to be 0.91 indicating that the items had a high internal consistency which could be employed. The questionnaire, was, then, administered for the selected samples of the two groups of listeners. Through the process, their knowledge, about HIV/AIDS, was measured. The FGDs also helped to further supplement the quantitative data gathered through the questionnaire. A semi-structured in-depth interview was also conducted with the coordinator of the GEMC. Subsequently, in line with supplementing the questionnaire results in the knowledge of the two groups of listeners, the possible advantage/s of combining the radio program with interpersonal communication activities were found out.

For the FGDs, 14 students, 7 from each *Yichalal* Radio listening group, were randomly selected. By matching the sex, age, grade level and academic performance, the same number of samples were chosen among the non-listening groups. Based on the adapted ideas of the transmitted programs, the researcher, together with a moderator, who used to be a coordinator in the formal follow-up discussions of the listener groups, undertook FGDs with both listener groups. In doing so, the researcher assessed the knowledge of the two listener groups. The

FGDs help to triangulate the findings of the questionnaire and the in-depth interview. They also indicate the possible advantage/s of *Yichalal* Radio program, in the fight against HIV/AIDS, when it was combined with interpersonal communication activities.

### **3.6. Data Analysis Procedure**

The in-depth interview, the FGDs and the questionnaire were primarily prepared in Amharic which the research subjects and informant (the interviewee) use to speak, read and write. The responses were, then, tape-recorded. Then, the data were transcribed and later translated in to English. Finally, when the questionnaire results were analyzed via t-test and other descriptive statistical tools and when the data were presented in the forms of tables, the in-depth interview and FGDs were thematically analyzed and interpreted.

## CHAPTER FOUR

### DATA PRESENTATION AND ANALYSIS

This chapter is devoted to presenting, discussing and analyzing the data gathered through the questionnaire, the FGDs and the in-depth interview. As stated in the previous chapters, the purpose of this research is to measure and find out whether differences exist in the HIV/AIDS knowledge of the two GEMC's *Yichalal* Radio listeners and thereby to analyze whether integrating the radio program with interpersonal communication enhanced the effect of the program or not. As the main tool of the research, the questionnaire is presented quantitatively by using tables and percentages. At the end of the discussions that follow the tables, the data that are gathered through the FGDs and the interview are complementarily used and analyzed as needed. Independent t-test samples were also carried out as necessary.

#### 4.1. Demographic Distribution of Respondents

As vividly pointed out in the methodology, the two most convenient schools that were found to have listener groups of *Yichalal* Radio were Aykel and Seraba Elementary and Junior Schools. The available listening group member students were considered for the questionnaire from the schools. By using precision matching, then, the same number of non-listener group respondents who were similar in age, gender, class level and previous semester academic average were taken for the study from Serako and Negadie Bahir Elementary and Junior Schools. Basically, the questionnaire has three parts. The first part inquires the demographic information of the respondents. The second part of the questionnaire asks the respondents' access of information about the epidemic. The last part of the questionnaire also tests the HIV/AIDS related knowledge of the respondents.

Hereunder, the demographic distribution (age, sex, previous year average and grade) the *Yichalal* Radio listening and non-listening group students for the questionnaire in Chilga Woreda's Aykel and Seraba Elementary and Junior

Schools (listener groups) and Serako and Negadie Bahir Elementary and Junior Schools (non-listener groups) is shown.

*Table 3: Demographic information of listener and non-listener groups of Yichalal Radio respondents*

Demographic Characteristics		No of Respondents N=23 for each	%
<b>Sex</b>	M	11	47.8
	F	12	52.2
<b>Age</b>	10-13	6	26.1
	14-17	17	73.9
<b>Previous Year Average</b>	50%-60%	3	13
	61%-70%	7	30.4
	71%-80%	6	26.1
	81%-90%	3	13
	>90%	4	17.4
<b>Grade</b>	7 <sup>th</sup>	7	30.4
	8 <sup>th</sup>	16	69.6

As the above table indicates, most *Yichalal* Radio listener group research subjects from Aykel and Seraba Elementary and Junior Schools - i.e. 73.9%- were from the 14-17 age group. As mentioned in many statistics, this age bracket (adolescent) is the time when most school youths are susceptible to HIV/AIDS. The remaining 26.1 % of the research subjects were children, in the stage of early adolescent, ranging in between 10 and 13.

Gender wise, females and males had got an almost similar statistical representation. While females counted 52.2% of the total 23 students, males became 47.8%.

Academically, 30.4% of the research subjects had scores of 61%-70% average in their previous year's (2002 E.C.) academic studies. 26.1% of the total 23 students also had 71%-80% scores in their previous year's academic studies. The 17.4% students had also scores of above 90% average. The other 13% of the students had previous year academic score averages of 50%-60%. The rest 13% of the students had scores of 81%-90%. Most (69.6%) of the current listening group member students of the two schools were eight graders while the remaining 30.4% are seventh.

With the same token, by using precision matching, the same students, whose number, age, sex, average and grade level were matched against the demographic elements of the radio listening groups, were purposefully chosen among the non-listening group students of Serako& Negadie Bahir Elementary and Junior Schools of Chilga Woreda. Accordingly, the same 23 students who were matched in every aspect of the aforementioned demographic elements with the *Yichalal* Radio listening group students were taken from the non-listening ones. Thus, the table above indicates the non-listener group respondents at the same time.

#### **4.2. HIV/AIDS Information Access of Respondents**

Making point pertaining to HIV/AIDS information access to HIV/AIDS is one mechanism of recognizing the possible intervening variables that may hinder the research outcomes. Subsequently, the table below shows the HIV/AIDS information access of both groups of respondents. It is evident that all of the respondents regularly listen to *Yichalal* Radio.

*Table 4: HIV/AIDS Information Access of Listener and Non-listener group Respondents*

HIV/AIDS Information Source	Response	Listeners N=23		Non-listeners N=23	
		N	%	N	%
Do you regularly listen to <i>Yichalal</i> Radio?	Yes	23	100	23	100
	No	0	0	0	0
Do you discuss about HIV/AIDS, with your family, at home?	Yes	22	95.65	17	73.91
	No	1	4.35	6	26.09
Do you discuss about HIV/AIDS with your nearby friends?	Yes	23	100	17	73.91
	No	0	0	6	26.09
Is there any other source from which you often get information about HIV/AIDS?	Yes	18	78.26	14	60.87
	No	5	21.74	9	39.13

The above table indicates that the whole *Yichalal* Radio listening group respondents, i.e. 100% (N=23) regularly listen to *Yichalal* Radio. Similarly, the whole *Yichalal* Radio non-listening group respondents, i.e. 100% (N=23), regularly listen to *Yichalal* Radio. However, as stated in Chapter One (Statement of the Problem), it is crucial to note that a very great difference exists between the two listener groups. While the radio station's listener group member respondents undergo formal follow-up discussions in their schools at the end of every program on each Saturday consecutively for a year, the non-listeners do not. The non-listening group respondents rather listen to the radio program either in their home or somewhere else regularly at each Saturday while the program is on air without a formal follow-up discussion with their schoolmates. There lies the basic difference between the two groups of listeners.

On the other hand, of the whole 23 listener group respondents, 95.65% (22) were found to discuss about HIV/AIDS with their families in their home. As raised in the focus group discussions of *Yichalal* Radio listening groups, being a member of the listener group had contributed to develop confidence on their knowledge of HIV/AIDS and enabled them to discuss about the epidemic with their families.

On the other hand, among all the non-listener groups of *Yichalal* radio, 73.91% (17) were found to deal about HIV/AIDS in their home with their families. The remaining 26.09% (6) of the non-listener respondents were not found to undergo discussions with their families about the epidemic in their home.

The total 100% (23) listener group respondents also were found engaging themselves in discussing about HIV/AIDS with their nearby friends. On the other hand, while 73.91% (17) of the non-listener group respondents were discussing about HIV/AIDS with their nearby friends, the remaining 26.09% (6) did not undertake that sort of discussion about HIV/AIDS.

Respondents of both groups of listeners were also asked to indicate whether they have other information sources than *Yichalal* Radio, their family and friends to consult about HIV/AIDS. Accordingly, while 21.74% (5) confirmed that they have no other information source, 78.26 (18) of the listener group member students indicated that they have other sources of information like books and teachers. On the other hand, while 39.13% (9) of the non-listener group respondents indicated that they have no other information source about HIV/AIDS, 60.87% (14) of them identified the presence of such other information sources of HIV/AIDS as teachers and books.

Generally, the above data shows that all members of the two listener group students listen to *Yichalal* Radio as a dominant source of information about HIV/AIDS. Most students in their focus group discussion explained that the radio station is their major information source about HIV/AIDS. This means the research subjects knowledge about HIV/AIDS is one way or the other highly influenced by *Yichalal* Radio. In the focus group discussions most *Yichalal* Radio listening group students also confirmed that they undergo discussions about HIV/AIDS with their families and friends for they developed the skill, confidence and knowledge to deal about HIV/AIDS. The non-listening group students also discuss with their families and friends, though with a slightly lower rate than the listening ones. Overall, the above points indicate that both groups of listeners

have a relatively balanced information access to HIV/AIDS except that the listening ones undergo formal follow-up discussion at the end of the radio program each Saturday while the non-listening ones do not.

### 4.3. Knowledge of Yichalal Radio Listener Group Respondents on HIV/AIDS

As vividly specified in the objectives of the study, the main aim of this research is to gauge the HIV/AIDS knowledge of the two listener group students. So as to tap Yichalal Radio listening group member respondents's knowledge of facts (meaning) about AIDS, modes of transmission of HIV and modes of prevention of AIDS infection, the respondents were provided with 38 statements which they were to state whether the given statement is "Yes", "No" or "Do not know". The thirty-eight items in the questionnaire in order of decreasing percentage of respondents who gave the correct responses to each item for each of the three sub-groups of knowledge category are presented in the table below.

*Table 5: HIV/AIDS test score percentages of each question for the listening group respondents*

Statements	Correct Answer	Yes		NO		Do not Know	
		N	%	N	%	N	%
<b>Meaning of HIV/AIDS</b>							
1. There is a disease called AIDS.	Yes	22	95.7	1	4.3	0	0
28. We can always tell if someone has HIV by looking at them.	No	3	13	20	87	0	0
37. A blood test is the only way to check for the presence/absence of HIV in somebody's blood.	Yes	20	87	2	8.7	1	4.3
36. If you test HIV negative, then that means you have HIV.	No	4	17.4	19	82.6	0	0
35. If somebody tests HIV positive, then that means the person does not have HIV.	No	5	21.7	18	78.3	0	0
29. One can have HIV without being sick from AIDS.	Yes	17	73.9	5	21.7	1	4.3
32. HIV/AIDS can be cured by traditional healers.	No	4	17.4	17	73.9	2	8.7
33. HIV/AIDS can be treated in advanced medication.	No	7	30.4	15	65.2	1	4.3
31. There is a cure for HIV/AIDS.	No	7	30.4	14	60.9	2	8.7
30. One can have HIV and spread it without being sick from AIDS.	Yes	13	56.5	10	43.5	0	0
34. HIV/AIDS by itself is not a killer.	Yes	8	34.8	12	52.2	3	13
<b>Prevention of HIV/AIDS</b>							
21. A woman cannot get HIV if she has sex with a man who has HIV during her period.	No	0	0	23	100	0	0
18. Using a condom during sexual intercourse can lower your	Yes	22	95.7	0	0	1	4.3

chance of getting HIV.							
23. Being abstinent and not having sex before marriage help decrease the chance of getting HIV.	Yes	22	95.7	1	4.3	0	0
27. Having sex with more than one partner can raise someone's chance of getting HIV.	Yes	22	95.7	1	4.3	0	0
24. Monogamy which means limiting sex to a spouse or a partner help decrease the chance of getting HIV.	Yes	21	91.3	1	4.3	1	4.3
26. Alcohol and drug consumptions can lead someone to unsafe sex (casual, without condom, etc.) and possibly to HIV infection.	Yes	21	91.3	2	8.7	0	0
14. Pulling out the penis before a man who has HIV climaxes keeps a woman from getting HIV during sex.	No	1	4.3	20	87	2	8.7
20. Showering, or washing one's genitals/private parts, immediately after sex keeps a person from getting HIV.	No	1	4.3	20	87	2	8.7
19. Eating healthy foods can keep you from getting HIV.	No	4	17.4	18	78.3	1	4.3
22. There is a female condom that can help decrease a woman's chance of getting HIV.	Yes	13	56.5	7	30.4	3	13
<b>Spread of HIV/AIDS</b>							
5. HIV can be spread by sharing a needle, razor, and the like with a person who has HIV.	Yes	23	100	0	0	0	0
6. There's a high chance that HIV can be spread by sharing a glass of water with someone who has HIV.	NO	0	0	23	100	0	0
8. HIV can be spread if a man has sex without condom with a woman who has HIV.	Yes	23	100	0	0	0	0
11. You can get HIV by shaking hands with someone who has HIV.	NO	0	0	23	100	0	0
3. People of any race, age, sex, religion, profession, etc. can get HIV and develop AIDS.	Yes	22	95.7	1	4.3	0	0
9. A woman can get HIV by having sex without condom with a man who has HIV.	Yes	22	95.7	1	4.3	0	0
12. There's a high chance of getting HIV if you get a blood transfusion in an unsafe manner.	Yes	22	95.7	0	0	1	4.3
2. AIDS is caused by a virus called HIV.	Yes	21	91.3	2	8.7	0	0
7. There's a high chance of getting HIV from a toilet seat immediately after use by someone who has HIV.	NO	1	4.3	21	91.3	1	4.3
13. HIV can't be spread when somebody who has HIV coughs and Sneezes.	Yes	21	91.3	1	4.3	1	4.3
10. A pregnant woman with HIV can give HIV to her unborn baby.	Yes	19	82.6	4	17.4	0	0
25. Prostitutes and their clients have a higher chance of getting HIV.	Yes	19	82.6	4	17.4	0	0
4. There's a high chance of getting HIV by kissing someone who has HIV on the mouth.	NO	6	26.1	17	73.9	0	0
16. People have been known to get HIV and develop AIDS from insect bites.	NO	5	21.7	17	73.9	1	4.3
17. You can get HIV and eventually AIDS through an open cut or wound.	Yes	17	73.9	6	26.1	0	0
38. A person can get the AIDS virus (HIV) from a virgin.	Yes	14	60.9	8	34.8	1	4.3
15. People are likely to get HIV by deep kissing, putting their tongue in their partner's mouth, if their partner has HIV.	Yes	11	47.8	12	52.2	0	0

As indicated above, the correct answers for the statement items ranges from statements 5, 6, 11, 21 at 100 % to statement 34 at 34.8%.

Following the 100% correct responses of the above statements, statements 1, 3, 9, 12, 18, 23, 27 and statements 2, 7, 13, 24, 26 shared the highest ratings of 95.7% and 91.3% respectively.

Statements 14, 20, 28 and 37 were correctly answered by 87 % of the respondents. Statements 10, 25 and 36 were correctly responded by 82.6 % of the respondents.

In short, respondents definitely knew that HIV can be spread by sharing a needle, razor, and the like with an HIV infected person, that a woman can get HIV even if she has sex with a man who has HIV during her period, that there's no high chance by which HIV can be spread by sharing a glass of water and shaking hands with an HIV infected person. The respondents also knew that there is a disease called AIDS, that people of any race, age, sex, religion, profession, etc. can get HIV and develop AIDS, that there's a high chance of getting HIV in an unsafe blood transfusion, that being abstinent and not having sex before marriage, using condom can lower someone's chance of getting HIV while having sex with more than one partner can raise the chance of getting the virus. The respondents also understood that AIDS is caused by a virus called HIV, that there's no high chance of getting HIV from a toilet seat immediately after use by someone who has HIV, that HIV can't be spread when somebody infected by the virus coughs and Sneezes, that monogamy help decrease the chance of getting HIV, and that alcohol and drug consumptions can lead someone to unsafe sex (casual, without condom, etc.) and possibly to HIV infection.

Most of the respondents also knew that pulling out the penis before an HIV infected man climaxes doesn't keep a woman from getting HIV, that showering, or washing one's genitals/private parts, immediately after sex doesn't keep a person from getting HIV, that we can't always tell if someone has HIV by looking at them, and that a blood test is the only way to check for the presence/absence of HIV in somebody's blood.

A high amount of ‘Do not know’ responses were registered by 13% of the respondents for each of the 22<sup>nd</sup> (There is a female condom that can help decrease a woman’s chance of getting HIV) and 34<sup>th</sup> (HIV/AIDS by itself is not a killer) statements.

Generally, except statements 15 and 34, which were correctly answered only by 47.8% and 34.8% of the respondents, the remaining thirty-six statements were correctly answered by at least 56.5 % of the respondents. This shows that most of the students have very good knowledge of the concept, modes of prevention and modes of transmission of HIV/AIDS.

Knowledge scores were computed by summing across the correct responses for each question, such that a score of 100% would indicate that all of the respondents, without differentiating age and gender, had answered all items correctly. Thus, it is quite difficult to realize to what extent male students differ in their knowledge of HIV/AIDS from females and respondents whose age is 10-13 from those who are 14-17. At the same time, it turns out difficult to differentiate knowledge level of respondents in terms of their grade level. Consequently, a group statistics and an independent sample t-test were carried out to outline the differences as indicated in the table below.

*Table 6: Group Statistics of HIV/AIDS knowledge score differences of the listener group respondents based on gender*

Group Statistics					
	Gender	N	Mean	Std. Deviation	Std. Error Mean
HIV/AIDS Knowledge	Male	11	34.5455	1.50756	.45455
	Female	12	28.3333	3.79793	1.09637

The group statistics table above shows that there are mean differences between the male and female *Yichalal* Radio listener group respondents. Out of the total 38 items aiming to test participants’ knowledge of HIV/AIDS, the mean score of the male listener group respondents (N=11) was found to be 34.54 with a

standard deviation of 1.51 indicating that each male respondent has an average of 1.51 deviation from the mean score. Whereas, the female listener group respondents (N=12) were found to have a mean HIV/AIDS knowledge score of 28.33 with a deviation of 3.80. Nevertheless, this difference of the two sexes cannot tell us the extent to which one is significantly better than the other as this stage is immature to talk about the significance level. Thus, a t-test was carried out to see whether there existed a statistically significant difference between the male and female *Yichalal* Radio listener group. The table below illustrates the independent samples t-test.

*Table 7: Independent Sample test of HIV/AIDS knowledge score differences of the listener group respondents based on gender*

Independent Samples Test										
		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	T	Df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
HIV/AIDS Knowledge	Equal variances assumed	8.381	.009	5.064	21	0.000	6.21	1.2268	3.66082	8.76342
	Equal variances not assumed			5.234	14.600	0.000	6.21	1.1868	3.67683	8.74742

The Levene's test (F=8.381) is found to be 0.009 which is quite below 0.05 indicating that the bottom row of the t-test value where equal variance is not assumed is taken for analysis. Accordingly, the HIV/AIDS knowledge test indicates that there existed a significant difference between the male and female listener groups of *Yichalal* Radio (t=5.23, df=14.60, p=0.000). The t-test, therefore, indicates that the difference is significant at p<0.05 which is the standard for measuring the level of significance in social science research.

Therefore, it may be seen that males outsmarted the females in their HIV/AIDS knowledge. On the contrary, females were found to be less knowledgeable than males.

Age wise, the mean score of the respondents who are in the age of 10-13 is found to be 30.83 with a standard deviation of 6.31 while the 14-17 age category have a mean score of 31.47 with a standard deviation of 3.56. In all, the t-test indicated that there is no significant difference in the test scores of the two age groups of Yichalal Radio listeners ( $t=-0.31$ ,  $df=21$ ,  $p=0.762$ ) (See Appendix 2.1.2).

When it is seen in terms of grade level also, insignificant knowledge differences were also evident in between grade seventh and grade eighth respondents of the listener groups ( $t= 0.194$ ,  $df=21$ ,  $p=0.848$ ) (See Appendix 2.1.3).

The focus group discussion also strengthened that the discussants have understood the meaning, modes of transmission, and modes of spread of HIV/AIDS well. Almost all of the discussants agreed that HIV is the virus which causes the disease AIDS. Most of the discussants also were of the same mind in that AIDS is not a killer by itself. According to one of the discussants, "AIDS does not kill, but attacks and weakens the white blood cells that defend other diseases and let people susceptible to other diseases". As one of the discussants puts it:

*Acquired Immuno Deficiency Syndrome is a disease of humans only. It is caused by the virus HIV. It affects people without differentiating their race, color, religion and sex. The disease can't be cured if once people catch it. That is what makes it different from other diseases.*

Though the explanation varied, most of the focus group discussants, one way or the other, strengthened the above quote. Thus, they understood that HIV is the virus that causes the disease AIDS which is a disease of humans only and is by itself not a killer rather it weakens one's body capacity of defending other

diseases. Most of the discussants also understood that AIDS' incurable nature, at least up to now, makes it different from other diseases.

However, some students fall short of vividly identifying the differences of HIV and AIDS. Three of the discussants in one of the listening group discussions and one of the discussant in the other group discussion of the listening group, for instance, quoted as saying, "HIV is an incurable disease". In this case, the discussants failed to differentiate HIV, the virus which causes the disease AIDS, from the disease itself. This implies that some of the discussants have misconceptions on the concept of HIV/AIDS.

Regarding the modes of transmission of HIV/AIDS, most of the discussants pointed out that HIV is transmitted by having unsafe sex and sharing needle and other related sharp things with an HIV infected person. Most discussants also noted that undertaking an unsecured blood transfusion can cause somebody to HIV. Discussants also stated that HIV can be transmitted from an HIV infected mother to her unborn baby unless proper medical assistance is provided.

As previous research works (e.g. Shitaye & Yohannis 2003) revealed, serious misconceptions like believing mosquitoes to transmit HIV and thinking that eating raw meat prepared by HIV infected people were prevalent in the area. Hence, it is worthy of mentioning the conceptions of the grey area whereby some people conflate the ways in which HIV/AIDS can't be transmitted with those which transmit the disease. With this regard, almost all of the discussants stated that shaking hands, learning and sleeping together, using the same toilet, swimming together, journeying together in the same car, playing together with HIV infected people do not cause HIV. Most discussants also stated that mosquito and butterfly do not spread HIV.

This implies that almost all of the respondents have understood the modes of HIV transmission very well. Most discussants also knew that HIV cannot be spread unless a blood or semen and women's sexual fluid of an HIV infected person mixes up.

It is also reckoned that there are lots of mechanisms by which people prevent themselves from HIV before they catch it. In line with this, the group discussants were asked to mention and explain the ways of prevention. Almost all of the discussants agreed on abstinence, having no sex before marriage; monogamy, the restriction of oneself with one sexual partner; and using condom as the main mechanisms of HIV/AIDS prevention. Some of the discussants have also gone beyond the common prevention mechanisms of the virus. A discussant, for example, underlines that:

*For youngsters who are in their 'fire age', emotional shrewdness is one best way of HIV/AIDS prevention. Emotional shrewdness refers to youths' ability of preserving themselves from some ostensibly uncontrollable emotional situations that may lead to sexual intercourse before marriage like kissing on the mouth and worming up with a sexual partner. [Translation mine]*

Another discussant also pointed out that a blood test is one of the mechanisms of preventing people from catching HIV/AIDS. The respondent deemed a blood test to determine people's HIV/AIDS result and thereby help them to prevent themselves from the virus provided that they are HIV negative and help them prevent others by keeping themselves away from having unsafe sexual intercourse with other people.

One of the discussants also indicated that one can prevent himself/herself from the virus by keeping themselves away from drinking excess alcohol as it may lead them to have unsafe sex with people living with HIV/AIDS.

Generally, most of the respondents properly knew the methods of preventing oneself from HIV/AIDS. Discussants understood monogamy, abstinence and using condom as the main methods of HIV/AIDS prevention. Some discussants also knew that controlling emotion, undergoing blood test and keeping away from excess alcohol can help people prevent themselves from catching the virus. Thus, undergoing formal follow up discussion after listening to *Yichalal* Radio

Programs about HIV/AIDS meaning, prevention and spread immensely helped the listening group students' conception of the pandemic.

#### 4.4. Knowledge of Yichalal Radio Non-Listener Group Respondents on HIV/AIDS

So as to find out Yichalal Radio non-listening group respondents' knowledge of facts (meaning) about AIDS, modes of transmission of HIV and modes of prevention of AIDS infection, like the listener ones, the non-listener respondents were provided with 38 statements which they were to state whether the given statement is "Yes", "No" or "Do not know". The thirty-eight items in the questionnaire in order of decreasing percentage of respondents who gave the correct responses to each item for each of the three sub-groups of knowledge category are presented in the table below.

Table 8: HIV/AIDS test score percentages of each question for the non-listening group respondents

Statements	Correct Answer	Yes		NO		Do not know	
		N	%	N	%	N	%
<b>Meaning of HIV/AIDS</b>							
1. There is a disease called AIDS.	Yes	22	95.7	0	0	1	4.3
32. HIV/AIDS can be cured by traditional healers.	No	2	8.7	21	91.3	0	0
37. A blood test is the only way to check for the presence/absence of HIV in somebody's blood.	Yes	21	91.3	2	8.7	0	0
31. There is a cure for HIV/AIDS.	No	3	13	20	87	0	0
33.HIV/AIDS can be treated in advanced medication.	No	4	17.4	19	82.6	0	0
35. If somebody tests HIV positive, then that means the person does not have HIV.	No	5	21.7	18	78.3	0	0
36. If you test HIV negative, then that means you have HIV.	No	6	26.1	17	73.9	0	0
28. We can always tell if someone has HIV by looking at them.	No	8	34.8	15	65.2	0	0
29.One can have HIV without being sick from AIDS.	Yes	11	47.8	11	47.8	1	4.3
34. HIV/AIDS by itself is not a killer.	Yes	11	47.8	10	43.5	2	8.7
30. One can have HIV and spread it without being sick from AIDS.	Yes	7	30.4	14	60.9	2	8.7
<b>Prevention of HIV/AIDS</b>							
24. Monogamy (limiting sex to spouse or partner) help decrease the chance of getting HIV.	Yes	22	95.7	1	4.3	0	0
23. Being abstinent and not having sex before marriage help decrease the chance of getting HIV.	Yes	21	91.3	2	8.7	0	0
27. Having sex with more than one partner can raise	Yes	20	87	3	13	0	0

someone's chance of getting HIV.							
18. Using a condom during sexual intercourse can lower your chance of getting HIV.	Yes	18	78.3	5	21.7	0	0
26. Alcohol and drug consumptions can lead someone to unsafe sex (casual, without condom, etc.) and possibly to HIV infection.	Yes	18	78.3	5	21.7	0	0
21. A woman cannot get HIV if she has sex with a man who has HIV during her period.	No	5	21.7	17	73.9	1	4.3
19. Eating healthy foods can keep you from getting HIV.	No	7	30.4	16	69.6	0	0
20. Showering, or washing one's genitals/private parts, immediately after sex keeps a person from getting HIV.	No	11	47.8	12	52.2	0	0
14. Pulling out the penis before a man who has HIV climaxes keeps a woman from getting HIV during sex.	No	13	56.5	9	39.1	1	4.3
22. There is a female condom that can help decrease a woman's chance of getting HIV.	Yes	7	30.4	15	65.2	1	4.3
<b>Spread of HIV/AIDS</b>							
5. HIV can be spread by sharing a needle, razor, and the like with a person who has HIV.	Yes	22	95.7	0	0	1	4.3
25. Prostitutes and their clients have a higher chance of getting HIV.	Yes	22	95.7	1	4.3	0	0
6. There's a high chance that HIV can be spread by sharing a glass of water with someone who has HIV.	NO	4	17.4	19	82.6	0	0
8. HIV can be spread if a man has sex without condom with a woman who has HIV.	Yes	19	82.6	4	17.4	0	0
2. AIDS is caused by a virus called HIV.	Yes	18	78.3	3	13	2	8.7
3. People of any race, age, sex, religion, profession, etc. can get HIV and develop AIDS.	Yes	18	78.3	5	21.7	0	0
9. A woman can get HIV by having sex without condom with a man who has HIV.	Yes	18	78.3	5	21.7	0	0
11. You can get HIV by shaking hands with someone who has HIV.	NO	6	26.1	17	73.9	0	0
10. A pregnant woman with HIV can give HIV to her unborn baby.	Yes	16	69.6	7	30.4	0	0
12. There's a high chance of getting HIV if you get a blood transfusion in an unsafe manner.	Yes	16	69.6	5	21.7	2	8.7
13. HIV can't be spread when somebody who has HIV coughs and Sneezes.	Yes	15	65.2	7	30.4	1	4.3
17. You can get HIV and eventually AIDS through an open cut or wound.	Yes	15	65.2	8	34.8	0	0
7. There's a high chance of getting HIV from a toilet seat Immediately after use by someone who has HIV.	NO	7	30.4	14	60.9	2	8.7
38. A person can get the AIDS virus (HIV) from a virgin.	Yes	12	52.2	10	43.5	1	4.3
15. People are likely to get HIV by deep kissing, putting their tongue in their partner's mouth, if their partner has HIV.	Yes	11	47.8	11	47.8	1	4.3
4. There's a high chance of getting HIV by kissing someone who has HIV on the mouth.	NO	10	43.5	10	43.5	3	13
16. People have been known to get HIV and develop AIDS from insect bites.	NO	13	56.5	9	39.1	1	4.3

As shown in the above, the correct answers for the statement items ranges from statements 1,5,24,25 at 95.7 % to statements 22 and 30 at 30.4%. Statements 1, 5, 24 and 25 were correctly answered by the highest rating of 95.7 % followed

by statements 23, 32 and 37 that were correctly answered by 91.3% of the respondents.

Statements 27 and 31 were also correctly answered by 87% of the respondents. The rest of the statements were correctly answered by 52.2% respondents or more with the exceptions of statements 4, 14, 15, 16, 22, 29, 30, and 34 which were answered by below average respondents.

As the above statistical figures witness, 95.7% of the respondents knew that there is a disease called AIDS. The same amount of students also knew that HIV can be spread by sharing a needle, razor, and the like with an HIV infected person, that monogamy help decrease the chance of getting HIV, that prostitutes and their clients have a higher chance of getting HIV.

91.3% of the respondents also knew that being abstinent and not having sex before marriage help decrease the chance of getting HIV, that AIDS cannot be cured by traditional healers and that blood test is the only way to determine the presence/absence of HIV/AIDS in somebody's blood. 87% of the respondents also understood that having sex with more than one partner can raise someone's chance of getting HIV. The same number of students also knew that HIV/AIDS has no cure if it once catches people.

On the other hand, eight of the statements were answered by below average respondents. Statements 22, 30, 16, 14, 4, 15, 29, and 34 were only answered by 30.4%, 30.4%, 39.1%, 39.1%, 43.5%, 47.8%, 47.8%, and 47.8% of the total 23 respondents respectively. This implies that, most of the respondents failed to know that there is a female condom that help to decrease a woman's chance of getting HIV and that one can have HIV and spread it without being sick from AIDS. Most of them do not also know that insect bites do not transmit HIV and that a woman cannot be kept from getting HIV during sex even if a man who has HIV pulls the penis out of her genital before climax. Most respondents also failed to understand that there is only a small chance of getting HIV by kissing an HIV infected person on the mouth, that people are likely to get HIV by deep kissing

with an HIV infected person, that one can have HIV without being sick from AIDS and that HIV/AIDS by itself is not a killer.

A high amount of 'Do not know' responses were registered by 13% of the respondents for the 4<sup>th</sup> statement (There's a high chance of getting HIV by kissing someone who has HIV on the mouth).

In all, however, the majority of the respondents have a fair knowledge of the meaning, modes of prevention and modes of transmission of HIV/AIDS. Yet, it is also clear that most of the respondents failed to know that:

- there exist a female condom that minimizes a woman's chance of getting HIV
- one can have HIV and spread it without being sick from AIDS
- insects do not transmit HIV
- pulling out penis before an HIV infected man climaxes doesn't keep a woman from getting the virus
- there is a small chance that one may get HIV by kissing an HIV infected person on the mouth
- deep kissing may usually lead to get HIV
- one can have HIV without being sick from AIDS
- HIV/AIDS by itself is not a killer

Knowledge scores were computed by summing across the correct responses for each question, such that a score of 100% would indicate that all respondents, without differentiating age and gender, had answered an item correctly. Thus, it is quite difficult to realize to what extent male students differ in their knowledge of HIV/AIDS from their female counterparts. It is also difficult to point out the possible differences between the respondents within the age group 10-13 and within the age group 14-17.

To find out these differences, therefore, a group statistics and an independent sample t-test were made. Accordingly, the gender group statistics indicated that

while the mean score of the male respondents was found to be 29.91 with a deviation of 3.86, the mean score of the female ones had become 23.50 with a deviation of 3.85(See Appendix 2.2.1). On the other hand, the age group statistics had shown that while respondents whose age ranges between 10 and 13 scored a mean value of 28.33, those whose age ranges between 14 and 17 scored a mean value of 25.94 (See Appendix 2.2.2). The independent sample t-test results also displayed that while males significantly surpassed the females ( $t=3.98$ ,  $df=20.82$ ,  $p=0.001$ ) in their knowledge of HIV/AIDS, insignificant knowledge differences were registered in age ( $t=1.01$ ,  $df=21$ ,  $p=0.324$ ).

When it is seen in terms of grade level also, insignificant knowledge differences were evident in between grade seventh and grade eighth respondents of the non-listener groups ( $t= -0.807$ ,  $df=21$ ,  $p=0.429$ ) (See Appendix 2.2.3).

The focus group discussions of the non-listener groups also witnessed that discussants had a fair knowledge on the meaning, modes of prevention and modes of transmission of HIV/AIDS. However, discussants have also some foggy areas where they failed to clearly state. Some of the discussants pointed out that AIDS is a disease caused by the virus HIV, that attacks the white blood cells of humans and make them weak in defending intruders in the proper functioning of the body. A high amount of discussants also stated that what makes AIDS different from other diseases is that it is not yet curable. A lot of students, however, were not cognizant of the differences that exist between HIV and AIDS. While talking about what is AIDS, they were implying about the virus and vice-versa.

When some of the discussants explained AIDS to be caused by HIV and is an incurable disease that attacks the white blood cells of humans, it is clear that they understood the concept of HIV and AIDS well. However, when it comes to most of the discussants, they did not clearly recognize the differences that lie between the disease AIDS and the virus HIV. They were not able to vividly clarify what HIV is and what AIDS is. They rather interchangeably used both terms

even when asked about the difference between them. This implies that they had rather some sorts of bizarre in their understanding of the concepts HIV and AIDS.

Almost all of the discussants also stated that unsafe sex, sharing sharp materials like blade, unsafe blood transfusion and mother to fetus transmission can lead someone to get HIV. Most of the discussants also underscored that HIV can't be transmitted by simply eating together, sleeping together, using the same toilet together and kissing with an HIV infected person. This implies that most discussants have a good understanding of the modes of HIV transmission.

Asked about the modes of prevention of HIV/AIDS, most discussants mentioned abstinence, monogamy, using condom, and undergoing blood test as major mechanisms. Most students also stated that avoiding the use of sharp materials together can help decrease the chance of getting HIV/AIDS. Some discussants also referred ART (Antiretroviral Therapy) as a mechanism to prevent people from getting HIV/AIDS. This implies that most discussants have a good knowledge of HIV/AIDS transmission. Yet, it is good to see that a few of the students did not know the prevention mechanisms well as they mention ART as a mechanism while it is a measure taken after someone is already caught by the disease AIDS.

Generally, except in some areas where erroneous misconceptions were evident, most of the non-listener group discussants of *Yichalal* Radio witnessed a good knowledge of the modes of transmission and modes of prevention of HIV/AIDS. However, most of them did not recognize the meaning of HIV/AIDS well as most of the group discussants were found to confuse HIV and AIDS. Some also had sorts of misconceptions on the prevention mechanisms of HIV/AIDS.

#### **4.5. HIV/AIDS Knowledge Differences between the Two Groups of *Yichalal* Radio Listeners**

In the previous sub-sections, the HIV/AIDS knowledge of the two groups of *Yichalal* Radio was studied independently. In this sub section, the comparative

differences witnessed between the two groups of listeners are discussed. In order to see the differences between the knowledge of the two listener groups, a group statistics and an independent t-test were undertaken.

*Table 9: HIV/AIDS knowledge score differences of the listener and non-listener group respondents*

Group Statistics					
Group		N	Mean	Std. Deviation	Std. Error Mean
HIV/AIDS Knowledge	Listener	23	31.3043	4.27928	.89229
	Non-listener	23	26.5652	4.98932	1.04034

A total of 38 items aiming to test participants’ knowledge of HIV/AIDS were given to every member of each group. The first group was composed of *Yichalal* Radio listeners while the other comprised of non-listeners of *Yichalal* Radio. The later were regular attendants of the radio programs but they did not undergo formal follow-up discussions on the HIV/AIDS themes of the radio in their school. The group statistics table above shows that there are mean differences between the listener and non-listener groups of *Yichalal* Radio. As indicated above, the mean score of the listener group (N=23) is 31.30 with a standard deviation of 4.28 indicating that each subject has an average of 4.28 deviation from the mean score. Whereas the non-listeners (N=23) have a mean HIV/AIDS knowledge score of 26.56 with a deviation of 4.99. Nevertheless, this difference of the two groups cannot tell us the extent to which one is significantly better than the other as this stage is immature to talk about the significance level. Thus, a t-test was carried out to see whether there existed a statistically significant difference between the listener and the non-listener groups. The table below illustrates the independent samples t-test.

*Table 10: HIV/AIDS knowledge score differences of the listener and non-listener group respondents*

**Independent Samples Test**

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
HIV/AIDS Knowledge	Equal variances assumed	.662	.420	3.458	44	.001	4.73913	1.37058	1.97690	7.50136
	Equal variances not assumed			3.458	43.002	.001	4.73913	1.37058	1.97509	7.50317

The Levene's test (F=0.662) was found to be 0.420 which is quite above 0.05 indicating that the top row of the t-test value where equal variance is assumed is taken for analysis. Accordingly, the HIV/AIDS knowledge test indicates that there existed a significant difference between the listener and non-listener groups of *Yichalal* Radio (t=3.46, df=44, p=0.001). The t-test, therefore, shows that the difference is significant at p<0.05 which is the standard for measuring the level of significance in social science research. Therefore, it may be seen that listening to *Yichalal* Radio followed by formal discussions significantly improved the experimental group participants' knowledge of HIV/AIDS. On the contrary, it can be noted that even though the non-listener groups accessed different sources of HIV/AIDS knowledge giving information as the listener group participants did, their inability to take part in the discussions that follow the radio program might have hindered their knowledge level on HIV/AIDS.

As previously stated in the unilateral presentations of HIV/AIDS knowledge of the two listener groups, while the non-listeners had failed to recognize that there exist a female condom that minimizes a woman's chance of getting HIV and that one can have HIV and spread it without being sick from AIDS, the listeners were found to know that very well. Many of the non-listener group questionnaire respondents did not also understand that:

- insects do not transmit HIV
- pulling out penis before an HIV infected man climaxes doesn't keep a woman from getting the virus
- there is a small chance that one may get HIV by kissing an HIV infected person on the mouth
- deep kissing may usually lead to get HIV
- one can have HIV without being sick from AIDS
- HIV/AIDS by itself is not a killer

In fact, above average listener group respondents of *Yichalal* Radio were also not able to correctly know that people are likely to get HIV by deep kissing if their partner has HIV and that HIV/AIDS by itself is not a killer.

However, it is quite evident in the results of the questionnaire that the rest of the statements were known by at least 56.5% of *Yichalal* Radio listener group respondents. Even, some of the statements were definitely known by the whole listener group respondents. All respondents, for instance, knew that HIV can be spread by sharing a needle, razor, and the like with an HIV infected person, that a woman can get HIV even if she has sex with a man who has HIV during her period, that there's no high chance by which HIV can be spread by sharing a glass of water and shaking hands with an HIV infected person.

Yet, none of the statements were correctly answered by all of the non-listener group respondents.

Moreover, as explained in the focus group discussion, while most of the non-listening group respondents failed to recognize the meaning (facts) of HIV/AIDS very well, the listeners knew that very well.

Generally, given the attempt made to control all the possible intervening variables, the knowledge difference between the two groups is thought to be exhibited because of the listener groups' discussion exposure that follows regular listening to *Yichalal* Radio.

#### **4.6. Advantages of Integrating *Yichalal* Radio with Interpersonal Communication (discussion)**

Since its establishment in 2003 as *Yichalal* Radio in four of the North Gondar Woredas, according to the information obtained through in depth interview from Ato Getnet, the chief aim of the radio station has been to develop the HIV/AIDS cognition of the target children and youths and to help them to pass the knowledge they acquire to the others. Ato Getnet also underlined that the radio station aimed to develop potential models to the society by producing efficient members of *Yichalal* Radio listener groups who are able to discuss and pass their knowledge of HIV/AIDS to the rest of their nearby society. He also stated that the aim of the station is also to initiate the listener groups of the radio station to give care and assistance for orphans and vulnerable children, old aged and ill people who reside around them by raising money through different mechanisms.

To accomplish the above aims, *Yichalal* Radio Station has the following programs:

- ✓ Listeners' letters, 30-35 minutes
- ✓ Drama- pertaining HIV/AIDS, HTPs and Child rights ,10 minutes
- ✓ Tikuret Lehtsanat (Focus on Children), 20 minutes
- ✓ Regarding HIV- programs like 'Enastawes' (Let's Remember), around 30 minutes.

Generally, Ato Getnet enlisted the modes of HIV prevention, transmission, spread, the ways in which HIV/AIDS is not transmitted, the benefits of blood test, support and care to PLWHA, conditions whereby children may get the svirus, peer-pressure in HIV/AIDS susceptibility, and the ways of expressing ideas and convince people to be extensively covered in the radio program. The listening and non-listening group research subjects also assured that the enlisted programs are transmitted through *Yichalal* Radio.

*Yichalal* Radio listener groups are also expected to have formal follow-up discussions and to send their feedbacks to the station after the above radio programs are broadcast every Saturday.

As most of the focus group discussants stated, *Yichalal* Radio is contributing a lot for them to understand HIV/AIDS very well. They also noted that it is initiating them to be involved in the practical activities that help to benefit their environment and the people around. They mentioned planting trees, cleaning their environment, raising money, use mini-media to teach the rest school children and youths about HIV/AIDS, providing tutorial programs each other as the main tasks they do because they are members of *Yichalal* Radio listening groups. They also said that they are advising and helping those members of the society who don't understand HIV/AIDS and those who are in trouble.

The listener group discussants also pointed out that they are positively changed in their outlook about HIV/AIDS, their environment, PLWHA, old aged people and the like because the radio program by itself motivates them. They said that whenever an outstanding experience report is sent to the radio station, that experience gets priority in its coverage on the 'debdabewoch' (letters) program. One of the discussants said, "So as to win and let our letters be on air, we have to perform a brilliant task". That way, the listener groups develop a habit of updating themselves with new directions of knowledge about the pandemic and do voluntary services that can help people in their vicinities.

Many of the listener group discussants reminded that they didn't clearly know the modes of HIV transmission and prevention before they joined *Yichalal* Radio as listener groups. A discussant, for example, spoke, "Before, I used to believe that coughing transmits HIV. After I joined *Yichalal* Radio's Listening group, however, I knew it doesn't." Another discussant also explained that since he did not know the modes of HIV/AIDS transmission before, he was using blade together with his family members. After he became a member of the listeners group, however, he stated that he knew sharp things like blade must be

unilaterally used as they may transmit the virus and he reported that he did not only use sharp materials alone but also convinced his family members to independently use them.

Some of the group discussants also described that even though they were cognizant of the modes of prevention and transmission well, until they became members of *Yichalal* Radio listening group, they were unable to openly tell their families and the rest of the society. These discussants stated that now, however, they are able to freely tell people about the epidemic.

These imply that taking part in *Yichalal* Radio's listening group contributed a lot in significantly developing their knowledge about the virus, building their confidence to openly speak, if not influence, what they know about the virus, and to carry out voluntary community services.

Most of the listener group discussants explained that it is quite useful to have discussion after the radio program is over. They described that at the beginning and upon the completion of the radio program, they discuss about the key ideas of the broadcast messages referring their notebooks where they put the main points of the message. A discussant has also explained that every Saturday, the listener group members of the school come to their school thirty-minutes earlier. When they come, as he said, they gather information from every source possible—from brochures, families, friends, etc and then, they discuss on the issues for thirty-minutes. Another term of discussion follows for thirty-minutes after listening to *Yichalal* Radio for one and half hour. By the time, he explained that the one who understands the points clearly tells the group in the context of their existing environment. He added that the discussion is extremely helpful as it helps them to see issues from the angle the other discussant sees.

The discussants have also stated that the discussion helps them to plan activities by taking lessons from the activities of the other students who are in different areas. Ato Getnet also strengthened the discussants' idea by referring the multi-media approach of communication:

*All listening group members do not equally understand what is vertically broadcast. Those who did not clearly understand the messages during the transmission get it from their friends in the discussion. While they express their ideas, the discussants also develop their knowledge significantly and internalize that. They use the manual which is prepared and distributed at the commencement of the program every year. They also reflect their ideas and experiences in their way to send to our center. In short, it has multi-faceted benefits (Translation mine).*

The implication of all the ideas above is that the discussion, which the listening group students are experiencing, helps them to search information for their discussion, to better understand the broadcast messages, to internalize what they listen and discuss and to see many angles of a story/an idea.

## CHAPTER FIVE

### SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

#### 5.1. Summary

This research was meant mainly to find out the integration effect of *Yichalal* Radio with interpersonal communication efforts as opposed to the top-down nature of radio. *Yichalal* Radio is a weekly radio program for youths and children under the GEMC. It is targeted in four Woredas of North Gondar- Chilga, Lay Armaciho, Alefa and Takusa.

The purpose of the research was seen in light of the main objectives of the radio station. The main aims of the radio station are to enable the school children and youths, who are in the target area, to know the basic HIV/AIDS related concepts and to create ideal and confident citizens who can pass the knowledge they get to the rest of the society. For that end, the radio station had established listening group students since 2003. To recruit members of listener groups, the station targeted elementary and junior schools of the targeted Woredas. The Listening Group members of *Yichalal* Radio have been recruited January every year comprising twenty-one students for a listener group in a school. Every listener group in schools is provided with radio sets. The members meet every Saturday in their respective schools to listen to the radio program that is broadcast from 11:30 AM to 1PM and to conduct follow-up discussions. After taking some notes while the radio program is on air, the listening members discuss on the main issues that had been broadcast. Mostly, as the focus group discussants assured, the listening group members discuss on HIV/AIDS. Moreover, they discuss to plan to undertake some voluntary services like helping orphans, vulnerable children and bedridden people. They also write feedback to the station on what they did and plan to do in line with the objectives of the radio station. In such a way, the program continues for a year. Upon completing a year of listening and follow-up discussions to the radio program, the listener group members graduate (GEMC 2004; In-depth interview with Ato Getnet)

Those listeners (students) who consume the information of *Yichalal* Radio either directly from the radio at their home or from the listening members without undergoing formal follow-up discussions in their school are the non-listener groups of *Yichalal* Radio. For this study, however, the non-listener groups refer to those students who regularly listen to *Yichalal* Radio and learn/live in a school /vicinity which is different from those schools that have *Yichalal* Radio Listening Groups for it minimizes contamination. In other words, what makes both listening groups similar is that they regularly listen to *Yichalal* Radio and what makes them different is that while the listening groups undergo formal follow-up discussion in their school upon listening to the radio program, the non-listening ones do not.

The primary task of the researcher was to differentiate these two groups of listeners. Members of the listener groups were, then, taken from the two nearby elementary and junior schools of Chilga Woreda. On the other hand, by matching the age, gender, grade level and academic performances of students, the same numbers of students were taken from two other schools where *Yichalal* Radio Listening Group doesn't exist. The research is, thus, a quasi-experimental study targeted to analyze the combination effect of the radio programs with interpersonal communication efforts in terms of the HIV/AIDS knowledge of the listeners. Hence, the special treatment provided for the experimental group (listening group) is the formal follow-up discussion the students had in their respective schools. The research was, then, set to analyze whether the combination of the radio program with interpersonal communication efforts (discussion) significantly enhanced the knowledge of the listener groups when it was seen in terms of the non-listeners who simply listen to the radio program as it comes top-down.

Primarily, the HIV/AIDS knowledge of the two *Yichalal* Radio listeners was tested unilaterally. Then, the existing knowledge difference between the two listener groups was compared. Finally, the potential advantages of combining the radio station with follow-up discussions were pointed out.

Questionnaire, FGDs and an in-depth interview were the methods through which the data were gathered. The FGD's and the in-depth interview were conducted for the purpose of triangulating the questionnaire datum and to ponder the advantages of combining the radio station with interpersonal communication efforts.

## **5.2. Conclusions**

On the basis of the findings, the research arrived at the following conclusions:

- Most listener group members exhibited a very good knowledge of the concept, modes of prevention and modes of transmission of HIV/AIDS. Regarding the HIV/AIDS knowledge of the Listening Group members of *Yichalal* Radio, the research found out that they knew that AIDS is an incurable disease, even by advanced medication and traditional healers, which is caused by a virus HIV and that it is a disease of all humans regardless of color, gender...etc. They also knew that a blood test is the only way to check HIV in one's blood and that it is difficult to tell people by looking at them.
- Yet, some of the listener group members were found confusing AIDS and HIV. Above average listener group members also failed to recognize that AIDS is not a killer by itself.
- The listener group members also knew that sharing a needle, razor, and the like, and having unsafe sex with an HIV infected person and undertaking an unsafe blood transfusion can lead someone to HIV/AIDS. They also knew that an HIV infected mother can give HIV to her fetus unless proper medication is given. Listeners also knew that eating healthy foods, being bitten by insects, having unsafe sex with an HIV infected person during a woman's period, washing genitals after sex with an HIV infected person and pulling out penis before climax with an HIV infected woman do not save people from getting the virus. Listeners also recognized

that HIV might not be transmitted by coughing and sneezing, kissing on the mouth, shaking hands, sharing a glass of water, swimming together, journeying together, sharing the same toilet, etc... with an HIV infected person. Most listener group members, however, did not understand that deep kissing with an HIV infected person may transmit the virus.

- The listeners also knew that while abstinence, monogamy, the use of condom blood test and controlling emotion minimizes ones' chance of getting HIV, having sex with more than one partner and consuming alcohol and drug on the flipside raise someone's chance of getting the virus.
- Though they had scored a relatively lower knowledge records in the test and FGDs than the listening ones, most of the Non-listener Group members of *Yichalal* Radio exhibited a fair understanding of the modes of prevention and modes of transmission of HIV/AIDS. The Non-listener Group members knew that there is an incurable disease, even by advanced medication, called AIDS which is only identified by blood test. However, most of the Non-listener group members were found to have a lack of clear understanding of the concept (meaning) of HIV/AIDS as they fail to clearly state the differences between HIV and AIDS.
- The non-listening group members also knew that HIV can be spread by having unsafe sex, having unsafe blood transfusion, sharing a needle, razor, and the like with an HIV infected person and that an HIV infected mother may give HIV to her unborn baby. They also knew that a high chance of getting HIV doesn't exist while an HIV infected person coughs and sneezes. They also knew that by sharing a glass of water, shaking hands, and sharing a toilet seat with an HIV infected people there is no high chance of spreading the virus.

- The non-listener group members also knew that monogamy, abstinence and using condom help decrease ones' chance of getting HIV.
- They also recognized that prostitutes and their clients, drag users, drunkards and those who make sex with more than one partner have a higher chance of getting HIV.
- The non-listener group members also understood that eating healthy foods, showering/washing genitals after having sex with HIV infected people (even with a virgin), having sex during a woman's period with an HIV infected man do not prevent people from getting HIV.
- However, most of the non-listener group members did not realize that HIV/AIDS by itself is not a killer and that one can have HIV and spread it without being sick from AIDS. Most of them also did not know the existence of a female condom that minimizes a woman's chance of getting HIV and that deep kissing may usually lead to get HIV. They also did not know that kissing an HIV infected person on the mouth and being bitten by insects do not have a high chance of getting HIV. The majority of the non-listeners also failed to know that pulling out penis before an HIV infected man climaxes does not keep a woman from getting the virus.
- As the t-test results witnessed, it was also reckoned that while both the listener and non-listener group members had shown a significant knowledge disparity of HIV/AIDS in gender, there was no significant differences in age and grade levels of member students. The males of both listeners outdid the females in their knowledge of HIV/AIDS. However, those students who were in the 10-13 and 14-17 years of age and those in the seven and eight grade level did not exhibit HIV/AIDS knowledge differences. This implies that while gender determines the status of HIV/AIDS knowledge, in both the listening and non-listening groups, age

and class level were found not to determine students' knowledge of the epidemic.

- When the knowledge about HIV/AIDS of the two groups of *Yichalal* Radio listeners was comparatively seen, the listener group members had in many ways significantly outdone the non-listeners. Given the attempt made to match both groups of listeners in access to HIV/AIDS information, grade level, academic performance, age and gender, it might be safe to say that the exposure of the listening group members to the formal follow-up discussions after listening to the radio programs significantly improved their knowledge about the epidemic. This finding assured the hypothesis which claimed that radio is effective while its top-down nature is redressed by initiatives like the discussion groups of *Yichalal* Radio. This is made when the listening group students of *Yichalal* Radio in their knowledge of HIV/AIDS outdid the non-listening ones who were not undergoing formal follow up discussions after the transmission of *Yichalal* Radio programs every Saturday. Though the non-listening group members were found to have a fair knowledge of HIV/AIDS by their own, when they were relatively seen with the listening ones, they were found to be less knowledgeable in every aspect of the epidemic.
- Moreover, the integration of *Yichalal* Radio with such interpersonal communication efforts as the discussion was found to have many advantages to contribute to the listening group respondents. The discussion, which the listening group students were experiencing, helped the listening group members to search information for their discussion, to better understand the broadcast messages, to develop their knowledge of HIV/AIDS, to pass their knowledge to people around them, to internalize what they listen and discuss and to see many angles of a story/an idea.

### **5.3. Recommendations**

In this research work, the integration of *Yichalal* Radio with interpersonal communication efforts was found to significantly develop the listening group members' knowledge of HIV/AIDS as opposed to the non-listeners who were simply listening to the radio program regularly. Furthermore, the listening group members contributed many societal services being motivated by the radio station. Such experiences were developed since the top-down nature of radio was remedied by initiatives like the follow-up discussions held every Saturday after the radio program was over by *Yichalal* Radio listener groups. This effective experience of the radio station can be a good lesson in many ways for other radio stations who simply broadcast information. In radio stations, feedback is decisive. An active engagement of listeners is also an important issue to meet the target of a program. As *Yichalal* Radio's experience witnessed, thus, those radio stations who are engaged in health issues like HIV/AIDS can be more effective by combining interpersonal communication efforts with the broadcast messages.

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## APPENDICES

### Annex I: Research Tools

#### 1.1. Questionnaire

Dear Respondent,

This questionnaire is for a Master thesis at Addis Ababa University, Ethiopia, that seeks to find out the effect of integrating *Yichalal* radio with interpersonal communication efforts by assessing the knowledge of the two types of *Yichalal* radio listeners about Human Immunodeficiency Virus, HIV and Acquired Immune Deficiency Syndrome, AIDS. You are kindly requested to provide your genuine response to each question. Your answers will be kept anonymous and confidential and they will only be used for the research purposes. Your participation is greatly appreciated.

#### Part I: Demographic Information

Your age is -----

Your sex is -----

Name of your Woreda -----

Name of your Kebele -----

Name of your School -----

Grade -----

Your Previous Semester Average-----

#### Part II: Information access to HIV/AIDS

**Instruction:** Please circle your answer for the following questions

1. Does your family have radio at home?

a) yes                      b) no

2. Do you regularly listen to *Yichalal* radio?

a) yes                      b) no

2.1. If 'yes', please mention some of the programs which interested you most? \_\_\_\_\_

3. Are you a member among the listener groups of *Yichalal* radio?
  - a) yes                      b) no
  - 3.1. If 'yes' how long have you been a member? \_\_\_\_\_
4. Do you discuss about HIV/AIDS, with your family, at home?
  - a) yes                      b) no
5. Do you discuss about HIV/AIDS with your nearby friends?
  - a) yes                      b) no
6. Is there any other source from which you often get information about HIV/AIDS?
  - a) yes                      b) no
  - 6.1. If 'yes', please mention the sources \_\_\_\_\_  
\_\_\_\_\_

**Part III: HIV/AIDS-related Knowledge**

**Instruction:** Below are statements about the meaning, spread and prevention of HIV and AIDS. The Gondar Educational Media Center's *Yichalal* radio has broadcast most of the issues. Please circle your answer for each question.

1. There is a disease called AIDS?
  - a) yes      b) no      c) don't know
2. AIDS is caused by a virus called HIV?
  - a) yes      b) no      c) don't know
3. People of any race, age, sex, religion, profession, etc. can get HIV and develop AIDS?
  - a) yes      b) no      c) don't know
4. There's a high chance of getting HIV by kissing someone who has HIV on the mouth?
  - a) yes      b) no      c) don't know
5. HIV can be spread by sharing a needle, razor, and the like with a person who has HIV?
  - a) yes      b) no      c) don't know
6. There's a high chance that HIV can be spread by sharing a glass of water with someone who has HIV?
  - a) yes      b) no      c) don't know

7. There's a high chance of getting HIV from a toilet seat immediately after use by someone who has HIV?  
a) yes      b) no      c) don't know
8. HIV can be spread if a man has sex without condom with a woman who has HIV?  
a) yes      b) no      c) don't know
9. A woman can get HIV by having sex without condom with a man who has HIV?  
a) yes      b) no      c) don't know
10. A pregnant woman with HIV can give HIV to her unborn baby?  
a) yes      b) no      c) don't know
11. You can get HIV by shaking hands with someone who has HIV?  
a) yes      b) no      c) don't know
12. There's a high chance of getting HIV if you get a blood transfusion in an unsafe manner?  
a) yes      b) no      c) don't know
13. HIV can't be spread when somebody who has HIV coughs and sneezes?  
a) yes      b) no      c) don't know
14. Pulling out the penis before a man who has HIV climaxes keeps a woman from getting HIV during sex?  
a) yes      b) no      c) don't know
15. People are likely to get HIV by deep kissing, putting their tongue in their partner's mouth, if their partner has HIV?  
a) yes      b) no      c) don't know
16. People have been known to get HIV and develop AIDS from insect bites?  
a) yes      b) no      c) don't know
17. You can get HIV and eventually AIDS through an open cut or wound?  
a) yes      b) no      c) don't know
18. Using a condom during sexual intercourse can lower your chance of getting HIV?  
a) yes      b) no      c) don't know
19. Eating healthy foods can keep you from getting HIV?  
a) yes      b) no      c) don't know

20. Showering, or washing one's genitals/private parts, immediately after sex keeps a person from getting HIV?  
a) yes      b) no      c) don't know
21. A woman cannot get HIV if she has sex with a man who has HIV during her period?  
a) yes      b) no      c) don't know
22. There is a female condom that can help decrease a woman's chance of getting HIV?  
a) yes      b) no      c) don't know
23. Being abstinent and not having sex before marriage help decrease the chance of getting HIV?  
a) yes      b) no      c) don't know
24. Monogamy (limiting sex to spouse or partner) help decrease the chance of getting HIV?  
a) yes      b) no      c) don't know
25. Prostitutes and their clients have a higher chance of getting HIV?  
a) yes      b) no      c) don't know
26. Alcohol and drug consumptions can lead someone to unsafe sex (casual, without condom, etc.) and possibly to HIV infection?  
a) yes      b) no      c) don't know
27. Having sex with more than one partner can raise someone's chance of getting HIV?  
a) yes      b) no      c) don't know
28. We can always tell if someone has HIV by looking at them?  
a) yes      b) no      c) don't know
29. One can have HIV without being sick from AIDS?  
a) yes      b) no      c) don't know
30. One can have HIV and spread it without being sick from AIDS?  
a) yes      b) no      c) don't know
31. There is a cure for HIV/AIDS?  
a) yes      b) no      c) don't know

32. HIV/AIDS can be cured by traditional healers?  
a) yes      b) no      c) don't know
33. HIV/AIDS can be treated in advanced medication?  
a) yes      b) no      c) don't know
34. HIV/AIDS by itself is not a killer?  
a) yes      b) no      c) don't know
35. If somebody tests HIV positive, then that means the person does not have HIV?  
a) yes      b) no      c) don't know
36. If you test HIV negative, then that means you have HIV?  
a) yes      b) no      c) don't know
37. A blood test is the only way to check for the presence/absence of HIV in somebody's blood?  
a) yes      b) no      c) don't know
38. A person can get the AIDS virus (HIV) from a virgin?  
a) yes      b) no      c) don't know

## **1.2. Focus Groups Discussions Guide**

This FGD is for a Master thesis, at Addis Ababa University, Ethiopia, that seeks to find out the effect of integrating *Yichalal* radio with interpersonal communication efforts by assessing the knowledge of the two types of *Yichalal* radio listeners about Human Immunodeficiency Virus, HIV and Acquired Immune Deficiency Syndrome, AIDS. You are kindly requested to provide your genuine response to each question. Your answers will be kept anonymous and confidential and they will only be used for the research purposes. Your participation is greatly appreciated.

### **Discussants' Demographic Information**

#### **Group A<sub>1</sub>**

Number of Discussants

Age of Discussants

Sex of Discussants

School of Discussants

Woreda of Discussants

Kebele of Discussants

Grade Level of Discussants

Discussants' previous semester average

**Group A<sub>2</sub>**

Number of Discussants

Age of Discussants

Sex of Discussants

School of Discussants

Woreda of Discussants

Kebele of Discussants

Grade Level of Discussants

Discussants' previous semester average

**Group B<sub>1</sub>**

Number of Discussants

Age of Discussants

Sex of Discussants

School of Discussants

Woreda of Discussants

Kebele of Discussants

Grade Level of Discussants

Discussants' previous semester average

### **Group B<sub>2</sub>**

Number of Discussants

Age of Discussants

Sex of Discussants

School of Discussants

Woreda of Discussants

Kebele of Discussants

Grade Level of Discussants

Discussants' previous semester average

### **FGD Discussions Guide**

- **HIV/AIDS meaning, prevention, spread and consequences**

1. When you hear the word AIDS, what comes to your mind?

- What do HIV and AIDS represent?
- Can you state the disease in a metaphoric expression as to how you see it?
- Is HIV/AIDS a unique pandemic? If so, why?

2. How is AIDS transmitted?

- Discuss the different ways of HIV/AIDS transmission?
- Mention some ways in which HIV/AIDS can't be transmitted?

3. How can one prevent him/herself from HIV/AIDS?
  - What methods can one apply to prevent him/herself from HIV/AIDS?
  - What are the different safe sex methods/practices for preventing AIDS?
4. What could be the consequences of AIDS?
  - Discuss the socio-economic consequences of HIV/AIDS?

- **Advantage of integrating the radio program with interpersonal communication (for the listeners' groups discussants ONLY)**

1. Advantage/s of taking part in *Yichalal* radio program's listener group
  - ✓ What are you doing as members of the listener group of the radio program?
  - ✓ What are the main issues of your discussions?
  - ✓ Do you discuss HIV/AIDS usually?
  - ✓ What do you benefit from your participation to the listener group?
  - ✓ Do you think that the integration of the radio program with such follow-up group discussion help you immensely in your cognition of HIV/AIDS? If so, how?
  - ✓ What useful lessons, on HIV/AIDS, do you infer from the follow-up discussions of the radio program?
  - ✓ Do you think that the follow-up discussion of the radio program lacks something useful?
  - ✓ If you have something to add on the radio program and the follow-up discussion?

### **1.3. Interview Guide**

This interview is for a Master thesis, at Addis Ababa University, Ethiopia, that seeks to find out the effect of integrating *Yichalal* radio with interpersonal communication efforts by assessing the knowledge of the two types of *Yichalal* radio listeners about Human Immunodeficiency Virus, HIV and Acquired Immune Deficiency Syndrome, AIDS. You are kindly requested to provide your genuine response to each question. Your answers will be kept anonymous and confidential and they will only be used for the research purposes. Thank you in advance for your cooperation!!!

#### **For the Coordinator of Gondar Educational Media Center**

1. What is your radio project about?
2. What motivated you to launch such a program?
3. Who are the target audiences of your radio program?
4. Would you describe the two types of listeners your radio project reaches?
5. Where do you recruit members of listener groups? Why?
6. What are the major issues that are extensively covered in your radio program?
7. What is the role of your radio project on the so-called listener groups in the fight against HIV/AIDS?
8. Would you brief the understanding of students about HIV/AIDS at the beginning of the project?
9. Do you receive feedbacks from the two types of listeners on your programs about HIV/AIDS? If so, what essential listener knowledge improvements, pertaining HIV/AIDS, have you inferred from them?
10. What is the advantage of integrating the radio programs with interpersonal communication?
11. Would you elucidate the integration effect of the radio program with interpersonal communication by using anecdotes that can compare and contrast HIV/AIDS knowledge differences among the two types of listeners

due to having or not having interpersonal communication together with the broadcast programs?

12. How is the current knowledge status of HIV/AIDS of the listener groups?
13. What do you think remains from your radio program transmission so as to optimize the effect of your project in terms of raising the audience understanding of HIV/AIDS?
14. If you have something to add?

1.4. መጠይቅ

ዉድ የመጠይቁ ተሳታፊ፣

ይህ መጠይቅ የተዘጋጀዉ የይቻላል ራዲዮ ፕሮግራም አድማጮች ያላቸዉን የኤች ኦይ ቪ./ኤድስ ግንዛቤ/እዉቀት በመመዘን የራዲዮ ፕሮግራሙ ከግለሰባዊ ተግባራት ወይም ከቡድን ዉይይት ጋር መጣመሩ ያስገኘዉን ፋይዳ ለማግኘት ነዉ። የጥናቱ ውጤታማነት ሙሉ በሙሉ እርስዎ በሚሰጧቸዉ መልሶች እውነተኛነት ላይ የተመሰረተ በመሆኑ ለጥያቄዎቹ ትክክለኛ ምላሽ የሚሉትን እንዲሰጡ በአክብሮት እጠይቃለሁ። የእርስዎ ምላሾች በአዲስ አበባ ዩኒቨርሲቲ ለማስተር ዲግሪ ጥናት ብቻ የሚዉሉ ሲሆን በሚስጢርም የሚጠበቁ ይሆናል። ለመልካም ትብብርዎ ከወዲሁ አመሠግናለሁ።

ክፍል አንድ፣ ስለራስዎ ለጥናቱ የሚሆን መረጃ

- ዕድሜ -----
- ፆታ -----
- የሚኖሩበት ወረዳ ስም -----
- የሚኖሩበት ቀበሌ ስም -----
- የሚማሩበት ትምህርት ቤት ስም -----
- ክፍል -----
- ያለፈዉ ሴሚስተር አማካይ ውጤት -----

ክፍል ሁለት፣ ስለ ኤችአይቪ ኤድስ የመረጃ አቅርቦት

መመሪያ፣ ለሚከተሉት ጥያቄዎች መልሶቻችሁን አክብቡ።

1. በቤታችሁ ውስጥ የአንተ/ች ወይም የቤተሰቦችህ/ሽ ራዲዮ አለ?
  - ሀ) አለ ለ) የለም
2. ይቻላል ራዲዮን አዘውትረህ/ሽ ታደምጣለህ/ሽ?
  - ሀ) አዎ ለ) አላዳምጥም
- 2.1. መልስህሽ አዎ ከሆነ፣ ከራዲዮ ፕሮግራሙ በጣም የምትወዳቸዉን/ ጃቸዉን አንዳንድ ፕሮግራሞች ጥቀስ/ሽ?-----  
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-----
3. የይቻላል ራዲዮ የአድማጮች ቡድን አባል ነህ/ሽ?

ሀ) አዎ ለ) አይደለሁም

3.1. መልስህ/ሽ አዎ ከሆነ፣ ለምን ያህል ጊዜ?-----

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4. ከቤተሰቦችህ/ሽ ጋር በቤታችሁ ስለ ኤችአይቪ/ኤድስ ትወያያለህ/ሽ?

ሀ) አዎ ለ) አልወያይም

5. ከጓደኞችህ/ሽ ጋር ስለ ኤች አይ ቪ /ኤድስ ትወያያለህ/ሽ?

ሀ) አዎ ለ) አልወያይም

6. ስለ ኤች አይ ቪ /ኤድስ መረጃ የምታገኝበት ሌላ ምንጭ አለ?

ሀ) አዎ ለ) የለም

6.1. መልስህ/ሽ አዎ ከሆነ ፣ የመረጃ ምንጮችን ግለፅ/ጨ?-----

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**ክፍል ሦስት፣ ስለ ኤች አይ ቪ /ኤድስ እውቀት/ግንዛቤ**

**መመሪያ፣** ከዚህ በታች ስለ ኤች አይ ቪ /ኤድስ ምንነት፣ መተላለፊያና መከላከያ የሚገልፁ ጥያቄዎች ተዘርዝረዋል። ኡብዛኞቹ ከዚህ በፊት በይቻላል ራዲዮ ፕሮግራም የተላለፉ ናቸው። ለእያንዳንዱ ጥያቄ ትክክለኛ የምትሉትን መልስ አክብቡ።

1. ኤድስ የሚባል በሽታ አለ?

ሀ) አዎ ለ) የለም መ) አላውቀውም

2. ኤድስ፣ ኤች አይ ቪ በተባለ ቫይረስ የሚመጣ ነው?

ሀ) አዎ ለ) አይደለም መ) አላውቀውም

3. ኤች አይ ቪ ማንኛውንም ሰው ዘር፣ ቀለም፣ እድሜ፣ ፆታ፣ ሐይማኖት፣ ሙያና የመሳሰሉትን ሳይለይ ሊይዝና ለኤድስም ሊዳረግ ይችላል?

ሀ) አዎ ለ) አይችልም መ) አላውቀውም

4. ኤች አይ ቪ ያለበትን ሰው አፍ መሳም ለኤች አይ ቪ የማጋለጥ እድሉ ሰፊ ነው?

ሀ) አዎ ለ) አይደለም መ) አላውቀውም

5. ምላጭ፣ መርፌና የመሳሰሉትን ስለታም ነገሮች ኤች አይ ቪ በደሙ ካለ ሰው ጋር በጋራ በመጠቀም ኤች አይ ቪ ይተላለፋል?

ሀ) አዎ ለ) አይተላለፍም መ) አላውቀውም

6. ኤች አይ ቪ በደሙ ካለ ሰው ጋር ባንድ ብርጭቆ በጋራ ውሃ መጠጣት የኤች አይ ቪን የመተላለፍ እድል ይጨምራል?

- ሀ) አዎ ለ) አይጨምርም መ) አላውቀውም
7. ኤች አይ ቪ በደሙ ያለ ሰው የተጠቀመበት ሽንት ቤት ውስጥ ወዲያውኑ መጠቀም ኤች አይ ቪ የማስተላለፍ እድሉ የሰፋ ነው?
 

ሀ) አዎ ለ) አይደለም መ) አላውቀውም
  8. ኤች አይ ቪ በደሚ ካለ አንዲት ሴት ጋር ያለኮንዶም የግብረ ስጋ ግንኙነት በማድረግ አንድ ወንድ ኤች አይ ቪ /ኤድስ ሊተላለፍበት ይችላል?
 

ሀ) አዎ ለ) አይችልም መ) አላውቀውም
  9. ኤች አይ ቪ በደሙ ካለ አንድ ወንድ ጋር ያለ ኮንዶም የግብረ ስጋ ግንኙነት በመፈፀም አንዲት ሴት ኤች አይ ቪ ሊተላለፍባት ይችላል?
 

ሀ) አዎ ለ) አይችልም መ) አላውቀውም
  10. ከአንዲት ኤች አይ ቪ በደሚ ካለ እርጉዝ ሴት ኤች አይ ቪ ወደ ፅንሱ ሊተላለፍ ይችላል?
 

ሀ) አዎ ለ) አይችልም መ) አላውቀውም
  11. ኤች አይ ቪ በደሙ ካለ ሰው ጋር በመጨባበጥ ኤች አይ ቪ ሊተላለፍ ይችላል?
 

ሀ) አዎ ለ) አይችልም መ) አላውቀውም
  12. አስፈላጊው ጥንቃቄ ሳይደረግ የደም ልገሳ የተደረገለት አንድ ሰው በኤች አይ ቪ የመያዝ እድሉ የሰፋ ነው?
 

ሀ) አዎ ለ) አይደለም መ) አላውቀውም
  13. ኤች አይ ቪ በደሙ ያለ ሰው በሚስልበትና በሚያስነጥስበት ጊዜ ኤች አይ ቪ አይተላለፍም?
 

ሀ) አዎ ለ) ይተላለፋል መ) አላውቀውም
  14. አንድ ኤች አይ ቪ በደሙ ያለ ወንድ ከሴቷ ጋር የግብረ ስጋ ግንኙነት ቢያደርግና በሴቷ ብልት ውስጥ ከመርካቱ በፊት ብልቱን ቢያወጣ ሴቷ ኤች አይ ቪ አይተላለፍባትም?
 

ሀ) አዎ ለ) ይተላለፍባታል መ) አላውቀውም
  15. አንድ ኤች አይ ቪ በደሙ ካለ ሠው ጋር አፍ ለአፍ በጥልቀት መሳሳም ኤች አይ ቪ ሊያስተላልፍ የሚችልበት እድል አለ?
 

ሀ) አዎ ለ) የለም መ) አላውቀውም
  16. ሰዎች በተደጋጋሚ በተናዳፊ ነፍሳት አስተላላፊነት በኤች አይ ቪ ሲያዙና ለኤድስም ሲዳረጉ ይስተዋላል?
 

ሀ) አዎ ለ) አይስተዋልም መ) አላውቀውም
  17. አንድ ሰው በደማ ወይም በቆሰለ አካሉ አማካይነት በቀላሉ ለኤች አይ ቪ ሊጋለጥና ለኤድስም ሊዳረግ ይችላል?
 

ሀ) አዎ ለ) አይችልም መ) አላውቀውም
  18. በግብረ ስጋ ግንኙነት ወቅት ኮንዶም መጠቀም የኤች አይ ቪ ተጋላጭነትን ይቀንሳል?
 

ሀ) አዎ ለ) አይችልም መ) አላውቀውም

- ሀ) አዎ ለ) አይቀንስም መ) አላውቀውም
19. የተመጣጠነ ምግብ መመገብ በኤች አይ ቪ ከመያዝ ያድናል?  
ሀ) አዎ ለ) አያድንም መ) አላውቀውም
20. የግብረ ስጋ ግንኙነት ከተደረገ በኋላ ብልትን ወዲያውኑ መታጠብ በኤች አይ ቪ ከመያዝ ያድናል?  
ሀ) አዎ ለ) አያድንም መ) አላውቀውም
21. አንዲት ሴት በወር አበባዋ ወቅት ኤች አይ ቪ በደሙ ካለ ወንድ ጋር የግብረ ስጋ ግንኙነት ያለኮንዶም ብታደርግ ኤች አይ ቪ አይዛትም?  
ሀ) አዎ ለ) ይይዛታል መ) አላውቀውም
22. የአንድን ሴት በኤች አይ ቪ /ኤድስ የመጋለጥ እድል የሚቀንስ የሴት ኮንዶም አለ?  
ሀ) አዎ ለ) የለም መ) አላውቀውም
23. ከጋብቻ በፊት መታቀብ የአንድን ሰው በኤች አይ ቪ የመያዝ እድል ይቀንሳል?  
ሀ) አዎ ለ) አይቀንስም መ) አላውቀውም
24. አንድ ለአንድ መወሰን በኤች አይ ቪ የመያዝ እድልን ይቀንሳል?  
ሀ) አዎ ለ) አይቀንስም መ) አላውቀውም
25. ሴተኛ አዳሪዎችና ደንበኞቻቸው በኤች አይ ቪ የመያዝ ሰፊ እድል አላቸው?  
ሀ) አዎ ለ) የላቸውም መ) አላውቀውም
26. አልኮልና አደንዛዥ እያችን መጠቀም ጥንቃቄ የጎደለው የግብረ ስጋ ግንኙነት እንዲደረግ ሊገፋፋና ለኤች አይ ቪ/ኤድስ ሊዳርግ ይችላል?  
ሀ) አዎ ለ) አይችልም መ) አላውቀውም
27. ከአንድ የትዳር ወይም የፍቅር ተጓዳኝ በተጨማሪ ከሌላ ጋር የግብረ ስጋ ግንኙነት ማድረግ የአንድን ሰው በኤች አይ ቪ የመያዝ እድል ያሰፋል?  
ሀ) አዎ ለ) አያሰፋም መ) አላውቀውም
28. ተክለ ቁመናቸውን በመመልከት ኤች አይ ቪ በደማቸው ያለ ሰዎችን ማወቅ እንችላለን?  
ሀ) አዎ ለ) አንችልም መ) አላውቀውም
29. አንድ ሰው በኤድስ በሽታ ሳይታመም ኤች አይ ቪ በደሙ ሊኖር ይችላል?  
ሀ) አዎ ለ) አይችልም መ) አላውቀውም
30. አንድ ሰው የኤድስ ህመምተኛ ሳይሆን በኤች አይ ቪ ሊያዝና ቫይረሱንም ሊያስተላልፍ ይችላል?  
ሀ) አዎ ለ) አይችልም መ) አላውቀውም
31. ኤች አይ ቪ/ኤድስ ፈውስ አለው?  
ሀ) አዎ ለ) የለውም መ) አላውቀውም
32. ኤች አይ ቪ/ኤድስ በባህል የህክምና አዋቂዎች ሊፈወስ ይችላል?  
ሀ) አዎ ለ) አይችልም መ) አላውቀውም

33. ኤች አይ ቪ./ኤድስ በተራቀቀ የህክምና ዘዴ ሊፈወስ ይችላል?  
 ሀ) አዎ ለ) አይችልም መ) አላውቀውም
34. ኤች አይ ቪ./ኤድስ በራሱ ገዳይ አይደለም?  
 ሀ) አዎ ለ) ነዉ መ) አላውቀውም
35. የአንድ ሰው የደም ምርመራ ውጤት ኤች አይ ቪ. ፖዘቲቭ ቢሆን ያ ሰው ኤች አይ ቪ. በደሙ የለም ማለት ነው?  
 ሀ) አዎ ለ) አይደለም መ) አላውቀውም
36. የአንድ ሰው የደም ምርመራ ውጤት ኤች አይ ቪ. ነገቲቭ ቢሆን ያ ሰው ኤች አይ ቪ. በደሙ አለ ማለት ነው?  
 ሀ) አዎ ለ) አይደለም ሐ) አላውቀውም
37. በአንድ ሰው ደም ውስጥ ኤች አይ ቪ. መኖር እና አለመኖሩን ማረጋገጫ ብቸኛው መንገድ የደም ምርመራ ነው?  
 ሀ) አዎ ለ) አይደለም መ) አላውቀውም
38. የግብረ ስጋ ግንኙነት አድርጎ ከማያውቅ ሰው ጋር ግንኙነት መፈፀም ኤች አይ ቪ. ሊያስይዝ ይችላል?  
 ሀ) አዎ ለ) አይችልም ሐ) አላውቀውም

**1.5. የቡድን ተኮር ወይይቶች አቅጣጫ**

ይህ የቡድን ተኮር ወይይት የተዘጋጀው የይቻላል ራዲዮ ፕሮግራም አድማጮች ያላቸውን የኤች አይ ቪ./ኤድስ ግንዛቤ/እውቀት በመመዘን የራዲዮ ፕሮግራሙ ከግለሰባዊ ተግባራት ወይም ከቡድን ወይይት ጋር መጣመሩ ያስገኘውን ፋይዳ ለማግኘት ነው። የጥናቱ ውጤታማነት ሙሉ በሙሉ እናንተ በምትሰጧቸው መልሶች እውነተኛነት ላይ የተመሰረተ በመሆኑ ለጥያቄዎቹ ትክክለኛ ምላሽ የምትሉትን እንድትሰጡ በአክብሮት እጠይቃለሁ። የእናንተ ምላሾች በአዲስ አበባ ዩኒቨርሲቲ ለማስተር ዲግሪ ጥናት ብቻ የሚወሉ ሲሆን በሚስጥርም የሚጠበቁ ይሆናል። ለመልካም ትብብራችሁ ከወዲሁ አመሠግናለሁ።

**ስለ ቡድን ተኮር ተወያዮች ለጥናቱ የሚሆን መረጃ**

- ቡድን ሀ<sub>1</sub>
- የተወያዮች ቁጥር
- የተወያዮች እድሜ
- የተወያዮች ያታ

የተወያዮች ት/ቤት

የተወያዮች ወረዳ

የተወያዮች ቀበሌ

የተወያዮች የት/ት ደረጃ

የተወያዮች ያለፈው ሴሚስተር አማካይ ወ.ጤት

**ቡድን U<sub>2</sub>**

የተወያዮች ቁጥር

የተወያዮች እድሜ

የተወያዮች ያታ

የተወያዮች ት/ቤት

የተወያዮች ወረዳ

የተወያዮች ቀበሌ

የተወያዮች የት/ት ደረጃ

የተወያዮች ያለፈው ሴሚስተር አማካይ ወ.ጤት

**ቡድን A<sub>1</sub>**

የተወያዮች ቁጥር

የተወያዮች እድሜ

የተወያዮች ያታ

የተወያዮች ት/ቤት

የተወያዮች ወረዳ

የተወያዮች ቀበሌ

የተወያዮች የት/ት ደረጃ

የተወያዮች ያለፈው ሴሚስተር አማካይ ወ.ጤት

**ቡድን A<sub>2</sub>**

የተወያዮች ቁጥር

የተወያዮች እድሜ

የተወያዮች ያታ

የተወያዮች ት/ቤት

የተወያዮች ወረዳ

የተወያዮች ቀበሌ

የተወያዮች የት/ት ደረጃ

የተወያዮች ያለፈው ሴሚስተር አማካይ ወጤት

**ቡድን ተኮር የመወያያ አቅጣጫዎች**

- ስለ ኤች አይ ቪ/ኤድስ ትርጉም፣ መከላከያ፣ ስርጭትና የሚያስከትለው ችግር
  1. ኤድስ የሚለውን ስትሰሙ በአእምሮአችሁ የሚመጣው ምንድን ነው?
    - ✓ ኤች አይ ቪና ኤድስ ምንን ይወክላሉ?
    - ✓ ኤድስን ይወክላል በምትሉት አገላለፅ ብታስረዱን?
    - ✓ ኤች አይ ቪ/ኤድስ የተለየ ክስተት ነው? መልሳችሁ አዎ ከሆነ፣ እንዴት?
  2. ኤች አይ ቪ/ኤድስ እንዴት ይተላለፋል?
    - ✓ ኤች አይ ቪ/ ኤድስ የሚተላለፍባቸውን መንገዶች አብራሩ?
    - ✓ ኤች አይ ቪ/ኤድስ የማይተላለፍባቸውን አንድ አንድ መንገዶች ብትገልፁልን?
  3. ኤች አይ ቪ/ኤድስን እንዴት መከላከል ይቻላል?
    - ✓ ራስን ከኤች አይ ቪ/ኤድስ የመከላከያ መንገዶችን አብራሩ?
    - ✓ ከኤች ኤይ ቪ የሚከላከሉ የጥንቃቄ የግብረ ስጋ ግንኙነት ዘዴዎችን ጥቀሱ?
  4. ኤች አይ ቪ/ኤድስ የሚያስከትላቸው ችግሮች ምን ምን ናቸው?
    - ✓ ኤች አይ ቪ/ኤድስ ሊያስከትላቸው የሚችሉ ማህበራዊና ኢኮኖሚያዊ ችግሮችን አብራሩ?
- የራዲዮ ፕሮግራሙ ከግለሰባዊ ተግባራት ጋር መጣመሩ ያስገኘው ፋይዳ /ለአድማጮች ቡድን የቡድን ተኮር ተወያዮች ብቻ
  - ✓ በይቻላል ራዲዮ አድማጭ ቡድን አባልነት ምን ምን አየሰራላችሁ ነው?
  - ✓ በዋናነት የምትወያዩባቸው ርዕሰ ጉዳዮች ምን ምን ናቸው?
  - ✓ ኤች አይ ቪ/ኤድስ የብዙ ጊዜ የመወያያ ርዕሰ ጉዳዮችሁ ነው?

- ✓ በአድማጮች ቡድን በመሳተፋችሁ ያገኛችሁባቸውን ጥቅሞች አብራሩ?
- ✓ ከራዲዮ ፕሮግራሙ በሁዋላ በምታደርጉባቸው የኤች አይ ቪ/ኤድስ ዙሪያ ወይይቶች አማካኝነት ስለ ኤች አይ ቪ/ኤድስ የነበራችሁ ግንዛቤ ክፍ ብሎዎል? መልሳሁ አዎ ከሆነ፣ እንዴት?
- ✓ ከወይይቱ ስለ ኤች አይ ቪ/ኤድስ ምን ምን ጠቃሚ ግንዛቤ አገኛችሁ?
- ✓ የራዲዮ ፕሮግራሙን በማድምጥና በመወያይቱ ሂደት ላይ ምን የጎደለ ነገር አለ?
- ✓ በመጨረሻ የምትሉት ካለ ዕድሉን ልስጣችሁ?

**1.6. የቃለ መጠይቅ አቅጣጫዎች**

ይህ ቃለ መጠይቅ የተዘጋጀው በአዲስ አበባ ዩኒቨርሲቲ ለማስተር መርሐ ግብር ማሙዋያ ጥናት ሲሆን ዐላማውም ሁለቱ የይቻላል ራዲዮ አድማጭ አይነቶች ያላቸውን የኤች አይ ቪ/ኤድስ ግንዛቤ/አወቀት በመመዘን የራዲዮ ፕሮግራሙ ከግለሰባዊ ተግባራት ወይም ከቡድን ወይይት ጋር መጣመሩ ያስገኘው ፋይዳ ካለ ማግኘት ነው። የጥናቱ ውጤታማነት ሙሉ በሙሉ እርስዎ በሚሰጧቸው መልሶች እውነተኛነት ላይ የተመሰረተ መሆኑን በመገንዘብ ትክክለኛ ምላሽ ይሰጡ ዘንድ በአክብሮት እጠይቃለሁ። እርስዎ የሚሰጡኝን ምላሾች ለተባለው ጥናት ብቻ የምጠቀምባቸው፣ ከእርስዎ ጋር በቀጥታ የማላገናኛቸውና በሚስጢርም የምጠብቃቸው መሆኑን ቃል እገባለዎታለሁ። ስለሚያደርጉልኝ መልካም ትብብር ከወዲሁ አመሠግናለሁ።

**ለጎንደር የትምህርት ማሰራጨ ማዕከል አስተባባሪ**

1. የይቻላል ራዲዮ ፕሮጀክት ዐላማን ቢያብራሩልን?
2. ይህን አይነት የራዲዮ ፕሮግራም ለመጀመር ምን አነሳሳችሁ?
3. የራዲዮ ፕሮግራሙ አድማጮች እነማን ናቸው?
4. የራዲዮ ፕሮጀክታችሁ የሚደርሳቸውን ሁለት የአድማጭ አይነቶች ቢያብራሩልን?
5. የአድማጭ ቡድኖችን የምትመለምሉት ከየት ነው? ለምን?
6. በራዲዮ ፕሮግራማችሁ በሰፊው ሽፋን የሚሰጣቸው ርዕሰ ጉዳዮች ምን ምን ናቸው?
7. የኤች አይ ቪ/ኤድስን ስርጭት ከመግተት አንጻር በአድማጮች ቡድን ላይ የእናንተ ራዲዮ ምን ሚና አለው?
8. ፕሮጀክቱ ሲጀምር የነበረው የተማሪዎች የኤች አይ ቪ/ኤድስ ግንዛቤ ምን ይመስል ነበር?

9. በኤች አይ ቪ/ኤድስ ዙሪያ በምታሰራጨቸው ፕሮግራሞች ላይ ከአድማጮቻችሁ ግብረ መልስ ታገኛላችሁ? መልስዎ አዎ ከሆነ፣ ከግብረ መልሶች በኤች አይ ቪ/ኤድስ ላይ ምን አይነት የአድማጮች የግንዛቤ መሻሻሎች አስተዋሉ?
10. የሬዲዮ ፕሮግራሙን ከቡድን ተኮር ግለሰባዊ ተግባራት ጋር ማዋሃድ ያስገኛቸው ጠቀሜታዎች ካሉ ቢያብራሩልኝ?
11. ምሳሌ በመጠቀም የሬዲዮ ፕሮግራሙን ከግለሰባዊ ተግባራት ጋር መቀላቀል ያስገኘውን ፋይዳና ያድማጭ ቡድን ያልሆኑት ሊያጡ የሚችሏቸው ጥቅሞች ካሉ ቢያስረዱን?
12. የአድማጭ ቡድኖች በአሁኑ ወቅት ያላቸው የኤች አይ ቪ/ኤድስ ግንዛቤ እንዴት ይገልፁታል?
13. የአድማጩን የኤች አይ ቪ/ኤድስ ግንዛቤ በከፍተኛ ደረጃ ለማሻሻል ከፕሮጀክታችሁ ምን የጎደለ ነገር አለ?
14. የሚጨምሩት ነገር ካለ?

## Annex II: The t-test values of *Yichalal* Radio Listening and Non-listening Group Questionnaire Respondents

### 1.8. Listening Group

#### 1.8.1. By Gender

**Group Statistics**

	Gender	N	Mean	Std. Deviation	Std. Error Mean
HIV/AIDS Knowledge	Male	11	34.5455	1.50756	.45455
	Female	12	28.3333	3.79793	1.09637

**Independent Samples Test**

	Levene's Test for Equality of Variances	t-test for Equality of Means								
		F	Sig.	t	Df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
HIV/AIDS Knowledge	Equal variances assumed	8.381	.009	5.064	21	0.000	6.21	1.2268	3.66082	8.76342
	Equal variances not assumed			5.234	14.600	0.000	6.21	1.1868	3.67683	8.74742

#### 1.8.2. By Age

**Group Statistics**

	Age	N	Mean	Std. Deviation	Std. Error Mean
HIV/AIDS Knowledge	10-13	6	30.8333	6.30608	2.57445
	14-17	17	31.4706	3.55524	.86227

**Independent Samples Test**

		Levene's Test for		t-test for Equality of Means							
		Equality of Variances								95% Confidence Interval	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper	
HIV/AIDS Knowledge	Equal variances assumed	5.337	.031	-.307	21	.762	-.63725	2.07522E0	-4.95291E0	3.67840E0	
	Equal variances not assumed			-.235	6.161	.822	-.63725	2.71501E0	-7.23892E0	5.96441E0	

**1.8.3. By Grade Level**

**Group Statistics**

		Grade Level	N	Mean	Std. Deviation	Std. Error Mean
HIV/AIDS Knowledge	Seventh		7	31.5714	3.99404	1.50961
	Eighth		16	31.1875	4.51986	1.12997

**Independent Samples Test**

		Levene's Test for		t-test for Equality of Means							
		Equality of Variances								95% Confidence Interval of the	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper	
HIV/AIDS Knowledge	Equal variances assumed	.065	.801	.194	21	.848	.38393	1.98308	-3.74011	4.50797	
	Equal variances not assumed			.204	1.298	.842	.38393	1.88567	-3.69053	4.45839	

## 1.9. Non-listening Group

### 1.9.1. By Gender

**Group Statistics**

	Gender	N	Mean	Std. Deviation	Std. Error Mean
HIV/AIDS Knowledge	Male	11	29.9091	3.85887	1.16349
	Female	12	23.5000	3.84944	1.11124

**Independent Samples Test**

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
HIV/AIDS Knowledge	Equal variances assumed	.032	.860	3.984	21	.001	6.40909	1.60872	3.06357	9.75461
	Equal variances not assumed			3.984	20.817	.001	6.40909	1.60890	3.06141	9.75677

### 1.9.2. By Age

**Group Statistics**

	Age	N	Mean	Std. Deviation	Std. Error Mean
HIV/AIDS Knowledge	10-13	6	28.3333	2.80476	1.14504
	14-17	17	25.9412	5.49398	1.33249

**Independent Samples Test**

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
HIV/AIDS Knowledge	Equal variances assumed	3.123	.092	1.010	21	.324	2.39216	2.36812	-2.53262	7.31693
	Equal variances not assumed			1.362	17.616	.190	2.39216	1.75688	-1.30469	6.08900

**1.9.3. By Grade Level**

**Group Statistics**

		Grade Level	N	Mean	Std. Deviation	Std. Error Mean
HIV/AIDS Knowledge		Seventh	7	25.2857	3.30224	1.24813
		Eighth	16	27.1250	5.57225	1.39306

**Independent Samples Test**

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
HIV/AIDS Knowledge	Equal variances assumed	3.950	.060	-.807	21	.429	-1.83929	2.27911	-6.57896	2.90039
	Equal variances not assumed			-.983	18.670	.338	-1.83929	1.87041	-5.75879	2.08022