

HIV/AIDS Information, Education and Communication in Zimbabwe: Why Focus on Young People?

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Abstract

In recent times, there has been an upsurge in the production of HIV/AIDS Information Education and Communication (IEC) materials for young people in Zimbabwe. This comes after a long-standing failure to address the HIV epidemic amongst this group, and the manifestation of World Health Organisation's guidelines for strengthening HIV/AIDS interventions for young people at risk or living with HIV. The aim of this study is to explore factors that strengthen the vigorous production of youth multimedia HIV/AIDS IEC in Zimbabwe. It responds to the research question: "what are the factors ensuing the strengthened production of youth HIV/AIDS IEC?" The study is informed by the Social Learning Theory (Bandura, 1977) which postulates that human beings learn from interactive situations through observation, followed by assimilation, and then imitation of positive behaviours. The extensive production of multimedia HIV/AIDS IEC in Zimbabwe is partly associated with the objective to modify undesirable behaviours that lead to youth vulnerability, owing to various socio-demographic factors defining this population. It is concluded that, HIV/AIDS IEC interventions are a vital part of HIV prevention, hence their production is goal directed. Suggested is the adoption of appropriate designs and systematic evaluation of IEC, in order to adequately address youth HIV/AIDS information needs.

Key Words: HIV/AIDS IEC; Young People; HIV Prevention; SLT Model; Zimbabwe.

Introduction

This study adopts the UNAIDS (2016) designation of young people as constituting both adolescents aged between 10 and 19 years and youths aged between 15 and 24 years. Its aim is to explore some key social factors that inspire the robust production of youth multimedia HIV/AIDS Information Education and Communication (IEC henceforth) materials in Zimbabwe. This comes after an enduring failure to address the HIV epidemic amongst young people. As will be explained later, early HIV/AIDS information in Zimbabwe was mainly awareness communication targeting adult populations, meanwhile excluding the young population, generally creating HIV/AIDS programming gaps (Herald, 2017). In this regard, UNESCO (2014) notes that young people are often forgotten in national HIV/AIDS plans and programmes, which mostly, typically focus on adult populations and children, resulting in youth-unfriendly health services. In the past, HIV/AIDS interventions often failed to take into cognizance the fact that HIV risks, challenges to

access services and solutions to HIV problems differ at various stages of life. Thus UNAIDS (2016) advocates for HIV programmes that both adopt a 'life-cycle' approach to prevention and respond to all ages and contexts.

Following the realisation that young people have been left out of the prevention initiatives, coupled with the widespread association between youth and high HIV prevalence in Zimbabwe and other countries worldwide, the World Health Organisation (WHO)(2015) crafted some guidelines for strengthening communication programmes that focus on young people at risk, and those living with HIV. It is clear that, Zimbabwe, similar to other Southern African countries, has taken initiative to address the problem of HIV/AIDS in young people, in order to bridge the prevention gap which has resulted in the exclusion of this group. The main objective of youth HIV/AIDS IEC is to change what is perceived as HIV risk behaviours and to inform

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about HIV prevention strategies, through distributing relevant information. However, the task according to Bessinger et al. (2004), is not easy as it requires a clear understanding of communication obstacles to effective HIV prevention education. To scale up HIV/AIDS education and knowledge uptake, these IEC programmes are channelled by the Ministry of Health and Child Care (MoHCC) in collaboration with National AIDS Council, non-governmental organizations, media organizations, broadcasters and other stakeholders.

Given the above deliberations, the study's assumption is that the strengthened focus on producing HIV/AIDS IEC materials for young people in Zimbabwe is symptomatic of this population's active role in the existence and eradication of the pandemic. Based on this assumption, the key research question of the study is: "what are the factors ensuing the accelerated production of youth HIV/AIDS IEC?" In order to effectively address this question, this article is demarcated into subsections which address various issues including review of related literature, theoretical framework, discussions, implications, conclusions and recommendations.

Defining HIV/AIDS Information, Education and Communication (IEC)

This section provides an overview description of HIV/AIDS IEC as a form of health communication. This outline commences with explaining the general understanding of IEC, and then proceeds to describe HIV/AIDS IEC precisely. Given its broad nature, and as demonstrated below, there are various definitions of IEC, which are, nevertheless, related.

Broadly, IEC is defined as a process of working with individuals, communities and societies to develop communication strategies in order to promote positive behaviours, which are appropriate to their settings (UNESCO, 2006). Rogers and Storey (1987) agree to IEC being a process, they characterise it as "a set of organised communication activities designed and implemented to achieve specific objectives among an intended audience within a specific, limited period of time" (p. 13). This is corroborated by WHO's (2000) claim that, IEC is a broad term comprising a range of approaches, activities and outputs.

IEC is also perceived as a process of social change, involving community engagement and activities, focusing on what is termed "client-identified end actions" (Global Malaria Action Plan (GMAP), 2010). In order to produce desired

results, IEC programmes need to integrate message delivery and other behavioural interventions and prospects, focused on community dialogue, shared learning and consensus-building (GMAP, 2010). In corroboration, WHO (2001) maintains that IEC is a multidisciplinary and 'client-centred' approach which attempts to change or reinforce a set of behaviours in a "target audience" concerning a defined problem in a specified period of time. If well executed, IEC will foster positive health practices, individually and institutionally, and can contribute towards viable change to healthy behaviour (WHO, 2001). Hence, as IEC involves community and behaviour modification, communication is at the centre, encompassing; information delivery, training and human resource development and awareness, and motivational communication concerns (UNESCO, 2006).

In health contexts, "IEC is broadly defined as providing knowledge to enable individuals, families, groups, organisations and communities to play active roles in achieving, protecting and sustaining their own health" (GMAP, 2010: 2). In the same token, Clift (2001) defines IEC as a public health approach concerning a specific problem and within a pre-defined period of time, aiming at changing or reinforcing health related behaviours in a target audience, through communication methods and principles. According to GMAP (2010), IEC can be compared with behaviour change communication (BCC), where "BCC includes the basic components of IEC, but starts with a focus on the key individual and group behaviours to be changed and employs a wider range of interventions, beyond cognitive-based knowledge transfer" (p. 2). This study adopts a broader definition of IEC provided by MoHCC and Zimbabwe National Family Planning Council (ZNFPC) encompassing aims, scope and purpose. It states that:

Information, Education and Communication (IEC) in health programmes aims to increase awareness, change attitudes and bring about a change in specific behaviours. IEC means sharing information and ideas in a way that is culturally sensitive and acceptable to the community, using appropriate channels, messages and methods. It is therefore broader than developing health education materials, because it includes the process of communication and building social

networks for communicating information. IEC interventions should involve the active participation of the target audience and adopt channels, methods and techniques that are familiar to their world view. Information, education and communication is an important tool in health promotion for creating supportive environments and strengthening community action, in addition to playing an important role in changing behaviour. (MoHCC and ZNFPC, 1998: 5).

Approaches to IEC may range from the use of mass media channels, employed to inform and establish positive behaviours amongst the general population, to the use of interpersonal communication activities that target specific groups, in order to evaluate own actions, leading to behaviour change (WHO, 2000). Arya et al. (2013) concurs that IEC approaches include mass media used to inform or establish positive norms among the general population or the use of interpersonal communication to assist those at risk to assess their own behaviour and develop new personal skills. Ewles and Simnett (2003) elaborate that there are various sub-categories to mass media IEC, incorporating both print and electronic mediated materials, as well as verbal and non-verbal interpersonal communication activities.

Based on the definitions above, HIV/AIDS IEC can be viewed as mass media and interpersonal communication, which is community based, tailor made for specific groups perceived most at risk (key populations) and executed to change behaviour in the task of HIV prevention. Key populations are defined as people who, as a result of specific higher-risk behaviours, are at an increased risk of HIV, and often have legal and social issues which escalate their vulnerability (Zimbabwe National AIDS Council (ZNAC), 2018). Examples of key populations in Zimbabwe are the youth, sex workers or people involved in multiple concurrent partnerships, men who have sex with men, people who inject drugs, people in prisons and closed places and transgender people.

In this study, HIV/AIDS IEC in Zimbabwe are perceived to incorporate Khuat's et al. (2004) subcategories, which include: print materials used to post information in the public (brochures, posters, wall calendars, playing cards, banners, billboards, stickers, murals, etc.); mass media approaches (30-60 seconds public service announcements, 5-10 minutes short dramas, docu-

dramas, documentaries and recorded musical and theatrical productions); give-aways which are quickly disseminated and integrated into community life (condoms, wrist bands, key holders etc. coded with key HIV prevention messages); community awareness events (focus group discussions, health fairs, theatrical performances, etc.) and innovative methods used to reach target groups (short message services, post cards conveying positive messages, puzzles with HIV messages). Mass media IECs are broadcast on national televisions and radios, viewed as DVDs and VCDs in public areas such as clinic waiting rooms, shops, bars or clubs (Khuat et al., 2004). Given the wide range of HIV/AIDS IEC types, it is important to note that this study is mainly interested in those that focus on young people, with a view to rationalise their strengthened production in the recent years.

Historical Phases in the Production of HIV/AIDS IEC in Zimbabwe

The purpose of this section is to trace the historical trends in the production of HIV/AIDS IEC materials in Zimbabwe. This review is useful as it provides an illuminating background into HIV/AIDS IEC activities in Zimbabwe, necessary to adequately answer the imposed study's research question, which enquires into the prevailing, intensified focus on HIV/AIDS IEC targeting young people. The productions of HIV/AIDS IEC interventions in Zimbabwe have progressed through stages, defined by their communicative objectives and the information needs of the target audiences. As such message content and form of IEC materials are consistently transforming over time, given the changing socio-biological nature of HIV/AIDS, owing to changes in perceptions, knowledge, social acquaintance with HIV and ongoing cure and treatment research. Thus, in order to successfully delineate the stages of development of HIV/AIDS IEC in Zimbabwe, this study focuses on the following indicators; period, themes, target groups and message types. The identified phase indicators differ from one stage to another, considering that the goals and circumstances of communication also vary in each phase as revealed below. Three phases of HIV/AIDS IEC production are delineated, namely: awareness; de-stigmatisation and prevention; and care and treatment phases.

HIV/AIDS Awareness Phase

The first decade (1987-1997) of HIV/AIDS information production in Zimbabwe, since the identification of the first AIDS case in the mid-

1980s, targeted various groups, especially the adult populations. When HIV first appeared, it proffered a new serious health problem. Its apparently incurable nature and the fact that it mainly spread through sexual means, posed a major challenge to the way people received it, conceived it and talked about it (Heald, 2002). According to Mashiri et al (2002), there were a lot of misconceptions concerning its origin, acquisition and treatment, and hence interlocutors employed negative and derogative language with reference to HIV and AIDS. In that context, dominant stigma was attached to the HIV pandemic, as well as discrimination against AIDS patients. Thus, during this period, the main objectives of HIV/AIDS messages were to raise public awareness and what the pandemic entailed. Although discrimination against AIDS patients was cropping, issues of stigma and its consequences on the prevention efforts were not yet an objective of IEC production. In fact, some critics believe that HIV messages promoted stigma through denouncing the nature of the disease (Heald, 2002). For instance, one popular early HIV/AIDS poster read:

*Use condoms, protect yourself from HIV / Beware!
HIV destroys families
HIV positive, condemned / Love life, protect
yourself from HIV infection.*

The main concern during the first phase was prevention from infection which was understood then, as an immediate cause of death, based on the knowledge that AIDS is an incurable disease.

AIDS was also mystified as an alien disease, a rare and unusual phenomenon, during the initial period of HIV experience and programming. One popular poster produced by Media Resource Desk read: *"We bring accurate HIV/AIDS information together when you need it"*. This message pointed to lack of awareness and knowledge of the pandemic, a period of grappling to understand its nature. Thus, information about HIV/AIDS was designed to aid people to detect the past, present and the future of the disease in their communities. Another message communicated in one of the early posters read: *"HIV, facing the challenges together"*. Here, HIV was viewed as a social adversity, seen in its cumbersome nature, burdening people who did not have sufficient resources or knowledge to deal with it. Hence a call for collective action in dealing with this challenge.

In addition to the fatal perception of the disease, early HIV/AIDS IEC messages also

focused on testing as the most significant step towards prevention. HIV testing and counselling messages were thus common, resonating with sprouting New Start Centres, located in most urban areas of the country. The New Start Centres focused on testing for HIV and pre and post-test counselling as prevention methods. In addition to print materials such as posters and flyers, people were encouraged to get tested through newspaper, television and radio announcements, enhancing outreach. The key message was: *Visit Your Nearest Clinic or New Start Centre and Get Tested Today!* This message laid foundation for HIV management and prevention in Zimbabwe, where discovering one's status was and still is perceived as the starting point in the fight against the pandemic. In addition, various other health messages such as those that focused on opportunistic diseases that lead to AIDS, for instance TB and STIs, adopted the phrase *"know your status"* as their campaign motto for several years. The emphasis on establishing one's status, although it was viewed as a strategic move towards prevention, it also reveals fear and uncertainty surrounding HIV infection.

Further, early talk about the disease was also essentially a discourse of blame, rejection, denial and hopelessness. It was typical of blaming one another, rejection of risk among people and even verbal denial of the presence of the pandemic in the society (Heald, 2002). Hence, initial HIV/AIDS IEC messages apparently laid clear responsibility for the burden of the pandemic on particular groups, whilst others were portrayed as victims. Thus, IEC programmes presented perpetrators versus the victims, promoting stigma and discrimination. For instance, the use of the phrase *"who's having sex with who?"* in a poster produced by National AIDS Council, encouraged the blaming game, where the responsibility for the spread of HIV was mainly placed on an individual or a group. This was typical of the initial phase of HIV/AIDS programming in Zimbabwe, a period of very little understanding of the pandemic. As already noted, the main forms of HIV/AIDS communication were mass media (television, radio and newspapers) and print (billboards, posters and flyers). Nevertheless, approaches to HIV/AIDS IEC transformed in later stages as producers identified more effective forms of communication such as computer mediated and interpersonal interactions.

HIV/AIDS De-stigmatisation and Prevention Phase

Approximately a decade later after the awareness period, research indicates that HIV/AIDS perceptions revolved from the fatalistic view to acceptance and tolerance of the pandemic. The change of perceptions is attributable to improved HIV/AIDS knowledge and the eventual acknowledgement of its presence. This phase is termed the de-stigmatisation and prevention period, stretching roughly from 1998 to 2007, focusing on restoration and rectifying previous misconceptions in the task of HIV prevention. Thus, in IEC materials, the silence that surrounded HIV/AIDS issues, prevailing in the early years of the disease, shifted from the implicit to explicit communication about sexual matters relative to HIV and illnesses.

Examples include, the Sexual Reproductive Health Rights poster by SAfAIDS which reads: *“It’s not all about sex-sexual and reproductive health rights are also about responsibility”*. Another poster by NAC reads: *“Be responsible for whom you have sex with”*. A similar message is also seen in a PSI poster message which reads: *“Are you aware of your sex partner’s status?”*. In these messages there is the explicit use of the term ‘sex’. Explicitness aids comprehension and communication efficacy by means of avoiding ambiguity and obscurity, although it might offend and alienate target audiences. Thus, HIV/AIDS IEC materials have since gone beyond the confinements of language taboo in order to achieve successful communication and hence meaningful behavioural change as a positive step towards prevention of the spread of HIV.

In addition, the improved HIV/AIDS IEC materials indicated an acute openness and support for people living with HIV (PLHIV) as opposed to the olden day silence, shame and discrimination. Some key messages indicating de-stigmatisation initiative include:

People living with HIV stand up and have a say in HIV Programming (People Living with HIV/AIDS) Inform yourself to stay healthy and stand up for your rights. (National AIDS Council)

One of us is HIV positive...love us and let us live (Ministry of Health and Child Care).

These messages aimed at eliminating stigma and promoting the rights of the PLHIV. Thus, Avert (2010) noted that there was a growing

tendency towards de-stigmatization in Zimbabwe and Africa, where people have begun to open up about their HIV status and that of their family members who are suffering or who have died from the disease. It is argued that these attitudes may be the result of the realization that HIV is a collective problem. The antiretroviral drug has played a significant role in piloting the change in attitudes towards the disease, and this change is mainly reflected in the progressively changing HIV/AIDS social discourses. However, as Avert (2010) warns, it will take years before the process of de-stigmatization is complete, given that the majority of the populations in Southern Africa still embrace negative attitudes towards the disease.

Moreover, HIV/AIDS messages produced during the period of restoration and de-stigmatisation encouraged behaviour change for HIV prevention. Prevention is thus perceived as a collective responsibility where everyone is accountable for HIV existence as well as elimination. Below are examples of such IEC messages produced by various organisations:

*One of us is HIV positive...we still care
Prevention of HIV is everyone’s responsibility
Only you can stop the sexual network.
You can do it.
If you care, you can be a leader
HIV is a business risk, have you made
HIV and AIDS your business?*

These messages indicate collective responsibility for the problem of HIV/AIDS, where every member of the public has a role to play in its prevention and management through behaviour change. This is contrary to the earlier messages which promoted silence, denial, stigma and discrimination as well as blame for one another.

HIV/AIDS Care and Treatment Phase

After the de-stigmatisation period, from around 2008 up to date (2019), a new wave of HIV/AIDS campaigns was introduced, whose objective was to promote HIV treatment and care, establishing a third phase of HIV/AIDS programming in Zimbabwe. This phase was inspired by advances in scientific HIV cure research, which, although has not managed to yield a cure, has succeeded in establishing various HIV treatment therapies such as; antiretroviral therapy (ART) (2007), voluntary medical male circumcision (VMMC) (2009), prevention of mother to child transmission (PMCT) (2011), treatment as prevention (TasP)

(2016) and pre-exposure prophylaxis (PrEP) & post-exposure prophylaxis (PEP) (2016). Recently, other medical prevention strategies have been introduced; HIV self-testing kit (2018), HIV self-screening kit (2019) and Instant-HIV self-test (2019). Thus, most HIV/AIDS IEC materials up to date, attempt to encourage people to use these newly acquired HIV treatment and prevention strategies as methods of controlling the spread of HIV and managing the disease. There is optimism based on the perception that acquiring HIV is not synonymous with death, but there is hope for survival. Hence, focus is on encouraging people to go for treatment of AIDS related ailments. For example, some poster messages advocate for ARV treatment:

People living with HIV need treatments for opportunistic infections and antiretroviral drugs (ARVs) (SAFAIDS) Treat the people. Save lives!(Ministry of Health and Child Care)

More examples of HIV/AIDS IEC messages that are currently produced, encouraging HIV treatment include:

*PrEP is a new and exciting approach to HIV prevention
PindamuSmart. Get circumcised today!
Early and accessible treatment makes the elimination of HIV transmission a possibility and makes treatment a key aspect of HIV prevention.
Take positive steps today-and protect your baby from HIV.*

It is clear here that HIV is perceived not as the end but the beginning of care towards one's health. Also, the use of the phrase "*living with HIV*" critically signifies the acceptance and understanding of the virus as part of human experience as any other infection. Relatively, as a way of facilitating an effective prevention process, HIV is perceived as a normal disease such as cancer or TB, for the sake of its de-stigmatization. An example of this objective is the NAC poster message that reads:

*HIV and TB + treatment = improved quality of life.
Living with HIV is now regarded as a chronic health condition-like diabetes or high blood pressure (BP)*

Here there is not only optimism for a healthy future, but the early terminal view of the pandemic is transformed as it is equated and associated with common conditions such as tuberculosis and hypertension.

As a result of major advances in HIV treatment in the past decade, there is belief that scientists are closer to finding a cure to prevent the transmission of HIV. Thus, basing on that notion, contemporary HIV/AIDS IEC materials are dedicated to urge the public to adopt the newly established treatment resources as we prepare for the imminent cure. Consequently, some messages carry an optimistic view of the future without HIV. An example of this contention is displayed in the NAC poster message which bears the message: "*An HIV free generation, it begins with you*".

In summation, the discussion above shows that the production of HIV/AIDS IEC materials in Zimbabwe can be broadly categorized into three phases, and that the changing form and content of these messages is reflective of their varying objectives determined by the social and scientific progress of the pandemic. As already stated, what is referred to as the awareness period, is the first stage of HIV/AIDS communication and programming, in the onset of HIV/AIDS, during which campaign messages were used to spread awareness of the disease. However, as the campaign grew in scope and margin, there was realization that awareness only is not enough in the task of HIV prevention. Removing the stigma associated with the virus, and encouraging behaviour change became the major objective to foster public acceptance and tolerance for HIV/AIDS. This constitutes the second phase of HIV/AIDS IEC material productions, termed 'de-stigmatisation and prevention', which departs from merely raising HIV awareness to promoting tolerance and acceptance for the pandemic. The last identified phase of HIV/AIDS programming and communication, extending from around 2008 up to date, is characterized with optimism for the present and the future based on availability of prevention and treatment methods. Thus, as indicated, current HIV/AIDS IEC materials mainly encourage people to get treatment and to utilize available prevention methods, so as to end the burden of HIV/AIDS.

Theoretical Orientation: The Social Learning Theory

The Social Learning theory (SLT), developed by Bandura (1977), has become one of the most influential theories of learning and development, as it promotes desirable behaviour change (Muro

and Jeffrey, 2008). It is often viewed as a bridge between behaviourist learning theories and cognitive learning theories, since it incorporates attention, memory and motivation. Bandura stresses that direct emphasis alone cannot account for all types of learning, instead, he refers a social element to the learning context, arguing that individuals learn new information and behaviours through observing others. In this context, the SLT is based on the view that human beings learn from their interactions with others through observing behaviours, followed by assimilation and then imitating those behaviours, especially if they are positive or include rewards. Nonetheless, it is emphasised that, whereas observational learning may occur at any age, imitation involving the actual reproduction of the observed behaviour may take place at life stage, and learning new information through the modelling process is always possible (Newman and Newman, 2007).

Thus, according to the SLT, the determinants of human behaviour reside not within the individual, but in the external (environmental) forces, given that the internal forces (for example needs, drives and impulses) are influenced by the environment (Komunda, 2007). Although this theory has been criticized for reducing individuals to mere respondents of external forces, its relevance lies in its ability to associate environmental factors with other personal and behavioural entities in the production of specific behaviours. In this regard, the theory further postulates that, although behaviour is modified by the external environment, human beings have the capacity to exercise some degree of control over their own behaviour through organising the environmental triggers, producing cognitive support and generating consequences for one's own actions (Komunda, 2007). This theory is useful for understanding the approaches used in HIV/AIDS communication.

The SLT model can be used to explain the view that HIV/AIDS IEC would result in learning outcomes and are bound to increase knowledge and awareness in individuals. It entails that through IEC exposure, individuals would certainly observe, assimilate and then imitate whatever is observed, especially when it is positive and rewarding. However, it also means that, since individuals have control over change of their behaviour through organising their own environment, behavioural modification through exposure to HIV/AIDS IEC is not guaranteed, although it is possible. In this study, the fast-track production of HIV/AIDS IEC for young people is perceived to be influenced by Bandura's model,

which places emphasis on exposure as a basis for learning and behaviour adoption. To this end, the producers of IEC messages rely on these to modify undesirable behaviours, actions and perceptions, which are believed to fuel HIV prevalence, a leading cause of death amongst young people in Africa.

HIV/AIDS IEC: Why Focus on Young People?

The first most compelling factor resulting in the strengthened production of HIV/AIDS IEC for young people in Zimbabwe is the perceived high HIV prevalence in this group. Despite the steady decline of HIV prevalence in adults, new epidemics are emerging in young people (National AIDS Council, 2018, Herald, 2017 and Hove, 2019). Currently, HIV prevalence in this population is estimated at 21%, against 13.1% in adults (Hove, 2019). Thus, whereas there is strong evidence of HIV/AIDS decline in the adult population in Zimbabwe, HIV prevalence in the youth population is on the rise. In fact, at present, there is growing evidence pointing to young people being the source of the budding new HIV epidemics in the country, as postulated by Dr Parirenyatwa the former minister of health and child care in a report on national HIV progress (Herald, 2017). He confirms that the youth in Zimbabwe, who are the sources of new HIV infections, embody an HIV prevention gap. Parirenyatwa underscores youth susceptibility when he notes that: 'We discovered that there are four groups in this country where the HIV rate is still high. Those on the lead of the group are young people, both girls and boys, especially those in colleges and universities' (Herald, 2017: 1).

The evidence showing growing HIV epidemics in young people is not unique to Zimbabwe. It is reported that young people aged between 15 and 24 years represent one of the most HIV/AIDS vulnerable groups (UNAIDS, 2018) and that the number of adolescents living with HIV worldwide rose by 30% between 2005 and 2016 (UNICEF, 2017). In the same token, UNICEF noted that the number of adolescents who died from AIDS related illnesses worldwide increased by 300% between 2000 and 2015. Thus, according to Avert:

The medical advances that have transformed HIV treatment have yet to alter the stark reality of young people, particularly in low to middle-income countries, such as those in sub-Saharan Africa, and young people within key

populations. While AIDS related deaths have halved in children since 2010, they have only fallen by 5% in adolescents. AIDS, in other words, is far from over-especially for young people (2019: 1).

UNAIDS (2015) confirms that AIDS is now the leading cause of death among young people in Africa, and the second leading cause of death in this population worldwide. It is also noted that 84% of the young people living with HIV are found in sub-Saharan Africa (UNICEF, 2017). In addition, UNICEF predicts that close to a million adolescents in Africa could become infected between 2016 and 2030, stalling the 'getting to zero new HIV infections, zero discriminations and zero deaths by 2030' goal. Thus, whereas HIV prevalence is high in young people, it is a cause of concern that most African countries are youthful populations, elevating the burden of HIV in these countries (UNAIDS, 2013).

Apart from high HIV prevalence in young people, another constraining factor, resulting in the accelerated production of HIV/AIDS IEC materials for this group, has to do with young people's vulnerability to HIV/AIDS. Their susceptibility emanates from aspects such as; premature engagement in sexual intercourse, failure to consistently use condoms in multiple sexual relationships, cross generational sex, being part of key populations, low HIV/AIDS risk knowledge and others (International HIV/AIDS Alliance, 2017 and Patton, et al., 2009).

Early sexual debut is a serious concern, calling for urgent HIV/AIDS interventions and programmes in Zimbabwe, as it escalates HIV prevalence in young people. According to reports, 60% of child births in Chiredzi involves girls aged between 12 and 16 years, consequent of child marriages and sexual abuse in this area (Hove, 2019). In agreement, UNICEF (2017) estimates that approximately 30-50% of girls in southern Africa give birth to their first child before 19 years. Thus, STOP AIDS (2016) notes that, child marriages are a key driver of early sexual debut, highlighting that abusive cultural practices heighten girl-child HIV vulnerability. In addition, it is projected that, every year since 2010, young women constitute up to 67% of new HIV infections among adolescents in sub-Saharan Africa (UN Women, 2016). In this context, it is argued that young women are two times more vulnerable than young males, doubling their chances of acquiring HIV (UNICEF, 2017 and UN Women, 2016). Thus, some of youth HIV/AIDS

interventions focus particularly on young women such as. For instance, multiple concurrent partnerships (National AIDS Council), sexual reproductive health rights (SAfAIDS) and gender based violence (PSI Zimbabwe).

HIV/AIDS IEC for young people also thrive to address the problem of failure in most cases by this group to use protection in multiple concurrent relationships. The youth are known to engage in risky sexual behaviours, which emerge at puberty, such as having many sexual partners without using protection and without considering the consequences (Patton, et al., 2009). A Demographic and Health Survey conducted between 2010 and 2016 indicated that less than 60% of young people (aged between 15-24 years) in most of the African countries did not use a condom in their last sexual intercourse encounter. Given that the main means of HIV transmission in Africa is heterosexual intercourse, this revelation is worrying, necessitating the acceleration of the production of HIV/AIDS information, that would address this concern. Examples of IEC programmes reacting to poor use of protection amongst the youth include condom campaigns such as; *Condomize*, *Protector Plus*, and *ABC* campaigns.

The gripping reality of cross-generational sexual relations within age-disparate relationships, are indications of immediate need for HIV/AIDS IEC interventions for young people. Cross-generational or intergenerational relationships involve young people having sexual associations with older people, perceived as important drivers of HIV epidemic in sub-Saharan Africa and other low to middle income countries (UNICEF, 2017). Sexual relations in these relationships are described as transactional in nature, where sex is exchanged for material gains. Young people, especially girls, are driven into age-disparate relationships owing to factors such as poverty, powerlessness or simply desire to experiment. However, it is alarming that in these relationships, young people are likely to be coerced into unsafe sex practices with older people due to unequal power balances, enhancing their vulnerability to HIV (ATHENA, 2013). Examples of HIV/AIDS IEC messages that react to this reality are those that discourage cross-generational sexual partnerships and promote healthy sexual relationships, in a bid to reduce HIV risk.

Further, young people's susceptibility, arising from their being a major part of the vulnerable populations, instigates urgency in the production of HIV/AIDS IEC programmes, targeting this group. It is quite unfortunate that young people in

Zimbabwe mainly constitute vulnerable populations, intensifying their HIV risk. Various forms of susceptibility derive from social issues such as age and low socio-economic status, rendering them powerless in relationships. This results in failure to make decisions that protect their own interests and/or physical or emotional predisposition to more powerful groups. In this context, young people's exposure to HIV is higher than that older populations. Thus, Avert (2019: 1) concurs that, "You have stigma if you are young, a sex worker and a transgender."

Young people vulnerability also results in failure to access health care. Instead, the youth bear disproportionate HIV burden in comparison to other populations, owing to various socio-demographic factors that defining them. To this end, it is noted that failure to access healthcare has to do with youth hood itself, where perceptions about right or wrong are still low. In support, MacPherson's et al. (2015) study involving selected countries in sub-Saharan Africa, including Zimbabwe, indicates that just 62% of young people aged between 12 and 24 years are able to adhere to medication effectively, as a result of immaturity. Thus, the role of HIV/AIDS IEC is significant in changing negative attitudes in young people, so as to prevent HIV risk.

Moreover, the perceptible low HIV knowledge amongst young people is an obliging factor, prompting manifest commitment to HIV/AIDS IEC production in Zimbabwe. This problem is largely associated with what is called 'HIV knowledge gaps' (Herald, 2017). Shedding light on this problem, van Dyk(2008) postulates that, there is inadequate HIV/AIDS information available for adolescents and youths, to enable effective HIV prevention in this population. Catchpole (2001) concurs that educative materials need to be made available and more accessible to adolescents so as to reduce lack of awareness about HIV and risks of infection.

In support of the views above, a survey conducted in Southern Africa between 2011 and 2016 indicated that, only 36% young women and 30% young men had comprehensive and correct knowledge about HIV (UNAIDS, 2016). Mishra et al. (2009) add that, most research outcomes from sub-Saharan Africa show a lot of misconceptions and myths about HIV, due to lack of knowledge, driving HIV infections in the region. Further, studies carried out elsewhere show evidence of lack of HIV/AIDS knowledge in young people (see for example, Kawai, 1997; Bessinger, 2004; Pido, 2012 and Mahapatra, 2014). Thus, the perceived knowledge gap amongst young people

suggests that there is an acute prevention rift, triggering urgency in the production of educative HIV/AIDS IEC materials for this group. As Komunda (2007) notes, in the absence of a known HIV cure, HIV/AIDS information is a 'social vaccine', owing to its continuing role in enhancing knowledge, especially in young people.

Implications for the Production of HIV/AIDS IECs for Young People

The urgency of production of youth HIV/AIDS IECs in Zimbabwe denotes their importance in HIV prevention. Goldstein et al. (2007), note that "environments need to be saturated with consistent messages that reinforce information" (p. 481). In agreement, WHO (2000) concurs that, in order to effectively perform their tasks, HIV/AIDS IECs must be integrated with all existing prevention programmes, in order to broaden exposure to target audiences. Further, Bekele and Ahmed (2008) agree that, to have effective IEC interventions, there is need to combine forms and approaches. Thus, combining IEC approaches would not only widen exposure, but will also ensure effectiveness in raising awareness, and will minimize stigma, discrimination and misconceptions.

It also follows that, as noted by LaCroix, Snyder, Huedo-Medina and Johnson (2014), HIV/AIDS IEC materials are an integral part of HIV prevention, expected to modify individual and group behaviours. As claimed by Bandura's (1977) SLT, which underlies HIV/AIDS information production, individuals learn through observing first, followed by assimilation and then imitation. In this context, HIV/AIDS IEC materials for young people are believed to raise awareness and change undesirable behaviours and perceptions in this group, through personification of what has been learnt. However, to ensure efficacy, and as already noted, Bekele and Ahmed (2008) emphasise that these should be used in combination with other prevention interventions. Moreover, basing on the view that without a cure, 'HIV education is vaccine' (Vandemoortele and Delamonica, 2002), HIV/AIDS IEC interventions in Zimbabwe, similar to other Southern African countries, should be considered as key in HIV prevention, since they deliver timely and essential information.

The production of HIV/AIDS IEC is not haphazard, it is purposeful and goal directed, targeting specific groups, at a particular time, with certain anticipated outcomes. Salam, Hoad, Das and Arshad (2016) explain that specific HIV/AIDS IEC materials, focusing on a specific environment,

are designed to address information needs of key and vulnerable populations. Hence, the impetuous need for successful communication, given that HIV prevention partly depends on how well the IEC materials achieve their objectives. The success of IEC is therefore crucial, as Futa (2008) and WHO (2001) explain, effective IEC programmes would foster positive health practices, individually and institutionally.

Moreover, since HIV/AIDS IEC materials are produced for specific audiences, at a particular time in order to achieve certain desired communication outcomes, these have to be audience oriented so as to realise their communicative goals. This entails use of familiar modes of communication, language and styles, depending on the target. On familiarity of HIV/AIDS IEC, Salam et al. (2016) note that, since IEC messages are community based, these should be sensitive to cultural, religious, political and economic systems of target communities, enhancing accessibility and ethical soundness. Also, by virtue of addressing the interests of local populations, IEC materials are deemed relevant and useful for the target audiences (Khuat et al. 2004). Thus, in order to appeal to young people, relevance and accessibility of HIV/AIDS IEC are important. In essence, Pratheepa and Nithya (2014: 53) conclude that "IEC become effective only when they are relevant, need based and used by the target audience."

Conclusions

The aim of this study was to establish some factors influencing the motion towards accelerated production of HIV/AIDS IEC for young people. It was informed by the Social Learning Theory (SLT), which postulates that individuals learn through observation of other's behaviours (communication or actions), followed by assimilation, and then imitation of such behaviours. Within the SLT framework, the study concludes that the strengthened focus on young people is spurred by the desire to modify undesirable sexual behaviours, which are believed to fuel HIV prevalence, a leading cause of death amongst this group in Africa. Some of the identified HIV risk factors that enhance young people susceptibility include; unprotected sexual intercourse with multiple partners, early sexual debut, cross-generational sexual relations, low HIV risk knowledge and various socio-biological based vulnerabilities. It follows that most HIV/AIDS IEC materials currently produced in Zimbabwe respond to this problem.

In addition, young people's vulnerability is shown to be partly linked to the failure by stakeholders to adequately address the HIV epidemic within this group. This is contrary to adult and children populations, who took centre stage of HIV prevention in Africa, from the onset. In order to close the perceived HIV programming gap in young people, most HIV/AIDS IEC materials developed are based on various youth campaigns. Some of these campaigns from which widespread youth HIV/AIDS IECs derive include: sexual reproductive health rights; HIV testing and counselling; voluntary medical male circumcision; gender-based violence; multiple concurrent partnerships; sexual networks; self-testing services; post-testing counselling services; antiretroviral therapy; PrEP and PEP amongst others. It is noted that HIV/AIDS IEC based on these programmes currently dominate the HIV prevention scene. Nevertheless, it is emphasised that the dominance of HIV/AIDS information for young people does not mean that other groups are entirely excluded.

Implications of the findings of the study include the view that HIV/AIDS IEC programmes are an integral part of HIV prevention as these are expected to modify undesirable youth behaviours that are perceived detrimental to HIV prevention. Another implication is that the production of HIV/AIDS IEC is not haphazard, it is purposeful and goal directed, focusing on specific groups and anticipating specific outcomes. For this reason, it is argued that the strengthened production of HIV/AIDS IEC for youths is consequent of the objective to reduce the HIV burden in this group, considered one of the most HIV susceptible populations in Zimbabwe.

Since HIV/AIDS IECs are an integral part of HIV prevention, are goal directed and audience specific, suggested is the use effective language, modes and styles, that are appropriate for particular groups. Fundamentally, HIV/AIDS information should be appealing, comprehensive and adequate, so as to eliminate misunderstandings, falsehoods and myths in relation to the pandemic. Moreover, there is need to establish evaluative criteria for determining the efficacy of HIV/AIDS IEC materials, which are crucial for HIV prevention. Evaluating HIV/AIDS IEC materials is important, as it helps in determining their educative value. As Bandura (1977) rightly observes, exposure to certain behaviours or communication should result in learning outcomes and behaviour change.

References

- Arya Anupama., Tiwari, V.K., Nair, K. S., Raj, S., Gandotra, Ramesh. and Kulkarni, P. D. (2013) Reach Effectiveness of IEC Activities and Awareness About Selected RCH Components in Urban Slums of Delhi. *Indian J. Prev. Soc. Med.* 44 (1-2). ISSN- 0301-1216.
- ATHENA (2013) Integrating strategies to address gender-based violence and engage men and boys as partners to advance gender equality through National Strategic Plans on HIV and AIDS: West and Central Africa Regional Consultation' [pdf].
- Avert (2010). *History of HIV and AIDS in Africa*. <http://www.avert.org/The History of HIV/AIDS in Africa>. (htm website accessed 31st July 2010)
- Avert (2019). Young People, HIV and AIDS. Available at: [avert.org/professionals/hiv-social-issues/key-affected-populations/young-people](http://www.avert.org/professionals/hiv-social-issues/key-affected-populations/young-people). (Last updated 10 October, 2019) (Accessed 27 October, 2019).
- Bandura Albert (1997) *Social Learning Theory*. Prentice-Hall, Englewood Cliffs: New Jersey.
- Bekele Abera and Ahmed Ali. (2008). Effectiveness of IEC interventions in reducing HIV/AIDS related stigma among high school adolescents in Hawassa, Southern Ethiopia. *Ethiop. J. Health Dev.* 22(3): 232–242.
- Bessinger Ruth, Katende Charles, and Gupta Neeru. (2004). Multi-Media Campaign Exposure Effects on Knowledge and Use of Condoms for STI and HIV=AIDS prevention in Uganda. *Evaluation and Program Planning*, 27, 397–407.
- Catchpole Mike. (2001). Sexually transmitted infections: control strategies. *BMJ (Clinical research ed.)*, 322(7295): 1135–1136. doi:10.1136/bmj.322.7295.1135.
- Clift Elayne. (2001). 'IEC Interventions for Health: A 20 Year Retrospective on Dichotomies and Directions'. *Journal of Health Communication*, 3, 367-375.
- Ewles Linda. and Simnett Ina. (2003). *Promoting Health: A Practical Guide*. 5th(ed). Edinburgh: Bailliere Tindall.
- Futa Salamatu. (2008) *Assessment of the IEC Activities in the Prevention and Management of Obstetric Fistula in the Savelugur Nation District* (Online Unpublished Master's Thesis, Kwame Nkrumah University for Science and Technology). (Accessed 3/2/2019).
- Goldstein Susan, Anderson Aadielah, Usdin Shereen and Japhet Garth. (2007). Communicating HIV and AIDS, What works? A report on the impact evaluation of Soul City's fourth series. *Journal of Health Communication*. 10(5), 465–483.
- Heald Suzette. (2002). It's never easy as ABC: Understandings of AIDS in Botswana. *African Journal of AIDS Research*, 1(1), 1-10.
- Hove Cain. (2019). "New HIV Infections Rise in Zimbabwe". *Daily News (Zimbabwe)*, September 8.
- International HIV/AIDS Alliance (2017). Adolescent HIV Programming [Online]. Available at: www.aidsalliance.org (Accessed 30 June 2019).
- Kavaiilan. (1996) *AIDS Scare Campaign 'A Flop'*. Nairobi: The Kenya Time Media.
- Khuat Thu Hong, Nguyen Thi, Van Anh and Ogden Jessica. (2004) "Because this is the disease of the century: Understanding HIV and AIDS-related Stigma and Discrimination in Vietnam." Institute for Social Development Studies, Hanoi Vietnam; International Centre for Research on Women, Washington DC. ICRW. 21-22.
- Komunda Noel Rodney. (2007) Education as 'a social vaccine' in the fight against HIV/AIDS: Is Uganda meeting the challenge? *Term Paper, Semester II*, Institute of Educational Research, Faculty of Education, University of Oslo, Spring, 2007.
- LaCroix Jessica, Snyder Leslie, Huedo-Medina Tania and Johnson Blair. (2014) Effectiveness of Mass Media Interventions for HIV Prevention, 1986–2013: A Meta-analysis *J Acquir Immune Defic Syndr*. Volume 66, Supplement 3, August 15, 2014.
- MacPherson Peter, Munthali Chigomezgo, Ferguson Jane, Armstrong Alice, Kranzer Katharina, Ferrand Rashida and Ross David. (2015). Service delivery interventions to improve adolescents' linkage, retention and adherence to antiretroviral therapy and HIV care. *Tropical Medical International Health*, 20 (8): 1015-1032.
- Mahapatra, Tanmay. (2014) Role of information, Education and Communication Materials in HIV Control: A perspective. *Ann Trop Med Public Health* 2014; 7: 3-4.
- Mashiri Pedzisai., Mawomo Kenneth. and Iom Patrick. (2002) Naming the Pandemic: Semantic and Ethical Foundations of HIV/AIDS Shona Vocabulary. *University of Zimbabwe Zambezia Journal* 2002, XXIX, ii. University of California Press.
- Ministry of Health and Child Care (MoHCC) and Zimbabwe National Planning Council (ZNFPC) (1998). *Information Education Communication Reference Manual for Health Programme Managers*. Harare: Zimbabwe National Family Planning Council.
- Mishra, Vinod, Praween Agrawal, Soumya Alva, Yuan Gu, and Shanxiao Wang. (2009). Changes in HIV-related knowledge and behaviours in sub-Saharan Africa. DHS Comparative Reports No. 24. Calverton, Maryland, USA: ICF Macro. Available at <http://dhsprogram.com/pubs/pdf/CR24/CR24.pdf>. (Accessed 1 July 2019).
- Muro, Melanie and Jeffrey, Paul. (2008). A Critical Review of the Theory and Application of Social Learning in Participatory Natural Resource Management Processes. *Journal of Environmental Planning and Management*. 51: 325-344. 10.1080/09640560801977190.

- National Aids Council of Zimbabwe. (2018). Key Population Programmes. HIV and AIDS Estimates Sentinel Surveillance Report.
- Newman Barbara M. and Newman Philip R. (2007). Theories of human development: Lawrence Erlbaum.
- Patton George Christopher, Coffey Carolyn, Sawyer Susan, Viner Russell, Haller Dagmar, Bose, Krishna et. al. (2009). Global patterns of mortality in young people: a systematic analysis of population health data. *Lancet*, 2009 (September): 881-92.
- Pido John Peter Odoch. (2012) The Design and use of AIDS Posters in Kenya (Unpublished DPhil Thesis, University of Nairobi).
- Pratheepa, C.M. and Nithya, K. (2014) Relevance of HIV IEC Materials-A study among PLHIVs. *IOSR Journal of Humanities and Social Science (IOSR-JHSS)* 19(3): 53-58.
- Rogers Everett M. and Storey Douglas J. (1987). Communication Campaigns. In CR Berger and S.H. Chaffee (Eds.), *Handbook of Communication Science*. Newbury Park: Sage, 55-65.
- Salam Rose, Hoadia, M. D., Das, J. K. and Arshad, A. (2016). Interventions to Improve Adolescent Nutrition: A Systematic Review and Meta-Analysis. *Journal of Adolescent Health*. 59 (2016) S29-S39.
- STOP AIDS (2016). 'Adolescents and young people and HIV' [pdf].
- The Global Malaria Action Plan for Malaria Free World (GMAP); Part IV. (2010). *The role of the RBM partnerships; Communication and Behaviour Change*. Geneva, Switzerland: World health Organization.
- The Herald (29 March, 2017) High HIV Prevalence in Students Worries Government. (Accessed 1 April, 2018). <https://www.herald.co.zw/shocking-hiv-statistics-in-tertiary-institutions>.
- UN Women (30 November, 2016) 'World AIDS Day Statement: For young women, inequality is deadly' (Accessed 21/3/2019).
- UNAIDS (12 August, 2015) Update: Active involvement of young people is key to ending the AIDS epidemic by 2030 (Accessed 21/3/2019).
- UNAIDS (2013). President of South Sudan commits to strengthening the country's response to HIV' [pdf].
- UNAIDS (2016) 'Get on the Fast Track: The Life-Cycle Approach to HIV' [pdf].
- UNAIDS. (2018) HIV prevention among adolescent girls and young women: putting HIV prevention among adolescent girls and young women on the Fast-Track and engaging men and boys. Available at: http://www.unaids.org/sites/default/files/media_asset/UNAIDS_HIV_prevention_among_adolescent_girls_and_young_women.pdf. (Accessed, 2 July, 2019).
- UNESCO (2014) 'In or Out? Asia-Pacific Regional Review of the Inclusion of Young Key Populations in National AIDS Strategic Plans' [Online pdf].
- UNESCO (2006) 'UNESCO Guidelines on Language and Content in HIV/AIDS-Related Materials'. [Online pdf: www.unesco.org] (Accessed 2 July, 2019).
- UNICEF (27 November, 2017) 'Press Release: Adolescent Deaths from AIDS tripled since 2000-UNICEF'. (Accessed 21/3/2019).
- Vandemoortele Jan. and Delamonica Enrique. (2002) The "Education Vaccine" Against HIV. *Current Issues in Comparative Education*, (2002) Vol. 3(1).
- Van Dyk Alta C. (2008). *HIVAIDS Care and Counselling*. Pearson: South Africa.
- World Health Organisation (WHO) (2015). 'A technical brief: HIV and young people who sell sex' [pdf].
- World Health Organization (WHO) (2000) *Information, Education and Communication: A Guide for AIDS Programme Managers*. apps.searo.who.int/PDS-DOC/B0224.pdf (Accessed 23/1/2019)
- World health Organization (WHO) (2001). Pop Reports 2001; 29: 3.