# A STUDY OF HIV/AIDS COMMUNICATION APPROACHES BY INTERVENTIONISTS IN SELECTED NIGERIAN STATES

A THESIS SUBMITTED TO THE SCHOOL OF POST-GRADUATE STUDIES, UNIVERSITY OF LAGOS, AKOKA-YABA, LAGOS IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF DOCTOR OF PHILOSOPHY (Ph.D) IN MASS COMMUNICATION

BY

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DECEMBER, 2009

# SCHOOL OF POSTGRADUATE STUDIES
# UNIVERSITY OF LAGOS

## *CERTIFICATION*

**This is to certify that the Thesis:**

**"A STUDY OF HIV/AIDS COMMUNICATION APPROACHES BY INTERVENTIONISTS IN SELECTED NIGERIAN STATES"**

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**By**

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## DEDICATION

To God Almighty, the One Who was, Who is, and Who is to come.

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**Bolu John FOLAYAN**

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## ABSTRACT

In this *Study of HIV/AIDS Communication Approaches by Interventionists in Selected Nigerian States*, the researcher sought to know the influences which communication approaches have on the outcome of HIV/AIDS interventions, the patterns of such influences and the implications for future interventions in Ondo, Lagos, Cross River and Nasaraw States (n=53).

The study found that: There is no statistically significant relationship between study locations and organisation's major programming areas ($x^2$ = 20.579, df= 15, P>0.05); the communication approaches applied by programmers produced more or less the same outcome ($x^2$+49.868, df=44, P >0.05): The hypothesis that interventionists have low communication competence for HIV/AIDS programming is validated by data generated from the in-depth interviews. Although most programmers succeeded generally, 'poor' and 'very poor' results were highly associated with those who did not use communication specialists: there is a significant relationship between Interventionists' knowledge of approaches and the results of their interventions, ($x^2$=18.467; df=4, P<0.05). Contextualization of programmes varied significantly among interventionists: $x^2$= 17.39, df=3, P<0.05.

This investigation provides scientifically-tested explanations on the recent drops in prevalence rates of HIV/AIDS in some states in Nigeria; offers theoretical and practical postulations on how to attack the HIV/AIDS problem and provides some reliable data for policy making and planning, especially in study locations.

The researcher developed two models- *Mustard Seed Approach* and *Octopus HIV/AIDS Communication Model*, and recommends them for use by interventionists while also suggesting that communication competence should be made compulsory for HIV/AIDS Interventionists.

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# CHAPTER ONE

## INTRODUCTION

The Human Immunodeficiency Virus (HIV) which leads to the Acquired Immune Deficiency Syndrome (AIDS) has remained a hydra-headed problem in Nigeria despite billions of naira spent containing and/or preventing its spread. Epidemiologists, physicians, anthropologists, social workers, support groups, civil society organizations, communication scholars, philosophers, psychologists, political administrators/scientists and even medical scientists in Nigeria have not been able to provide enough research-based answers to why the scourge has persisted.

In 2004, the National Action Committee on AIDS (NACA) - now renamed National Agency for the Control of AIDS - coordinated an integrated multi-sectoral appraisal of national HIV/AIDS response since 1986 when it was first reported in Nigeria and found that among others, ***wrong tactical approaches contributed largely to the unimpressive results***. These included the following:

- National response was top-down and subsumed under the Federal Ministry of Health (FMoH), until NACA was created, thereby denying the important problem the right attention;
- Support groups and civil society organizations, (CSOs) were not actively involved in the combat;
- Funding was inadequate;
- Lack of care and support for People Living With HIV/AIDS (PLWHA);
- Lack of data to serve as basis of strategic planning;
- Emphasis on "information" at the expense of "communicating behaviour change".

(NACA/Society for Family Health, SFH, 2005).

The above problems were addressed in the *HIV/AIDS Strategic Framework for Action: 2005-2009* against the scourge and we are now witnessing a gradual decline in prevalence rates in many states. Due to the devastating nature of the disease, however, there is the need for accelerated, not gradual, decline. To achieve this, NACA and major stakeholders shifted focus to behavioural change communication and care/treatment as the umbrella strategy, using mainly support groups/organizations (interventionists) as key instruments to sustain and improve on recent encouraging results.

This research is an investigation concerning the communication approaches of support groups in Lagos, Cross River (two of the states where prevalent rates dropped in the past few years) and Nasarawa and Ondo States (two of the states where prevalent rates have remained high in the past few years).(FMoH, 2005).

**Background to the Study**

The 2003 national HIV/AIDS prevalence rate was 5.0%, which represented a slight decrease from 5.8% recorded in 2001. The latest sero-prevalence survey by the Federal Ministry of Health indicates the national average as 4.6%, ranging from the lowest, 1.6% (Ekiti) to 10.0%, the highest (Benue) with 4.0% (Abia) being the median. (FMoH 2005).

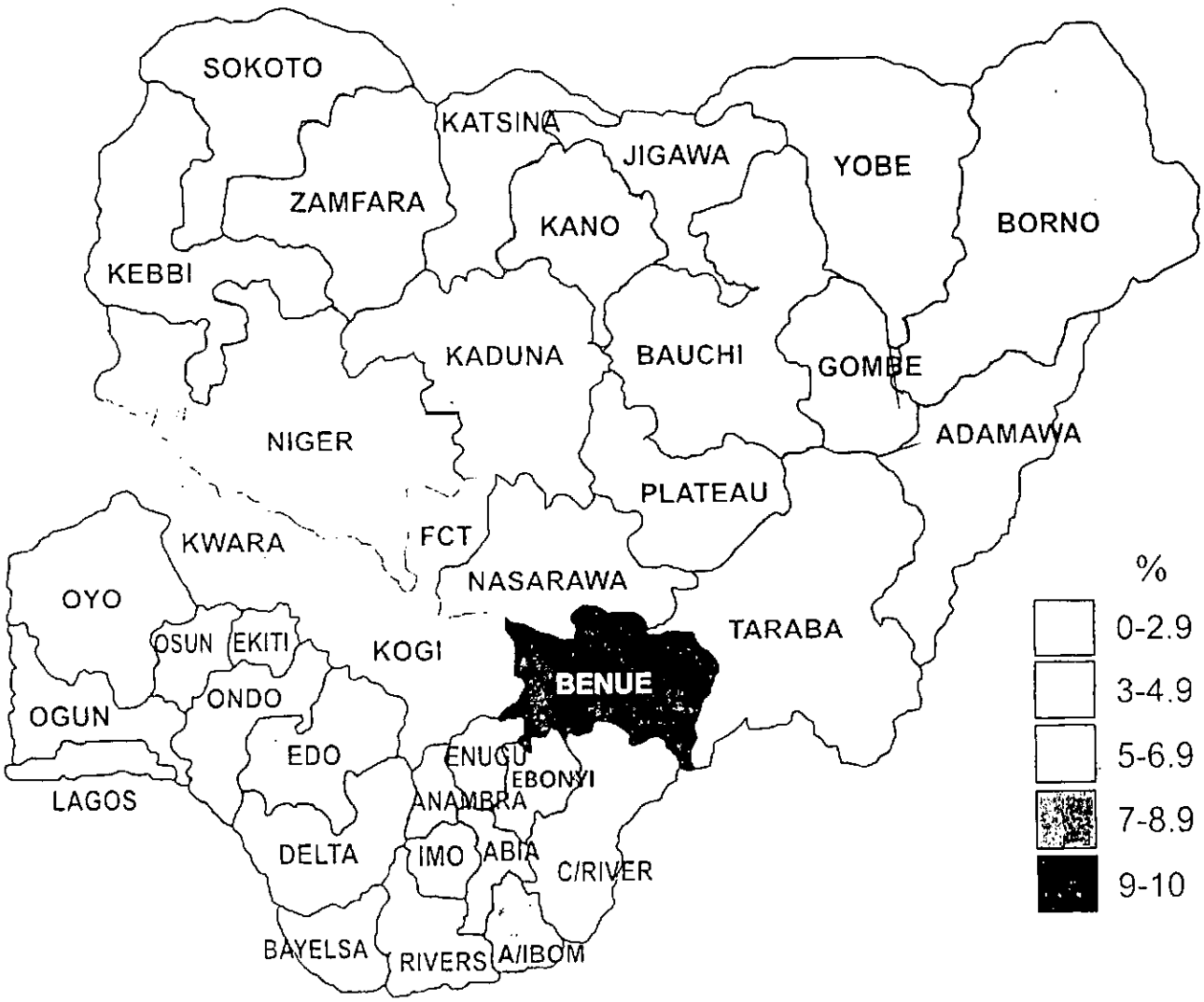
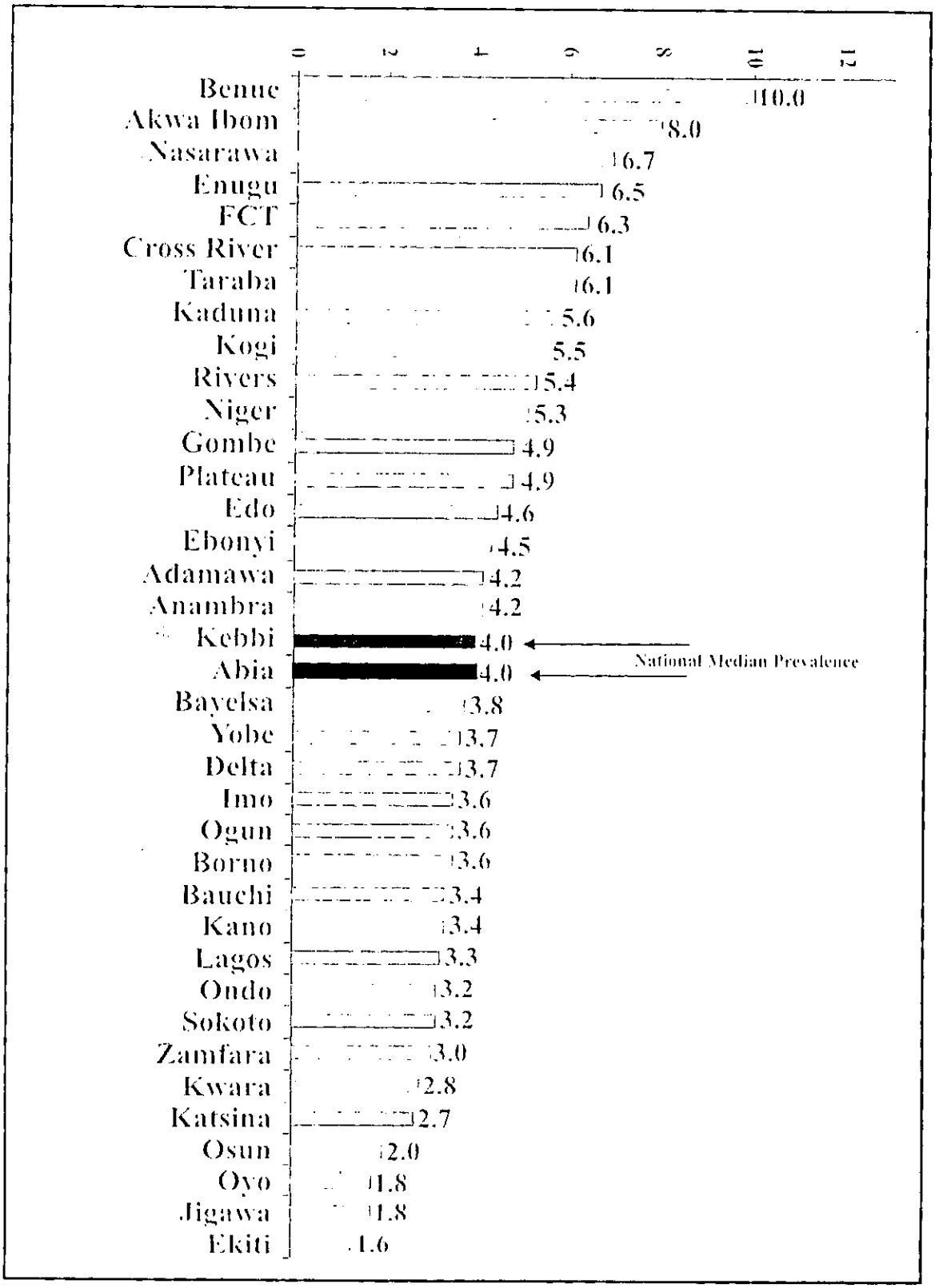



*Figure 1. Spatial Distribution of HIV/AIDS Prevalence in Nigeria showing high, medium and low prevalent areas based on the 2005 sero-prevalence, the latest national survey by NACA.*

Table 1.
Comparative HIV/AIDS Prevalence in Nigeria by States




Data Source: Federal Ministry of Health, 2005

However, there is little or no research evidence to explain the encouraging figures. Since communication approach is key to the HIV/AIDS problem (Airhihenbuwa and Obregon, 2004), this researcher investigated the communication approaches employed by key stakeholders in the battlefield against HIV/AIDS, using four Nigerian states as comparative case studies.

Recent reports of successes have mostly been recorded where theoretical communication frameworks had been carefully and creatively adapted contextually to specific situations (approaches). (UNAIDS, 2004; Hemer and Tufte, 2005). This researcher, through this study, explored the contributory role of *communication approach* in areas of successful as well as failed interventions in the past three years, using the State Action Committees on AIDS (SACAs) in the four states and organizations collaborating with them, as units of analyses.

*The Response so far*

Response to the HIV/AIDS scourge in Nigeria has been in four stages:

- ***Initial period of denial, (1980-1987)***: After the debates and counter arguments over the presence of the disease, the Federal Government pronounced the presence of HIV/AIDS in Nigeria in 1986, set up an Ad Hoc National Experts Advisory Committee on AIDS, known as NEACA in 1987.
- ***The phase of largely medical response, (1988-1997):*** In 1988, the Federal Government established the National AIDS and STDs Control Programme (NASCP) and placed it under the Federal Ministry of Health to coordinate HIV and AIDS activities across the country. The Programme had State counterparts.
- ***The phase of public health response, (1998-2003)***: The National Council on Health (NCH) formally endorsed a multi-sectoral approach in 1997. In 2000, Federal Government established the Presidential Advisory Committee on HIV/AIDS (PAC)

and the National Action Committee on AIDS (NACA), the two main institutions that have been coordinating HIV/AIDS activities in Nigeria till date.

- *The phase of multi-sectoral response, (2004-date)*: NACA drew up a three-year response plan, which it called the *HIV and AIDS Emergency Action Plan* (HEAP) in 2001, which was dominated by public health programmes. The Committee replaced HEAP in 2004 with another four-year plan, this time focusing on prevention, treatment and impact mitigation interventions, using a multi-sectoral strategy – health institutions, government (Federal, State, Local), private sector, academia, NGOs, support groups and interventionists, international and multi-lateral agencies.

HIV/AIDS interventions in Nigeria take place at five levels:

i) Government (Federal/State/Local Governments)

ii) Health Institutions (Public and Private)

iii) Private Sector Organisations (PSO)

iv) Non-Governmental Organisations, NGOs; (including Faith-based Organisations, FBOs; Community-based Organisations, CBOs; and Civil Society Organisations, CSOs):

v) International Organisation (such as UNAIDS, Ghain, Society for Family Health, SFH).

This study examined communication approaches adopted by NGOs from 2003-2007. According to Ogbodu and Idogho (2006), NGOs are a recent phenomenon in Nigeria, despite the long years of the existence of traditional institutions such as community development associations and women's groups. During the country's long years of military dictatorship (which changed to democratic system in 1999), Nigeria's international development partners were willing to work mainly with NGOs. Donor requirements of formal registration disenfranchised most indigenous groups in favour of these newer creations; a tradition that

continued. Yet, according to scholars, most interventions in Nigeria are managed by NGOs/CSOs. (Ogbodu and Idogho, 2006:p.297).

*Results so far*

> In the earlier phase of Nigeria's response to the epidemic before 1999, the predominant role of the local CSOs was programme implementation. The CSO response was fragmented, limited in scope and even incoherent. Their funding was mainly limited to implementing interventions. Few donors were willing to invest in strengthening local organizations...relationships among CSOs were marked by distrust, competition and limited collaboration. Some NGOs made their marks. After the HIV/AIDS Emergency Plan (HEAP), all stakeholders reasoned the need for CSOs to broaden their roles beyond program implementation.
>
> (Ogbodu and Idogho, 2006)

A more detailed summary of results so far is stated under 'Empirical Studies' in Chapter Two of this report. Due to tactical error in the communication approach to the HIV/AIDS problem in Nigeria at the initial stage (amongst other intervening variables), results have not been impressive. Apart from not taking into consideration the limited power of the mass media to cause change, early efforts in Nigeria failed to consider that access to the mass media is limited, especially access to the print media and television. (Akinfeleye, 2003). This meant that only a small percentage of the population was reached through the initial mass media-oriented campaigns.

Attitude and behaviour pose a serious challenge in communicating change. Akinfeleye notes:

> To achieve effective participation of the masses (social mobilization), the masses must be motivated so as to cause a modification and/or a change in their pattern of attitude, which will bring about the desired modification of behaviour. Therefore, attitude formation and attitude modification precede behavioural change and/or modification for the achievement of the desired goals.
> ...In brief, research studies say that we as human beings are able to remember 30% of what we read (newspapers, magazines, etc.); 40% of what we hear (radio); 50% of what we see and read (graphics and photos); 60% of what we see and hear (television and film, etc.); 70% of what we do (social mobilization).
> (2008a:p.126-127)

In Thailand, Brazil, Uganda, Senegal and some other countries where communication is helping to successfully combat HIV/AIDS, there has been a paradigm shift to emphasize vibrant and internally-derived 'dialogue'; long term rather than short term plans; centrality of social contexts, including government policy, Social Economic Status, SES, cultural relations, spirituality, social norms and policies. (PANOS, 2003).

Waisbord has noted:

> Development communication faces two sets of challenges. The first set of challenges deals with two critical aspects of development projects: scale and sustainability. After more than five decades of experience in development communication, we seem to know what works. Because there are persuasive explanations and findings about 'what works' in small scale, community projects, yet there is shortage of convincing results at national level, 'scaling up' projects, has become an important concern, particularly for donors. Results from community empowerment and participation projects can't be easily 'trickled up'. How can successes in community project concerning...infectious diseases be replicated on a larger scale? Are lessons directly applicable to programs that target large groups? (2005:p.88)

The 'failure' of the mass media and communication to produce the expected behaviour change was not limited to Nigeria. It was a worldwide trend. A special report which appraised communication efforts so far in combating the scourge, notes:

> Over the last 20 years, communication scholars have failed spectacularly to confront and contain HIV/AIDS. Communication strategies on HIV have failed miserably and continue to fail.
>
> (PANOS, 2003).

This view may have been exaggerated. Experts believe communication scholars' efforts helped in terms of creating awareness and enhancing policy shift through advocacy even though they could not achieve much in prevention. (UNFPA, 2003). In fact, many scholars and international agencies have been reporting more of successes than failures in the past

three years. Morris (2005:p23) after a review of development communication projects on HIV/AIDS noted:

> Examination of many studies shows that many types of interventions produce at least some of the desired results, but under different conditions they produce different results, some more successfully than other.

The 'poor' results certainly had to do with the problematic nature of 'attitude and behaviour' in communicating change. Some scholars even argue that behaviour change is theoretical and that what is achievable is '*behaviour modification*' – shift in outward reflection of in-held beliefs and attitude, which may or may not be permanent. They argue that it requires a long period before one could ascertain 'behaviour change' although in the short run one could ascertain 'behaviour modification'. (Akinfeleye, 2008).

**Statement of the Problem**

In the field of health communication, HIV/AIDS poses additional communication challenges (than, for instance, malaria, cancer and polio which are equally deadly). HIV/AIDS is more complex because it is not just about a disease but also about poverty, sexuality, gender, culture, and incurability, unlike other diseases.

The contributory role of communication in fighting the HIV/AIDS scourge, according to the *National HIV/AIDS Behaviour Change Communication Strategy 2004-2008*, includes "advancing beyond awareness creation and addressing the issues underpinning behaviour change through strategic, evidence-based, theory-driven and result-oriented interventions." (Osotimehin, 2004:p.4). This requires determining if interventionists have communication competence.

Spitzberg and Compach (1984:7) define *communication competence* as "a situational ability to set realistic and appropriate goals and to maximize their achievement by using knowledge

of self, other, context, and communication theory to generate adaptive communication performances."

In Uganda, Thailand, Vietnam, Brazil, Senegal and Zambia where successful HIV/AIDS interventions have been reported, such successes have been credited largely to *approaches* (creative adaptation of communication methods or framework and theories to suit particular local contexts). (FHI, 2006). It is pertinent therefore to investigate approaches being used in Nigeria.

The *National HIV and AIDS Behaviour Change Communication Strategy 2004-2008* called for studies "to determine the exact pattern of HIV and AIDS transmission in Nigeria." (NACA/SFH 2004: p.5).

*The Debilitating Effects of the Scourge*

The raging spread of HIV/AIDS in Nigeria is already taking heavy tolls on the people and the economy. People are dying younger. The age group of 20-25 years are worst affected (5.6%), followed by those aged 24-29 years (2.9%) while youths in the age group of 15-24 years account for at least 60% of total HIV infections. Women constitute the bulk of the nation's agricultural labour and the disease worst hits them. (UNAIDS, 2004). This means the scourge may soon eat up the country's active *human labour* or workforce. The disease is making steady incursions into rural areas. (Adeniyi, 2006).

Besides, the additional care and support burden associated with the HIV/AIDS epidemic is further weakening the already weak Nigerian *health system*. People living with HIV related diseases increasingly need hospital services and care and support which are very inadequate. Perhaps more fundamental is the *social impact* of the scourge. There is stigmatization. More

orphans are being generated, and this would bring more strains on social systems in the near future as these orphans may end up on the streets as beggars, criminals or prostitutes; family ties would break up due to deaths of either or both parents; fewer children may go to school and the level of poverty may further shrink.

These grim realities pose great concern for not only the government but to communication scholars who are relied upon to stem the tide of the epidemics as medical scientists continue to explore possibilities for a cure. The good news however, is that medical and social scientists are making some progress in tackling the HIV/AIDS problem. For instance, it is now possible for PLWHA to live longer if the drug therapy is applied early enough. The life expectancies of PLWHA are becoming close to the uninfected population. ("People Living with HIV," 2008).

The 'liberation' of national response under NACA's multi-sectoral platform, not only strengthened NACA, it also brought in more NGOs, CSOs, Faith Based Organisations (FBOs), Community Based Organisations (CBOs), Private Sector Organisations (PSO) and other stakeholders. Many SACAs which were more or less idle under the first phase of HEAP were now "geared up" and many more CSOs, NGOs, FBOs and CBOs have continued to spring up and they collaborate with the SACAs and international funding agencies. Support groups now constitute the beams while NACA/SACA and fund agencies serve as pillars in the combat against HIV/AIDS pandemic in Nigeria.

Unfortunately people, who are mostly volunteers, stricken with compassion, spurred by concern and moved with pity to stem the ravaging disease, mainly run these support groups. They had little *capacity*, including communication capacity, in most cases. (Imam, 2000; Osotimehin, 2004).

Communication experts drawn from around the world, after the 2001 Roundtable in Nicaragua convened by UNAIDS to examine communication and HIV/AIDS, noted:

> ...While awareness is an essential prerequisite for changing behaviour, in itself, it is not enough. Behaviour and behaviour change are ultimately linked to the social, cultural, political and physical environments in which people live; focusing on prevention alone does not address the primary needs of many, if not most, people at risk...Behaviour change is a complex process motivated by several factors including awareness of the need for change and of its benefits, practice of new skills in different settings and confidence in one's own ability to maintain new behaviour in the light of changing circumstances and setbacks or failures.
>
> (UNFPA, 2002:p.25). [Emphasis mine]

In other words, HIV/AIDS is a monster that cannot be fought with mere enthusiasm to save the endangered and compassion for the dying. Support groups must have the required knowledge and the skill – in support, care, treatment and prevention – in order to have successful interventions.

The HIV/AIDS Communication Roundtable in Nicaragua Report, noted that "current theories and models may not provide an adequate foundation upon which to develop interventions" (UNFPA, 2002: p.30)

Numerous experts argue that a major missing link has been a gap between theory and practice: the "approach".

> We argue that the flaws in the application of the commonly used 'classical' models in health communication are due to contextual differences in locations where these models are applied. That is to say that these theories and models are being applied in context for which they were not designed.."
>
> (Airhihenbuwa & Obregon, 2005:p.10-11).

After 'scaling up' HIV/AIDS intervention (increasing the geographic coverage and number of individuals served by the programme), which has been successfully attained in many countries including Nigeria, the next level of focus, according to experts, would be on "increasing coverage to different population types and improving the quality and scope of the services offered": a concept known as **Expanded and Comprehensive HIV/AIDS Response (ECR).**

ECR may be defined as "the mobilization of adequate resources and augmented capacity to carefully and rapidly deliver an expanded and comprehensive response to the HIV/AIDS epidemic" (Lamptey, Zeitz and Larivee, 2002:p.45).

> Further examination of the relations between individual behaviour and contextual factors (such as policy, law, systems) is necessary. On the other hand, the presence of contextual factors does influence behaviour... on the other hand, the availability of institutional and contextual conditions that are, on principle, conducive to specific behaviour does not always result in desired specific behaviours, does not always result in the desired social and healthy behaviour. 'Build systems and they will always come' does not always work. The existence of health posts in rural areas is not guarantee that mothers will choose institutional childbirth'
>
> (Waisbord, 2005: p.82).

There is thus a need to discover, understand, describe and develop pragmatic communication approaches by studying organizations at the forefront of HIV/AIDS battle in Nigeria.

Imam, Falana, Faweya, Jackson, Odumosu, Ranu and Victor-Ahuchugo (2000:p.15), in their rapid assessment in selected LGAs of Nasarawa State, for instance, found that "the skills and knowledge of healthcare providers were limited" and that "only a very few have any technical or programmatic capacity." In a similar study in Lagos State, Oke (2000:p17)

discovered "a preponderance of ad-hoc enlightenment campaigns and an array of prevention programs but...**no one is coordinating or monitoring these activities.**"[*emphasis mine*].

It is necessary therefore to establish how important communication ability should be for interventionists, find out which are the *domains* of communication approach dominantly in use in Nigeria using these four states as study locations and suggest ways through which SACAs and interventionists can develop, adapt or choose suitable approaches for their projects in different situations?

**Purpose of the Study (Aims & Objectives of the Study)**

Specifically, this study's aims and objectives are:

1. To analyze the general communication ability of people and/or organizations at the forefront of the fight against HIV/AIDS in Nigeria.

2. To enumerate and explain the various approaches being used by interventionists in their programmes.

3. To assess the impact of the various approaches in terms of the outcome of the interventions.

4. To investigate problems being encountered by interventionists in the implementation of their programmes.

5. To find out possible correlations between the approaches employed and the outcome of interventions.

6. To determine the importance of *communication ability* as a pre-requisite for interventionists in fighting the HIV/AIDS.

7. To provide information that may help interventionists to choose appropriate approaches from various approaches that could be used in their programmes.

8. To expand the literature on HIV/AIDS in Nigeria.

## Significance of the Study

1. This is perhaps the first scientific comparative study on the communication competence of those directly involved in HIV/AIDS programmes in Lagos, Ondo, Nasarawa States and the Cross River States. At the moment, there is little information on the communication-knowledge skills of programmers in these states. This study provides basic data in this area.
2. The study provides some explanations on the recent drops in prevalence rates of HIV/AIDS in Nigeria require an investigation into what may have led to the encouraging results.
3. Programmers would, through this study, be able to cross-fertilize ideas on approaches suitable in particular situations or circumstances. In other words, the study offers theoretical and practical postulations in in attacking the HIV/AIDS problem.
4. The study, being perhaps one of the few case studies on HIV/AIDS in Nigeria that focuses principally on approaches, confirms some recent findings on successful interventions elsewhere in the world, which stressed the importance of *approaches* used, all things being equal.
5. The bulk of the literature on HIV/AIDS in Nigeria is on sero-prevalence, effects of the scourge and generally clinical studies. This study has expanded and refined the literature on HIV/AIDS in the country regarding methods, techniques and tactics employed in previous and current interventions.
6. The NACA, donors, support groups, and other stakeholders will through this study be able to obtain reliable data for policy making and planning, on HIV/AIDS and interventionists, in Ondo, Lagos, Cross River and Nasarawa States.

## Research Questions

**Two main research questions and five subsidiary questions are answered in this study.**

*Main Questions:*

1. What influences does application of 'communication approaches' have on the outcome of HIV/AIDS Interventions?

2. Do Interventionists possess communication competence for the successful implementation of HIV/AIDS programmes?

*Subsidiary Questions:*

3. What is the relationship between Interventionists' knowledge of communication approaches and the results of their interventions?

4. What is the relationship between knowledge of communication approaches and patterns of HIV/AIDS prevalence?

5. To what extent do HIV/AIDS Interventionists contextualize their communication approaches?

6. What challenges (not limited to those related to communication) do Interventionists face in attaining their goals?

7. What factors may be responsible for successful and failed interventions?

## Hypotheses

Seven hypotheses were tested in this study. These are:

*H1: Interventionists will not differ significantly in major programming areas.*

*H2: There is no significant relationship between communication approaches and the outcome of interventions.*

*H3: There will be no significant difference in the reasons attributed for success achieved.*

*H4: Interventionists will have low communication competence for HIV/AIDS programming.*

*H5: There is no significant relationship between interventionists' knowledge of communication approaches and the results of their interventions.*

*H6: There is no significant relationship between knowledge of communication approaches and patterns of HIV/AIDS prevalence.*

*H7: There is no significant difference among interventionists regarding contextualization of programmes.*

## Definition of Terms

### Communication Approach

A practical, tactical and contextualized plan for successful execution of a task through sharing of ideas, information, knowledge, values and meanings. They are usually derived from strategies.

### Nigerian States

Second-tiers of government in the Nigerian Federal system of government. Thirty-six such geographical boundaries (known as 'states') are listed in the Nigerian Constitution.

**HIV/AIDS**

Human Immunodeficiency Virus, HIV: a retrovirus that causes Acquired Immune Deficiency Syndrome, AIDS, i.e. weakening and destroying of the body's immune systems by infecting 'helper T cells' of the immune system. The most common serotype, HIV-1, is found worldwide while HIV-2 is primarily confined to West Africa.

**Interventions**

A programme with objectives, goals, strategy and time frame, initiated and implemented to fix a problem. An intervention could be short-run or long-run but is usually time-framed and goals-driven. Those who carry out such programmes are often referred to as **'interventionists'**. For instance, NACA, Society or Family Health, Actionaids are interventionists on the HIV/AIDS issue.

**Programmers**

This term is used in this study interchangeably for 'interventionists' but more particularly for managers and field officers of projects/interventions.

**Support Groups**

Refers to Programmers/Interventionists, i.e. CSOs, CBOs, FBOs, PSOs, and NGOs.

**Prevalence rates**

Ratio of occurrence among the population or sub-groups

**Scaling up**

Increasing the geographic coverage and number of individuals served by a programme.

**Expanded and Comprehensive HIV/AIDS Response (ECR)**

The mobilization of adequate resources and augmented capacity to carefully and rapidly deliver an expanded and comprehensive response to the HIV/AIDS epidemic.

**Counselling**

Sharing of meaning such that an action is recommended or/and sought during the communication process.

**Attitude Change**

A person having an opinion about something or issue different from one he or she previously held.

**Behaviour Change**

Exhibiting a different habit: a person acting consistently in a way that is different from how he or she usually acts.

**Behaviour Modification**

Outward demonstration of attitude change in the short run.

**Behaviour Therapy**

A form of treatment, which tries to change someone's particular behaviour, rather than treating the causes.

**Communication Competence**

A situational ability to set realistic and appropriate goals and to maximize their achievement by using knowledge of self, other, context, and communication theory to generate adaptive communication performances.

**Communication Framework**

Basic structure or broad outline of plan that supports and gives shape to the sharing of ideas, information, knowledge and meanings.

**Self-efficacy**

Ability of the objects of communication to carry out the desired task of the communicator by themselves.

**Influences**

The powers to affect people or things.

**Empathy**

Ability to share someone else's feelings or experiences by imagining what it would be like to be in their situations.

**Contextualization**

Taking into local conditions such as language, norms, socio-economic situations, culture, audience characteristics etc into consideration.

**Successful Intervention**

An intervention in which the Interventionist attains at least 50 per cent of set goals.

**Failed Intervention**

An intervention in which the Interventionist attains less than 50 per cent of set goals.

# CHAPTER TWO

## LITERATURE REVIEW

This chapter is divided into six major sections:

- A theoretical framework providing exposing three strands of HIV/AIDS communication theory;
- The theoretical framework of the study (The Activity Systems Theory);
- A general critique of HIV/AIDS communication theories;
- A conceptual framework of 'Working Theories' in HIV/AIDS communication (approaches currently in use);
- Empirical framework (cross-national and national)
- A summary and conclusion.

## THREE STRANDS OF HIV/AIDS COMMUNICATION THEORIES

Probably because of the heady nature of HIV/AIDS, so many theories of communication have been applied solely or in concert to tackle the scourge. From the array of theories on communication, those applied frequently in health communication and HIV/AIDS programming have formed three major strands -Psychological Framework; Sociological Framework and Communication Framework.

### *Psychological Framework*

These are theories mainly derived from the field of psychology or are based on psychological postulations. They are mostly cognitive and include the Cognitive Theories, Activation Theory, Fear Appeals Theory, Extended Parallel Process Model (EPPM), Perception (Health Belief Model, HBM, Belief Congruency, etc.), Theory of Reasoned Action, Elaboration of Likelihood Model, (ELM), Stages of Change Theory and the Social Judgment Theory.

There are four popular inter-related theories in cognition, which have been widely used in health communication. We may, for convenience, refer to them as 'Cognitive Theories'. These are Balance Theory (Heider and NewComb, T, 1946); Congruity Theory (Osgood and Tennenbaum, 1995); Belief Congruency (Rokeach, 1965); and Cognitive Dissonance (Festinger, 1962).

*Balance theory* states that when tensions arise between or inside people, they attempt to reduce these tensions through self-persuasion or try to persuade others. Everyone holds opinions on various issues and whenever these opinions conflict, there is imbalance. Change would not occur in a situation of imbalance hence the challenge of the communication agent is to create a balance. Similarly, *Congruity Theory* predicts that in a scenario of conflicting ideas in which a judgment is to be made, it would be easier to make such judgment when the ideas or sets of information are similar or congruent.

*Belief Congruency* suggests that there are hierarchies of beliefs, attitudes and values and that beliefs are the building blocks of attitudes. To change attitudes, we succeed more easily when we first attempt to change beliefs. The emerging faith-based approaches in HIV/AIDS communication are hinged essentially on the Belief Congruency Theory. *Cognitive Dissonance* says human beings often have conflicting beliefs with the actions they take or other beliefs they have. Simply put, it says we do not usually carry out actions that we believe to be wrong, so we either cease the action or just believe that we are right. This theory has been successfully used to understand attitudes of cigarette smokers. People systematically avoid information that is against their beliefs or downplay such information to reassure themselves of their in-held position: 'AIDS cannot infect me'; 'if AIDS exists, everybody in Nigeria would have died because we are all promiscuous'. People who hold

these attitudes would most likely not watch AIDS documentaries on TV, according to Cognitive Dissonance Theory.

The **Social Judgment Theory** posits that people accept a statement/message or reject it based on their cognitive map. HIV/AIDS messages would be accepted or rejected based on the audience's ego-involvement and if it falls within their latitude of acceptance. In other words, when people are exposed to HIV/AIDS messages on TV, radio or through personal contacts, they immediately judge where the message should be placed on a scale in their mind by comparing the message with their currently held view.

The **Activation Theory** states that an individual will seek to satisfy the need for stimulation and information when attending to a message before seeking to fulfill information need alone. It explains how individuals seek messages that fulfill their cognitive need for information as well as their need to be entertained. Donohew et al. argue, for instance, that teenagers who are alcoholics or sexually pervert could be persuaded through TV commercials that are very entertaining. On the other hand, the **Fear Appeals** states that fear motivates individuals to take action to reduce their apprehension about health issues. It posits that Fear Appeals can be used as a motivator for positive behaviour, reaction or even lifestyle change, especially when the targets really do not want to change. Witte later expanded the Fear Appeals Theory with her **Risk Diagnosis: The Extended Parallel Process Model (EPPM).** The EPPM recommends that campaign messages should contain a 'threat' component and 'efficacy' component. The threat in the message attempts to make the audience feel liable to a severe consequence e.g. contacting HIV or dying. The efficacy in it attempts to convince individuals that they are capable of performing the recommended action. (Example: 'I can use condom always'). The recommended action helps to nullify the

threat. (Example: 'I won't die of AIDS because I use condom always and condom protects me.')

**Health Belief Model, HBM** says an individual's behaviour can be predicted using how he or she perceives the risk involved: the severity, and the possibility of being affected by a health risk. It suggests that the likelihood that an individual will take action concerning a health condition is determined by the person's desire to take action and by the perceived benefits of the action weighed against the perceived costs of barriers. Core assumption of the HBM is that a person will take a health-related action (e.g. use a condom) if that person feels that a negative health condition (i.e. HIV) can be avoided in doing so; has a positive expectation that by taking a recommended action, he/she will avoid a negative health condition (i.e. using condoms will be effective in preventing HIV), and believes that he/she can successfully take a recommended health action (for instance, use condoms comfortably and with confidence). HBM also attempts to build the person's confidence in the ability to successfully carry out an action. ('Self-efficacy' e.g. not just accepting to use a condom but being able to wear it and use it properly). A very similar theory to HBM is the **Theory of Reasoned Action**: People make conscious choices based on how strong they perceive the benefits to lead to a positive outcome and the social norms, risks and rewards they associate with that choice. This theory states that people consider their actions before they decide to perform or not to perform them. Its central assumption is that individuals usually act upon their intentions; based on their perception of it as right or wrong weighed against social pressures to carry out (or not carry out) that particular behaviour.

The **Elaboration of Likelihood Model, ELM** is based on the idea that persuasion is the primary source of attitudes although it can result from a number of other things. The model features two routes of persuasive influence: Central and Peripheral. It argues that when people are motivated and are able to think about the content of the message, elaboration is

high. Elaboration in this sense is, enhancing the ability to think about the content of the message (cognitive processes such as evaluation, recall,. critical judgment and inferences). The **Stages of Change** is another persuasive psychological theory initially applied in stimulating behaviour change in drug addicts but has also been applied to the HIV/AIDS problem. It is about 'tailor-theraping' a person's need in the change process. This process takes place in a linear form from ***pre-contemplating*** (individual has the problem whether she recognizes it or not and has no intention of changing); ***contemplating*** (recognizing the problem and seriously thinking about changing); ***preparation for action*** (intends to change behaviour within the next month; ***action*** (carries out the new behaviour repeatedly in the short run) and ***maintenance*** (maintains new behaviour for six months or more).

*Sociological framework*

Many scholars faulted psychological theories as being individualistic and physiological. In a critical assessment of theories and models used in health communication for HIV/AIDS, for instance, Airhihenbuwa (1995) noted that most of the theories were based on social psychology that emphasizes individualism at the expense of societal and regional contexts. Airhihenbuwa and Obregon (2000); Diop (2000); Kelly et al.. (2003); Diop (2000) argue that the flaws in the commonly used classical theories and models in health communication are due to the contextual differences in locations where these theories and models are applied. Theories in this genre are built from the sociological framework. They include: *Source Credibility Theory, Activity Systems Theory, Spiral of Silence, and Behaviour Change Communication (BCC).*

The **Source Credibility Theory** emphasizes the importance of the change agent in communicating change. If someone is told to change his or her sex behaviour in order to

avoid HIV/AIDS. such a person will likely oblige if the source is credible or presents itself as credible.

**Activity System Theory** posits that communication can result in HIV/AIDS behaviour change if a multi-disciplinary use of psychological, sociological, cultural and communication theories/models, is applied - what Kelly et al. called 'social network'. This theory is examined in more details on page 33.

**Behavioural Change Communication, BCC** is one of the contemporary theories for HIV/AIDS communication campaigns. "At the community level, BCC seeks to change knowledge (so that people do not act out of ignorance), attitudes (so that individuals and communities approve and work for an enabling environment for healthy behaviour), behaviour and practices (so as to reduce known risks to individuals and to the community) and to foster interpersonal communication advocacy (so that people can privately and publicly encourage others to act in a positive manner". (UNFPA, 2002: p.37). In other words, BCC addresses individual change through social change: You can change the individual to change the community and you can also change the community to change the individual. Also you can change several communities to change a state.

Noelle-Neumann uses the **Spiral of Silence Theory** to explain why people often feel the need to conceal their opinions, preferences or views when they fall within the minority of a group. The theory has explanatory power concerning AIDS-related issues such as stigma, discrimination, defiance, use or non-use of condom, and carefree sexual practices. People hold certain opinions and engage in certain behaviours just because they want to do 'what everyone else does'. In other words, in order to avoid isolation on public issues, many people are guided by what they believe to be the dominant opinions in their environment. They often

conceal their views if they feel they are in a minority and would be more willing to express them only when they think their views are gaining ground.

*Communication framework*

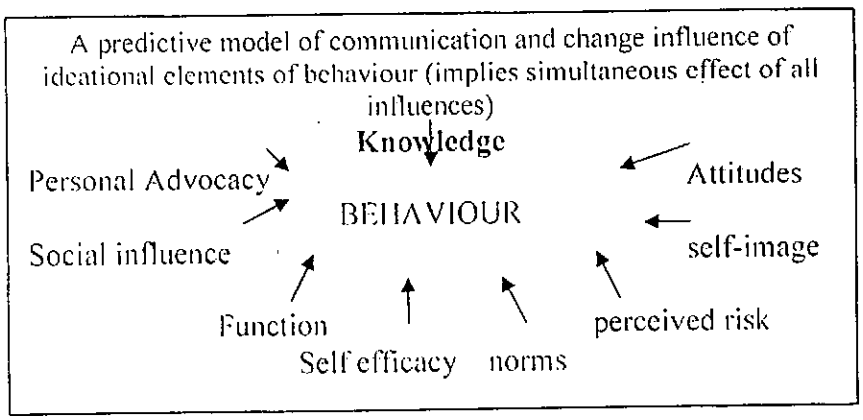
Current HIV/AIDS communication theories, irrespective of their root disciplines – psychological or sociological – have also drawn largely from development communication theories, especially in terms of their application. From the 1950s when transmission of information was regarded as the major task of communication change to the era of 'powerful media', 'adoption of innovation' and 'communication extension' of the 1960s, through the information-education-communication of the 1980s to 'empowerment' and 'exchange' of the 1990s to 'participation' at the turn of the century, communication has played a dominant role in providing a theoretical framework for stimulating change. It is however remarkable that many of these theories have not recorded as much success when applied to HIV/AIDS as in other health problems such as malaria and smoking. Below are some of the major theories in this regard.

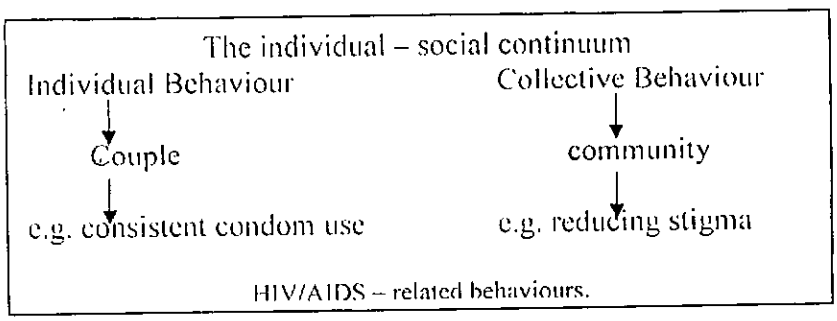
**Social Learning Theory** is also known as the *Observational Learning Theory*. It states that we cannot learn all or even much of what we need to guide our own development and behaviour from direct personal observation and experience alone. We learn much from indirect sources, such as the mass media. Bandura (1986) posits four basic processes of social learning – attention, retention, production and motivation, and argues that they occur in the above stated sequence.

"Our attention is directed at media content of potential relevance to our lives and personal needs and interests. We may then retain what we have learnt and add it to our stock of prior knowledge. The third stage – that of production – refers to actual application in behaviour, of

lessons learnt, where it may be rewarded (reinforced) or punished, leading to greater or less motivation to follow any particular path." (McQuail, 2005:p.492). Bandura's thesis is that media can have direct effects on people and (that) their influence does not have to be mediated by personal or social networks. (Bandura, 2002).

**Diffusion of Innovation & Ideation Theories.** *Diffusion* suggests that people can be influenced and encouraged to adopt particular opinions and behaviours when people who have strong opinions express them through the media. *Ideation* is the spread of new ways of thinking through communication and social interaction in local, culturally defined communities. (Jose Rimon, JHU/UNFPA, 2002).




L. Kincaid, M.E. Figueroa, J.G. Rimon, JHU/CCP, 2002

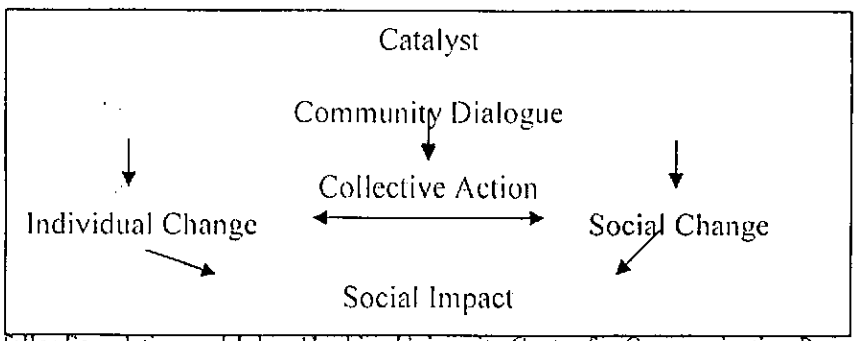
***Figure 2. Ideational elements of behaviour change.***

Ideation helps to approach the modification of an individual's behaviour by distinguishing individual behaviour change from collective behaviour change. Ideation is therefore more of behaviour development than behaviour change, though it includes both.

**Sensation Seeking Theory** was developed by pragmatics. This theory postulates that misconception occurs because people are not 'speaking the same language'. In other words, when people's content and relationship component do not match up, miscommunication is likely to occur.

**Communication for Social Change, (CFSC),** like the BCC, is a holistic framework for development communication in several or large communities. Rather than focus on changing an individual, CFSC attempts to engender change in a large community or several communities. Two key concepts central to this approach are 'participation' and 'dialogue'.

"It stresses the importance of horizontal communication, the role people as agents of changes, and the need for negotiating skills and partnership. In a process of public and private dialogue, politically and economically, marginalized people defined who they are, what they want and need, and how to attain what they need to better their lives. Change is defined as the people themselves define it". (UNFPA, 2002:p.44)




Rockefeller Foundation and Johns Hopkins University Centre for Communication Programs

*Figure 3. Johns Hopkins' CFSC model.*

What principally distinguishes CFSC from BCC is that CFSC, unlike BCC, does not focus on content, messages, information dissemination, products or even the desired behaviour

change but on the process of dialogue through which people can remove obstacles and build structures and methods to help them achieve the goals they set for themselves.

According to UNFPA (2002:p.44):

> CFSC moves communication and its practitioners away from individual behaviours to collective community and long term social change; away from persuasion and social marketing to negotiating the best way forward in partnership; from external agencies dominating the means and methods of community control and the community becoming advocates for change; away from people as objects for change to people as agents of change; away from communicators seeing themselves as the experts placing information in public domains, making it more accessible and elevating local experts.

The CFSC is a bit different from **Social Mobilization,** which has been successfully applied by United Nations agencies. It is more like 'Socialization' i.e. using human beings and modes/instruments as mutual influences between individuals, adapting them to cause change. In fact, **social mobilization** is more about diffusion of innovation and sharing of experiences and may be seen as a tool for the CFSC approach. **Social Mobilization** entails "situation analysis" (magnitude, severity, context, resources, knowledge gap, "establishment of objectives" (specific targets, time frame, measurable goals); "Strategy" (geographical implementation, community involvement, costs; formulation of projects); "Feasibility Analysis" (political, administrative, technical, financial, human); "Implementation, Monitoring and Evaluation" (awareness section, partnership efforts, techniques selection, pilot experiment, message design; message dissemination, monitoring and impact evaluation) (Czaplicki, 2008:p.71-79). While social mobilization is 'top down' in approach, CFSC is 'horizontal'.

**Functional Approach to Mass Communication Paradigm** states that there are five functional approaches the media serve users: surveillance, correlation, transmission,

entertainment and mobilization. The theory attempts to explain functions of the media or the audience's use for the media. 'Surveillance' refers to news information; 'Correlation', means that the media presents the information to the people after they select, interpret and criticize it; 'Cultural transmission' is about the fact that the media reflects its own beliefs, values and norms; 'Entertainment' lies in the media offering an escape from everyday life; while 'Mobilization' refers to the function of promoting society's interest. All these functional areas have been variously applied in HIV/AIDS communication campaigns. (Lasswell, 1948).

**Information-Motivation Behaviour Skills (IMB) Model** is based on an analysis and integration of theory and research in the HIV prevention and social psychological literature. It posits that information and motivation work primarily through behavioural skills to influence HIV preventive behaviour. 'Information' helps the target person to take a decision (for example a pregnant woman hears on the radio that she should go for HIV test) while 'Motivation' helps maintain an attitude or behaviour (for example, an undergraduate continues to maintain her sexual abstinence pattern rather than change to use of condoms.) Usually, the most difficult aspect of the theory to replicate is 'motivation'. According to the IMB Model, HIV prevention includes personal motivation to practice preventive behaviours. It also recognizes the importance of social or community norms as motivational factors for sustaining behavioural change. McKee et al. define behavioural skills as "an individual's objective ability or his or her perceived self-efficacy to perform HIV preventive behaviour (such as delaying sexual debut until marriage, providing and using condom effectively, negotiating consistent condom use and mutual fidelity...)" (McKee, et al. [2000], quoted by NACA, 2004:10).

The **Agenda Setting Theory** has offered strong theoretical foundation for HIV/AIDS advocacy. The theory says the media (mainly the news media) are not always successful at telling viewers/listeners/readers what to think, but they are quite successful at telling them what to think about. It predicts that if people are exposed to the same media, they will place importance on the same issues. Thus, even though the press may not be very potent in changing people's attitudes regarding HIV/AIDS, it is potent in making people feel that the HIV/AIDS issue is very important. The thinking of many scholars on this theory currently is that the media and the public jointly set the agenda. (Newcomb and Shaw, 1973). Similarly, Gerbner's **Cultivation Hypothesis** states that television can have direct effect on viewers through consistent exposure to particular programmes on it. The theory predicts that those who watch four or more hours a day of TV (heavy viewers) would suffer from the 'mean world syndrome' (seeing the world as worse than it actually is) more than those who view less than four hours per day (light viewers). Gerbner argues that too much viewing of violence on TV, for instance, would produce a more fearful populace. (Gerbner & Gross, 1976).

## A THEORETICAL FRAMEWORK OF THE STUDY: ACTIVITY SYSTEMS THEORY

The Activity System Theory was developed by Kevin Kelly, Warren Parker and Graeme Lewis (2001). The scholars formulated the theory specifically to "re-conceptualize the concept of behaviour change for HIV/AIDS programmes." (Kelly et al. 2001:p1). The thesis of the theory is that communication is more effective in HIV/AIDS behaviour change programmes if the nexus of mediating factors such as individual/group differences, societal characteristics, context and the message ('compelling forces') are taken into consideration in the intervention process. The authors argue that people do not take volitional/intentional actions all the time and that people often take actions in 'group' or in a kind of 'social

network' (activity). Using the Systems Theory as a superstructure, the scholars posit aht in African societies, decisions on sex, marriage, gender and health (key issues interwoven with HIV/AIDS are more often taken communally and that this normative influences on people by group or society induce behaviour.

*Philosophical foundations of the theory*

Kelly et al. underpinned their Activity System theory on the fact that approaches to behaviour change were largely deficient by over-emphasizing cognition. They argue that cognitive models focus much on the individual while ignoring the contingencies which bring intentions to fruition. According to the scholars, "a behavioural outcome which appears to derive from a cognitive intention...is often really a by-product of a complex interplay of intentionality, communality and sociality." (2001:p.2).

'Action and behaviour' are distinct, though closely-related. The use of the term 'action' refers to that which is intentional or that which is deliberately achieved. Behaviours, in contrast, are not necessarily or specifically performed as 'intentional acts'.

> Behaviour is, broadly speaking, 'what humans do' and refers to all human events, whether or not they are consciously willed; actions may be motivated but the performance of actions must be willed in some sense."
> (Kelly et al. 2001:p.3).

Examples of 'behaviours' that may not be willed are sleep, feelings, spontaneous laughter and passions. While actions are presumed to originate from the mind of the actor, behaviour may be contingent on concurrent and preceding events.

According to Kelly *et al.* actions are derivatives of social rules:

> If we wish to understand why a person performs a ritual, custom or ceremony in a particular way or why a person acts superstitiously or what lies behind a particular set of manners or why a person finds it difficult to refuse sex to another, it will not usually be that helpful

> to ask the person why he or she feels this way. The *reason* why is not carried in the mind of the actor but is carried out in the social model of action which the person adopts. (2001:p.4).

Activity system analysis amounts to an attempt to understand the way a system is organized or operationalized. A system is made up of components (known as sub-systems) that inter-related and inter-dependent. Kelly *et al* posit that human behaviour system has three sub-systems of mediation – the subsystems of *intentionality, communality* and *sociality.*

'Intentionality' implies that behaviour is consciously willed. 'Communality' describes how people adopt social practices which are not of their own making. 'Sociality' is behaviour as a contingent activity beyond the level of intentionality and communality – i.e. human activity is a product of macro-social systems.

*Key postulations of the Activity System Theory*

- Cognition is not 'in the head' or something that people *do*. Rather, "what we think and what we imagine ourselves to be capable of doing is a product of our experience, of the world we live in and the affordances it offers, of the relationships we are involved in and the structures thereof and of the possibilities and sense of a future that our circumstances promise." (Kelly *et al.* 2001:p15).
- When the supportive context is not in place, the required change will simply not take place.
- When it appears that a willed activity produces an intended outcome, it is usually the case that foundations upon which the activity is founded have already been set in place. For example, even when an HIV/AIDS interventionist has a well-produced TV advertisement and the target audience may wish to change, the interventionist must also ensure that the context of predisposing circumstances to aid acceptance of the message in the TV advertisement are in place.

- In communicating social change, simple appeals to change are likely to fall on deaf ears when context is ignored and what campaigners should be do is try to understand the way in which communities of people are engaged in jointly crafting the outcomes.
- Human beings operate in 'communities of response' and "until we understood what mediates these patterns of response, we do not really have an understanding to base our interventions upon." (Kelly, et al. 2001, p.16).

*A critique of the Activity System Theory*

Activity System Theory does not radically contradict (but rather complements) many other wide ranges of models of understanding behaviour change. For example, the Theory of Reason Action (Fishbein and Azjen, 1975) views behaviour as a function of the intention to perform that behaviour. Thus, changing a behaviour is primarily a matter of changing a person's cognitive structure. The Activity System Theory suggests further that apart from changing the cognitive structure of the audience, the change agent needs to change or affect the subject norms and beliefs which do also affect the cognitive process.

The theory has strong explanatory value in terms of understanding HIV/AIDS prevention behaviour. It predicts that an HIV intervention is not likely to succeed if it fails to address the problem holistically.

> The correct solution to the need to get people to respond more actively to the HIV/AIDS epidemic lies in creation of contexts for change...through engaging people in activities through which practices develop...than appealing to people to change their attitudes or sexual practices.
> (Kelly et al. 2001: p.16)

A major criticism of the Activity System Theory is that it mainly describes how behaviours take place and says very little on why they (behaviours) take place. Thus, the predictive power of the theory is limited.

## A CRITIQUE OF THE THREE STRANDS OF HIV/AIDS COMMUNICATION FRAMEWORK.

Waisbord (2005:p.81) notes:

> These days the field of development communication is more theoretically diversified and strategically nuanced. It has become an umbrella term for a wide range of communication programs and research. Evidence of this diversity is the alphabet soup of approaches and interventions that commonly fall under 'development communication', such as communication for development, communication for social change, information, education and communication, behaviour change communication, social mobilization, media advocacy, strategic communication, social marketing, participatory communication, strategic participatory communication, and so on. Given this conceptual cacophony, no wonder there is a maddening confusion and persistent questions about similarities and differences. The proliferation of labels or approaches is founded in several factors.

In a critical assessment of theories and models used in health communication, particularly HIV/AIDS, Airhihenbuwa and Obregon (2000:p.2) argue that the flaws in the commonly used classical theories and models occurred because contextual differences in locations where these theories and models were applied. Kelly et al., similarly argue that the **psychological framework** assumed wrongly that people take decisions volitionally or intentionally. They stress that, in reality, especially in African societies, people's decisions are often 'communal' (p.12-13).

A major shortcoming of the psychological framework is that the theories rely too heavily on individuality. They assume that an individual determines his or her actions hence they address the task of changing individual attitudes and behaviours from the individual

perspective. It will be a waste of time and resources to treat every HIV/AIDS case individually; hence a more practicable framework would be that which is applicable to small groups, large groups and mass groups.

We may use the *Theory of Congruity* to illustrate the limitations of many psychology-based communication theories. Though it has a high predictive power in terms of how third party observers may react to arguments between two main parties, it does little to explain why people do what they do in a given situation. It however explains how their actions and reactions may change. Yet, the psychological framework provides a basis to understand behavioural change. For example, various 'infortainment' or 'edutainment' approaches being used in HIV/AIDS communication today derive from Donohew's *Activation Theory of Information Exposure* and Lasswell's *Functional Approach*, both of which stress the power of entertainment to influence behaviour change. The *Fear Appeals Theory* has been found helpful in understanding the consequences of destructive behaviour. According to NACA, "Fear appears to have a critical influence on whether or not one engages in health-related behaviours. For example, for many people, especially those living in high prevalence areas like motor parks and border crossings, discussions about HIV and AIDS infection are intensely fear-arousing." (2004:p.12). The Fear Appeals Theory may be very useful in *behaviour therapy* but it does not appear to be very helpful in *behaviour change*.

Similarly, faith-based approaches that are gaining increasing attention among international organizations and scholars working on HIV/AIDS have roots in attitude-based theories such as *Belief Congruency* and *Balance Theory*. The *Source Credibility Theory* provides insights into why some NGOs and fund agencies now more frequently use PLWHAs in their interventions. The ELM theory, though helpful in understanding how people change, especially people who are addicted to a particular behaviour, is too individual-centred and

does not take into consideration environmental issues and influences. Also, the relationship between stages is not clear in the ELM model. The *Social Judgment Theory* merely tells us which latitude people place in-coming message for processing and does not help communication experts to make people place information in the latitudes they (communicators) prefer them placed.

The **sociological framework**, though becoming more popular, has some shortcomings. For instance, the *Spiral of Silence* has epistemological value in rural Nigeria setting where most families are 'extended' in nature such that family heads, even village heads, could voice opinions on behalf of members of the family or the village. Urban settings present a different scenario. In an urban setting, people tend to be more opinionated and may not bend their opinions to conform to prevailing views. The *Activity Systems Theory* appears to be an expository of the *General Systems Theory*. It describes how a given phenomenon operates but says little on why it operates like that. This means its predictive power is limited.

The **communication framework** has been applied variously to social change and development programmes since the **1950s**. The paradigm six decades ago was that development problems were rooted in lack of knowledge and that these problems would be solved by transmission of information. It was a break-away from 'the traditional society' and introduction of *modernization*, in which ownership and exposure to radio, television and newspapers were considered the pathway to development. The most popular models during this period were woven around theories that portray the media as "very powerful". In the **1960s**, scholars found that the mass media's power may have been exaggerated. 'Transactional' models gained acceptance during the era. The **1970s** witnessed the gradual integration of communication theories from various disciplines. Scholars found that communication designs must take into cognizance economic, political, social and cultural

factors to bring about change in people's attitudes and behaviours. This paradigm went on to the 1980s when Social Marketing, Information-Education-Communication (IEC) became dominant. The 1990s triggered communication frameworks anchored on 'exchange', 'empowerment' and 'capacity building'. The framework has been made popular by the United Nations and its agencies such as UNICEF, UNAIDS and UNFPA. At the turn of the century, (2000s) 'participatory communication' became dominant. It was a step forward from social marketing. Participatory Development Communication (PDC) "is a planned activity based on participatory processes and interpersonal communication, which assist individuals and community groups to understand causes of problems and identify/implement possible solutions." (UNFPA, 2002:p.14).

Recent traditions in development communication theory tilt towards integration of psychological, sociological, economic theories with communication theories based on the proper redefinition of communication as "a sharing; a meeting of minds, bringing about a common set of symbols in the minds of participants – in short, an understanding." (Merrill and Lowestein, 1979:p.5). At the turn of the century, there began a gradual recourse to the 'powerful media model' working alongside 'coterminous factors'. Any theory on health promotion, ideally, then, should emphasize information, education, empowerment, participation, social context, and sustainability.

## A CONCEPTUAL FRAMEWORK FOR HIV/AIDS COMMUNICATION ('WORKING THEORIES'/APPROACHES)

There are at least fourteen (14) widely used "approaches" worldwide, based on the convergence of theory and practice in the field of HIV/AIDS communication. The more widely used approaches are summarized thus:

1. *Advocacy*

UNFPA defines Advocacy Communication (AC) as "organized attempts to influence the political climate, policy and programme decisions, public perceptions of social norms, funding decisions and community support and empowerment towards specific issues", UNFPA(2002:p.52).

2. *Social Marketing*

The approach uses commercial advertising techniques to promote social development. Good health, safe sex, healthy sexual practices are portrayed as marketable goods and are therefore "sold" to intended beneficiaries.

Social marketing is currently the main approach in the sales of condoms and contraceptives. According to R. Marnoff, an advocate of this approach, communication professionals should by now be able to "sell" good health like they are able to sell *coca-cola, toothpaste, cigarettes or presidential candidates* (Marnoff, [2001], cited by Czaplicki, [2008]:p.85)

3. *Counselling*

Though, generally seen as more of medical approach in HIV/AIDS programming, counselling involves more of communication. It is the sharing of meaning such that an action is recommended or sought during the communication process.

It requires knowledge of the subject-matter and communication skills to carry out effective counselling. Counselling is also an "epidemiological approach" (Rodriguez, 2004:p.2), which makes individuals to change by "injecting" in them "a message that will cause that individual to change in the direction you want him or her to change". It is person-to-person and very systematic and controlled.

4. *Formal Education*

The formal education approach aims at reducing vulnerability to HIV/AIDS by increasing literacy and general educational level. It includes: expanding early access

to universal childhood education; school-community partnerships; safer recreational activities in schools; integration of HIV/AIDS into schools curriculum at all levels (with content and methodology age-graded appropriately; location of HIV/AIDS counseling Centres in schools; and impartation of life-skills-based HIV/AIDS education in schools. The curriculum is planed in three phases: curriculum and materials development, teacher training and supervision/evaluation of the programme. The ministries of education and health and NGOs play key roles in the formal education approach to HIV/AIDS.

5. *Peer Education*

Peer Education is a popular concept that implies an approach, a communication channel, a methodology, a philosophy, and a strategy. 'Peer' refers to one that is of equal standing with another; one belonging to the same societal group especially based on age, grade, or status. 'Education' refers to the 'development', 'training' or 'persuasion' of a given person or thing, or the 'knowledge' resulting from the educational process. (Mishra, 2005:p.189).

This approach has been used in many areas of public health (notably nutrition, family planning, substance abuse and HIV/AIDS).

> HIV/AIDS peer education stands out owing to the number of examples of its use in the recent international public health literature. Because of this popularity, global efforts to further understand and improve the process and prevention, care and support have also increased. (Mishra, p.190)

Peer education is based on behavioural theory, which posits that people make changes not because of scientific evidence or testimony but because of the subjective judgment of close, trusted peers who have adopted change and who act as persuasive role models for change.

6. *Information – Education – Communication (I-E-C)*

Despite paradigm shifts from the all-powerful model of the mass media to democratic-participant models (which stress interactive communications) the approach of using the mass media for linear, one-way communication, is still much in use in Nigeria. Many NGOs and CSOs commonly use this approach – text messages, radio/TV jingles, testimonial advertisements, newspaper features and news stories with emphasis lately on 'communication', conferences, workshops and seminars feature as key components of I-E-C. This approach is premised on the thinking that "an informed laity helps in the promotion of good health practices in any community and that the degrees of awareness, seriousness and importance with which the general public hold health matters; this ultimately plays vital roles in good-health promotion" (Gladom, 1989).

7. *Edutainment*

Also known as 'enteredutainment', or entertainment-education (E-E), this approach entails using entertainment techniques to inform, educate and produce behaviour change. Edutainment is the intentional placement of educational content in an entertainment message (Singhal & Rogers, 2003). This may be in form of music, musical video, film, home video, drama, theatres, story telling, cartoons, road shows and rallies for small or large groups.

According to Tufte (2005:p.166) "the use of E-E has for decades been seen in addressing health–related issues as blood pressure, smoking, vaccine promotion and family planning; it has also been used for the past 15 years in HIV/AIDS prevention." He sees E-E as not just one tool of social marketing but as the use of entertainment as a communicative practice crafted to strategically communicate about development issues in a manner and with a purpose that range from the more narrowly defined social marketing of individual behaviours to the liberating and citizen-driven

objective. It has recorded reasonable success in Latin America in numerous social change programmes.

8. *Social and Cultural Construction*

Social and cultural construction is a recent approach, which attempts to reconstruct previous socially constructed interventions. Scholars such as Singhal, Arhihenbuwa and Paiva have proposed this technique, arguing that too often and in too many interventions, HIV/AIDS has been socially constructed as a life-threatening disease to be feared, resulting from "promiscuous" and "deviant" behaviours. (Singhal, 2007). It is therefore pragmatic, they argue, to discard the approach of seeing HIV/AIDS as anti-sex, anti-pleasure and change to an approach that adopts the social construction of "love". According to Arhihenbuwa "culture can also be viewed for its strengths and the HIV/AIDS problem can be addressed from attributes of a culture that are helpful." (Arhihenbuwa, 1995:p.35). For example, instead of portraying polygamy as an archaic African culture, the practice can be reconstructed to encourage fidelity. Instead of being married to one woman and having ten concubines who are exposed sexually to numerous other men, why not encourage the man that desires more than one woman to marry as many as he wants provided he stays only with those legally married to him and the wives are all faithful to him? Instead of seeing the African culture of polygamy as bad, it can be reconstructed to be a practical way to stop adultery and promiscuity.

A very similar working theory, developed by Clemencia Rodriguez, is known as the *'social fabric approach'*. Here HIV/AIDS is seen as a social problem resulting from interaction of many factors ranging from poverty; weak state presence; collapse of values; defiant behaviours; and presence of illegal economies. In these contexts, communication initiative is to 're-knit' the social fabric. In a community of violent

youths, for instance, a 'social fabric', made of responsible and empowered citizens raised within such a community would eventually repel violence. (Rodriguez, 2004).

The *'Social Capital'* technique also falls within this practical approach, (Lamptey, Zeitz, Laviree, 2002:p.71). It refers to the mutually beneficial interactions that establish networks, norms, and trust between people, and which facilitate coordination and cooperation.

9. *Multiple Response Model*

This approach entails using multiple fronts to target the same audience (Rau, 2006). People may be infected with the HIV through various sources such as school, workplace, home and the multiple response approach attempts to tackle prevention, care and mitigation.

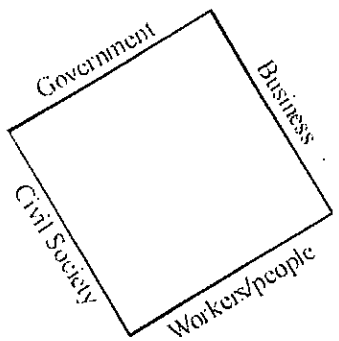



***Fig. 4. The four-sided multi-response model in HIV programming.***

The approach has little methodical value other than it emphasizing the fact that it is better to approach prevention, care and mitigation from multiple angles simultaneously for good results, especially for society- or large-community-based interventions.

10. *Empowerment*

The term 'empowerment' has been used variously to describe the need for government to provide basic necessities for sustainable living for citizens and the centrality of power in form of educating people through necessary information that could enable them fend for themselves and liberate themselves from poverty and ignorance. Sometimes, it is used in a holistic form to describe the provision of infrastructure for development, especially those which enhance economic well-being of citizens.

This approach is being used in HIV/AIDS interventions to address the element of poverty, which has been found a major reason for commercial sex, for example. Empowerment is thus expected to be an effective approach, especially when used in combination with other pragmatic approaches, to cause behaviour shifts amongst commercial sex workers. The Federal Government of Nigeria has officially adopted 'empowerment' as a proactive approach to tackle HIV/AIDS, through the National Economic Empowerment and Development Strategy (NEEDS). NEEDS has five fundamental core components: realistic target setting; strategies derived from policy target; resource allocation based on set targets and strategies; budget implementation and fiscal discipline and monitoring, evaluation, impact and sustainability.

11. *Negotiation/Partnership/Participation*

Some NGOs and CSOs use approaches that are predicated on negotiation and partnership, especially when behavioural change is desired.

**Partnership** involves people coming together through associations, organizations and representative bodies to share their concerns and voice their opinions. Communication technique under this approach is centred on self-efficacy (ability of

the audience to do-it-themselves), which may be inter-personal, group or mass media channels e.g. workshops, conference and community radio programmes development. *International HIV/AIDS Alliance*, an international organization with extensive works on HIV/AIDS uses this approach:

> Our organization recognizes that all facilitators have their own ideas and styles and that this is a great strength. Participatory approaches are widely used to encourage the involvement of those directly affected–learning through drawing, role-plays, small group work allows people to become actively involved in the process. Participatory approaches encourage people to think for themselves, contribute to funding and learning rather than passively receiving information from outside 'experts' who may not have local understanding of the issues.
>
> (Actionaids, 2003:p.1-2).

Participatory approaches are creative and contextualized to suit the target audience. They are inexpensive, sustainable, non-stigmatizing, easy to learn, and they instill self-confidence. Target audience members share information, learn from one another, and make informed contributions; sometimes, they are financially involved. It synchronizes with the African adage that when one is part of a decision, one is more inclined to accept the decision.

**Negotiation** is discussion of an issue in order to reach an agreement. It is discussion aimed at bringing some result, especially through bargaining. This approach arose because of the special non-health related issues woven with HIV/AIDS problems – stigma, sexuality, gender, poverty, discrimination and norms, etc. Many communication programmers have gone beyond analyzing and influencing the bubbling of individual corks on surface waters and now focus on redirecting the stronger undercurrents that determine where the cork clusters end up along the shoreline (McMichael, 1995).

One of the key approaches through which the "undercurrents" are being addressed is "negotiation". Many NGOs working on commercial sex workers, for instance use this approach. Similar complex issues such as marriage, culture, and religious beliefs are being addressed by communication programmers via *negotiation*. Also, youths and PLWHA are being taught, to negotiate sex.

Servaes and Malikhao succinctly describe the **Participatory Communication Paradigm:**

> Participatory communication requires **first of all** changes in the thinking of 'communicators'... it requires much more imagination, preparation and hardwork to have dialogical learning. It is far easier to prepare and give lectures. However, there is possibly a valid reason why we have two ears, but only one mouth. Communication between people thrives not on the ability to talk fast, but the ability to **listen** well. People are 'voiceless' not because they have nothing to say, but because nobody cares to listen to them. Authentic listening fosters trust much more than incessant talking.[emphasis mine].
> (2005:p.91)

According to Freire, there are two major approaches to participatory communication: the **dialogical pedagogy** (Freire, 1973) and UNESCO's **self-management, access** and **participation**. This implies dialogical communication. Although the theory is based on group dialogue with little attention to the language or form of communication and amplifying of media resources such as radio, newspaper and television, there is wide acceptance of his approach normatively.

The UNESCO Conference on participatory communication in Belgrade, 1977 highlighted the Self-management, Access and Participation (SAP) paradigm in its final report in the following way:

- **Self-management**: is the most advanced form of participation. In this case the public exercises the power of decision making within communication

enterprises as is also fully involved in the formulation of communication policies and plans. (Servaes and Malikhao, 2005:p.96).

- **Access:** refers to the use of media for public service. It may be defined in terms of the opportunities available to choose varied and relevant programs and to have a means of feedback to transmit its reactions and demands to production organization.
- **Participation:** implies a higher level of public involvement in community systems. It includes the involvement of the public in the production process and also in the management and planning of communication systems. May be no more than representation and consultation of the public in decision-making.

Cadiz (2005) has developed a three-pronged participatory communication approach for community development because the multiple approaches have been found effective lately ('kit-tool system', FAO, 2002) in development communication. These are:

- *Community Organizing (CO):* Here the community is empowered with knowledge and skills to identify and prioritize its needs and problems, harness its resources to deal with these problems and take action collectively. CO proceeds in three stages: **Awakening:** Area Selection; Entry in Community; Social Investigation/Community Study; Integration; Contact-Building and Spotting of Leaders; Core Group Formation; Core Training and Mobilization and Formation of Community Organization. **Empowerment:** Programme Planning; Project Planning; Implementation; and Evaluation. **Restructuring:** Phase Out; Establishment of New Systems of Working Relationships. According Cadiz, *"In a community where people are passive recipients of changes in wider society and are locked up in dehumanizing poverty and*

*other social ills, community organizing is an intensive process of awakening people's social consciousness and developing their leadership capabilities to take action on their development problems."*

- *Action Research (AR).* Here both the people and the researcher intend to be involved in a process of changing the system and solving some problems. AR proceeds logically in six systematic steps: Analysis; Fact-finding; Conceptualization; Planning; Execution; More Fact-finding and Evaluation in a spiraling circle. Its major difference from CO is its use of a more scientific method.
- *Participatory Action Research (PAR) or Participatory Research (PR)* is a form of action research, taking questions from the perceptions of practitioners within local contexts and building description and theories within the practice context itself and testing them there. Its three dimensions are: **1)** it is a method of social investigation, **2)** an educational process, and **3)** a means of taking action for development where the role of the professional researcher is primarily to complement people's initiative and efforts.

12. *Traditional Communication Approach*

Many African Scholars such as Doob (1966), Nwuneli (1980), Jefkins and Ugboajah (1986), Ansu-Kyeremeh (1998), Wilson (1998) and Akpabio, (2000, 2003) have proposed the use of traditional African Communication Systems for social change programmes.

This approach has come to prominence now that culture and context have become crucial elements in HIV/AIDS communication. Ansu-Kyeremeh (1998) defines traditional communication as:

> Any form of endogenous communication system, which by virtue of its origin, form, and integration into a specific culture, serves as a channel for messages in a way and manner that requires the utilization of the values, symbolism, institution and ethos of culture through its unique qualities and attributes.

Some African communication scholars point out that failed social communication campaigns in Africa occurred largely because of the neglect of the traditional communication approach. The Europeans who colonized Africa saw African traditional values and lifestyles as wrong and outmoded, and that there was need for "the passing of traditional societies" for development to take place. Indigenous communication systems such as social forum, village meeting, village market, town crier and folklores had to be marginalized for 'modern' and 'more effective' mass media – radio, television, newspapers which were considered as symbols of modernity and better tools of development communication. Many scholars are giving more voices to the possibility of using the traditional communication approach, possibly in combination with other forms or approaches for social change programmes. (E.g. Jefkins and Ugboajah, 1986; Moemeka, 2000). A good example is Ugboajah's *oramedia.* According to Ugboajah, oramedia is folk or traditional media which are based on indigenous culture produced and consumed by members of a group. Unlike the mass media which reach many people at a time but have only cognitive influence (knowledge, awareness and interest), oramedia can only reach few people at a time, but can be an effective relay chain to the mass media. (Jefkins and Ugboajah, 1986: p.154).

Ansu-Kyeremeh (1998) lists African traditional communication types as:

(1) **Instrumental: Idiophones** (wooden drum, woodblock, ritual rattle, bell, metal gong, xylophone, hand shakers, pot drum); **Membraneophones** (skin drum;

aerophones (whistle, deer horn, ivory tusk, reed pipe); **Symbolography** (decorated bamboo rino, tattoo, chalk marks);

(2) Demonstrative: **Music** (songs, choral and entertainment music); **Signal** (cannon shots, gun shots, whistle call, camp fire);

(3) Iconographic: **Objectified** (Charcoal, white dove, kolanut, curtail, white clay, egg, feather, beads, drinking guards); **Floral** (young unopened palm frond, plantain stems);

(4) Extra-Mudane: **Incantatory** (ritual, libation, vision); **graphic** (announcement of death)

(5) Visual: **Colour** (White cloth, red cloth, hairstyle head-shaven); **Appearance** (dressing)

(6) Institutional: **Social** (Marriage, naming, chieftaincy); **Spiritual** (Shrine, masquerade).

Akpabio (2003) adds two important classifications **myths/legends** and **folktales /proverbs**. Due to lack of widespread application, the literature on the use of the African traditional communication for HIV/AIDS programmes is paltry. Sometime ago, South Africa's health minister Tshabalala Msimang raised some controversy when he suggested eating of lemon, garlic and beetroot as preventative measures for HIV. The minister claimed that the South African government wanted to give AIDS patients a choice between traditional (extra-mundane) remedies and ARVs. (Dickson, 2006).

13. *Faith-based Approach*

Since 'belief' is now seen as a significant intervening variable in HIV/AIDS behavioural change communication, the faith-based approach has become popular amongst many international scholars and NGOs, some of who contextually place their interventions within Christianity, Islam, Hinduism and Buddhism - the four principal faiths being explored by UNAIDS at the moment (UNAIDS, Windhoek, 2005). Faith-based approach (or *theological*

*approach* as it is more often referred to by those using the Christian faith) has been particularly employed to reduce stigma, discourage discrimination and prevent infection (the latter through abstinence). Its application to healing (treatment) is controversial but it is being used also as foundation for care and support.

The Christian faith is based on precepts that are salient with issues such as abstinence, stigma, and discrimination and since religious belief is often deep-rooted in people, it has a strong influence on attitude and behaviour.

Christian precepts include:

- *Equity of all persons* (stigmatization is unchristian);
- *Sin* (sex before marriage is known as sin of fornication and sex outside marriage is the sin of adultery, and anyone who commits them will spend his or her life-after-life, the central doctrine of Christianity, in eternal hell fire). It is sin to deliberately infect others with HIV. The opposite of sin is holiness or purity.
- *Life after death* (Heaven/Hell): People sick of AIDS can still make heaven if they change to good (recommended) behaviour. God will forgive them if they repent.
- *Love:* The Christian faith teaches three types of love: **eros** (physical love), **phileo** (sexual love) and **agape** (charity). Charity is the ultimate Christian love, which every Christian must have. It is the unconditional love. Also central to charity in the Christian faith is giving (tangible and intangible). Why the theology approach is being seriously explored is because adherents see the precepts as laws from the Supreme Being which if they violate, they will face the eternal death penalty. It is a command; an irrevocable law which takes priority over their personal thinking.

In terms of specific methods used in the Christian faith-based approach to combat HIV/AIDS, the following have been identified by MacDonald (2005:41):

- *Preaching* (which is essentially interpersonal persuasive communication)
- *Teaching* (to inform, interpret, expose and sometimes to persuade)
- *Deliverance* (forceful ejection through prayers, of demonic powers that make people to sin).
- *Healing Ministration* (a sick person is healed after praying for him or her) Jesus Christ in Mark 16:17-18 states: "And these signs will follow those who believe. In my name... they will lay hands on the sick and they will recover" (Holy Bible, 1994).
- *Prayer* (Two-way communication between God and those who believe in Him).

Ackermann (2005) has proposed five 'approaches' in using the cardinal Christian doctrines for HIV/AIDS campaigns. These are: the *one-off or add-on approach* (an AIDS Bureau is invited to send an 'expert' to give a one-day update to the congregation on what is happening in the field of HIV/AIDS and speak about prevention); the *sensitivity mode approach* (the church incorporates HIV/AIDS into the church Sunday School and Bible Study Curriculum); the *immersion experience* (groups of parishioners and pastors are taken out to visit HIV/AIDS field projects to 'immerse' them into the experience of suffering caused by the disease; the *theological education approach* (the review and reconciliation of theological and Christian practices – role of narrative in disseminating knowledge, telling stories in claiming one's identity) and *Christian praxis* (Christians in reality, becoming God's hands in the world in treatment, care and support).

In Islam, the other popular religion in Nigeria, faith-based projects on HIV/AIDS have been springing up. Most mosques in Nigeria do not operate HIV/AIDS programmes directly. Rather, Islamic NGOs use religious public opinion leaders (Sheikhs, Ulamas or Mallams) to carry out enlightenment. For example, the Jamaatul-Nasril – Islam, in collaboration with NACA once used the former Sultan of Sokoto, Maccido Mohammed in its enlightenment and education campaigns. Other NGOs using Islamic faith-based approach are Ansar-ud-deen, NASFAT and MICA (Movement for Islamic Culture and Awareness). Key precepts related to HIV/AIDS prevention, care and support in Islam are *zakat* (compulsory giving by the wealthy), *alms*, *fidelity* (including abstinence) and *marital faithfulness*. The Qur'an 8:25 states: "And fear the *Fituah* (affliction and trial) which affects not a particular (only) those of you who do wrong (but it may affect all the good and bad people) and know that Allah is severe in punishment." Also, the Qur'an (17:32) outrightly forbids unlawful sex. (Ogunlayi, 2006:p.37).

The traditional religion also enjoys huge patronage by many of those who profess to be Christians and Muslims but because of its secretive practices, traditional faith-based approaches are not clearly known.

However, apart from the controversies surrounding the efficacy of faith-based approaches, it appears there is the problem of believers in the faiths not doing as they preach.

> As a community of Jesus Christ, the church should be a sanctuary, a safe place, a refuge, a shelter for the stigmatized and the excluded. The church is called to work towards both the prevention of stigma and the care of the stigmatized. And yet, churches have habitually excluded and stigmatized those who are 'different', those who did not conform, and those who have sinned or were thought to have sinned. (UNAIDS, Windhoek, 2005:p.7).

The Family Health International's *Called to Care Project* is an example of faith-based projects being implemented through international, ecumenical collaboration between churches, mosques and other faith-based organisations (using participatory techniques such as focus group discussions and outreaches). (Steinitz, 2005).

### 14. *ACADA Model*

The ACADA Model is a communication design which uses many of the above afore-mentioned working theories based on the 'Triple A' planning cycle: Assessment, Analysis and Action. (UNICEF, 2000). It is widely used by many international organizations and NGOs such as the World Health Organization (WHO), United Nations Children's Fund (UNICEF) and the Planned Parenthood Federation of Nigeria (PPFN) for health communication programmes.

The Model has nine key elements:

1) Situation Assessment – successes, weaknesses, lessons learned, issues and problems.
2) Problem Analysis and Formulation – problems (manifestations, immediate causes, underlying causes and basic causes); differentiating between behavioural and non-behavioural causes; problem statement.
3) Determination of Problem Behaviours to Address – behaviour rating and prioritization; changeability and importance rating.
4) Behaviour, Participant and Channels/Media Analysis – behaviour (manifestation, ideal behaviour, barriers to ideal behaviour and factors encouraging ideal behaviour; participants (primary, secondary, partners, allies), channels (channels to be used in EPI/NIDs/surveillance communication.
5) Communication Objectives – SMART (specific, measurable, appropriate, realistic and time-bound) objectives.

6) Monitoring and Evaluation Indicators – strategies and activities (determining how to achieve the desired behaviour change); monitoring (tracking programme progress); evaluation (process, impact and outcome indicators measure programme progress).

7) Development of Plans for Message and Material Development and Dissemination – message (concepts, communication approach, appeal and tone); materials (mass media, group settings and one-on-one); dissemination (material distribution and utilization strategy).

8) Development of Training Plan – training content, duration, organization and identification of funding source).

9) Putting Together the Communication Plan- combination of all of 1-8 above into a single planning matrix; communication objectives for the different programmes. (UNICEF, 2000:pp.5-10).

## Empirical Studies

### *Epidemiology of HIV/AIDS in Nigeria*

The national prevalence rates of HIV/AIDS in Nigeria were 1.8% in 1991; 4.5% in 1996; 5.8% in 2001; 5.0% in 2003 and 4.6% in 2005. (FMoH, 2005). The slight drop in national average notwithstanding, reports of rapid assessments in several states of the country have raised genuine cause for concern. (FHI Nigeria, 2005).

*The 2005 Sentinel Survey* by the FMoH however showed a slight drop in the rates, with some states having increasing prevalence and others recording decreases: Benue 10%; Akwa Ibom 8.0%; Nasarawa 6.7%; Enugu 6.5%; FCT 6.3%; Cross River 6.1%; Taraba 6.1%; Kaduna 5.6%; Kogi 5.5%; Rivers 5.4%; Niger 5.3%; Gombe 4.9%; Plateau 4.9%; Edo 4.6%; Ebonyi 4.5%; Adamawa 4.2%; Anambra 4.2%; Kebbi 4.0%; Abia 4.0%; Imo 3.6%; Borno 3.6%; Bayelsa 3.8%; Yobe 3.7%; Delta 3.7%; Ogun 3.6%; Borno 3.6%; Bauchi 3.4%; Kano 3.4%;

Lagos 3.3%; Ondo 3.2%; Sokoto 3.2%; Zamfara 3.0%; Kwara 2.8%; Katsina 2.7%; Osun 2.0%; Oyo 1.8%; Jigawa 1.8% and Ekiti 1.6%. (FMoH/SSP, 2005).

Overall, 10 of Nigeria's 36 states and the FCT have prevalence rates of over 5%, (NACA, 2005:3). Latest available figures still paint grim estimates of explosive, localized epidemics in some states (- the 2007 national prevalence survey has not been officially released by NACA and the 2005 survey is the latest available figures). For instance, in Benue, rapid situation assessment indicates a steady rise in prevalence rate. From 1.6% in 1991, the rate rose to 4.7% in 1993; 6.7% in 1995 and ballooned to 16.8% in 1999, only reducing marginally to 13.4% in 2001 and to 9.3%% in 2003, (which placed Benue just behind Cross Rivers which led with a prevalence rate of 12.0% as at then). Benue has since risen to 10% while Cross River dropped from 12.0% in 2003 to 6.1% in 2005. (NACA/SFH, 2005).

Although these prevalence rates are much lower than what obtains in many other African countries such as Zambia, Uganda and South Africa, the huge size of Nigeria's population - 140 million according to the 2006 National Census (National Population Commission, NPC, 2007) – meant that as at the end of 2005, over 4 million people were living with HIV/AIDS in Nigeria. This is the largest incidence in the world after India and South Africa, (UNAIDS, 2006).

The epidemic in Nigeria has extended beyond the traditional high-risk groups such as sex workers and migrant labours and now affects the general population. NACA (2003), notes:

> Though some parts of the country are more affected than others, there is no state or community that is free from the effects of the HIV/AIDS. Every state in Nigeria is experiencing a growing HIV epidemic within its general population...Lately, an increasing number of children are being infected with the virus, through mother-to-child-transmission and we are losing one or more both adult parents to the disease. By all indications, the HIV/AIDS epidemic

> has continued to grow largely through heterosexual unprotected sexual encounters, through mother-to-child-transmission and through contaminated blood products. (p. 5)

Probably because 'awareness and information' were the priorities of early interventions, the literature on HIV/AIDS communication approaches in use have been dominated by IEC (Information – Education – Communication) projects.

### Cross-national Perspective

In a comprehensive literature review, UNAIDS found that of 53 studies that evaluated specific interventions, 27 reported that HIV/AIDS and sexual education either increased or decreased sexual activity or attendant rates of pregnancy and STIs, when social marketing was applied. HIV and/or sexual health education delayed the onset of sexual activity, reduced the number of sexual partners or reduced unplanned pregnancy. Only three studies found increases in sexual health education. (Rau, 2005).

A 1995 study on the media and gender by UNESCO monitored presentation of women by the media in 71 countries and found that women made up just 17 per cent of all interviews in the news worldwide and that those interviewed were more of lay voices, even on topics which were woman – focused. Twenty-nine per cent of all female interviewees were portrayed as victims of crimes or accidents, compared with just 10% of male interviewees. A follow-up study in 2000 has found similar results and these are relatively consistent across regions. In a similar Kenyan study by UNESCO, a striking 76% of rural women who appeared in the media were portrayed as criminals or victims. (Rau, 2005).

Recent literature on HIV/AIDS suggests that new interventions lay more emphasis on social marketing, peer education, partnerships, care and support, empowerment, and faith-based approaches.

In *Brazil*, **Terrada Promessa** (Land of Promise) is a care and support approach that has recorded tremendous success. Situated in the outskirts of *Serra da Cantareira* forest reserve area, near Sao Paolo, *Land of Promise* is a community of PLWHA operated by the Alliance for Life Association (ALIVI). *Terra da Promessa* started a bakery project with a grant from Elton John AIDS Foundation. Three months after installation of all equipment for bread-making, the bakery was up and running. Residents of the area's upscale communities initially reacted negatively to the idea of having people living with HIV/AIDS as neigbhours, worse eating the bread they made. Some residents feared the PLWHA would contaminate the region's water supply. However, the stigma and prejudices soon disappeared and the bakery project promoted great transformations in the community. *Terra da Promessa* has added another income-yielding project; bottling of mineral water. (FHI, 2004b)

The Mae Tao Clinic project in *Thailand* combines *counselling* with *care and treatment* creatively. The clinic was located in Mae Sot on the Thai-Burmese border where undocumented workers – about two-thirds of all Burmese working in Thailand – are denied services from other sources. Without access to services or education, many migrants and their families, particularly women have little knowledge of HIV risk factors. Using *Peer education*, a widely used approach the international HIV/AIDS support agency, Family Health International, has recorded successes in *Vietnam*, *Cambodia* and *Nairobi* among other interventions.

The *Cambodia project* was targeted at military and police forces, whose occupational hazards – long periods away from home, peer pressure to drink alcohol and engage in sexual activity – have made the dreaded virus thrive amongst them and their wives and girlfriends. Since 1998, a peer education programme to encourage safer sex practices and to raise

HIV/AIDS awareness has made significant inroads to stem HIV transmission. More than 7,000 peer educators have been trained to discuss decision-making and negotiation skills in the face of peer pressure from their colleagues, impact of the disease on their families, the society and associated problems such as stigma and discrimination. Military and police commanders play important role by selecting peer educator trainers and obtaining feedback from their units. The results of the project have been remarkable; HIV prevalence among urban police dropped from 6% in 1998 to 3% in 2002. The percentage of Cambodian military, reporting sex with a sex worker in the previous year dropped by more than half between 1998 and 2001 (from about 70% to 32 %). (USAID, 2003a). Primarily run by volunteers and occasionally Western-trained physicians, the clinic provides reproductive health care and family pre- and post-natal care, and education programmes aimed at disease prevention, notably for HIV/AIDS.

Between April 2003 and March 2005, the clinic delivered counselling and testing services to 3,000 clients 20% of who were HIV- positive. From July 2004 to March 2005, 2,123 pregnant women received counselling and 1,590 of them were tested for HIV of which 3.2% were HIV – positive. Thirty Mae Clinic volunteers have already been trained to conduct home-based care. (USAID, 2005).

In *Vietnam,* a combination of *social marketing* and *peer education* brought about significant awareness and attitude shift on HIV/AIDS by targeting barbers. Participating barbers, after induction training, work in teams of 10 at barbershops set up against walls edging city sidewalks and they took their task seriously. Their 'shops' had a variety of posters and stickers that educated clients on HIV/AIDS e.g. against sharing needles, condom use. Over 90,000 male customers have been reached through the programme. A 2001 study found that 24 per cent of long-distance truck drivers in Hai Phong, a group particularly vulnerable to

HIV, had visited project barbers. The barbers and shoe shiners were very happy that they are making a difference in the society. (USAID, 2003b).

Also in Vietnam, the *peer education* scheme for motorcycle taxi drivers has been widely reported in the literature of successful interventions. The project used teams of motorcycle taxi drivers (known as "xe om" drivers) as volunteer HIV/AIDS peer educators (PEs) to community men and to men traveling through the province for work or recreation. A leader headed each of the educators. The drivers transported vast numbers of people daily and are especially used by men seeking sex workers. After training, the PEs provided HIV/AIDS prevention information (printed materials, condoms, leaflets) and they got a monthly allowance as incentive. Within few months, 290 "xe oms" were able to reach 47,357 male customers in Quang Ninh. Lessons learned from the intervention were: need to focus on men as key decision makers in sexual negotiation; community authorities such as police, local government officials must be factored in as important players; availability of condoms is as important as disposition to use it. (FHI, 2006)

The FHI had earlier used the "condom tunnel", a localized social marketing technique to create massive condom use awareness among sex workers and their clients in Vietnam located on the northeast corner of Can Tho Province of Vietnam. The highway used for the campaign records huge trucker's traffic as it links six other provinces and is a gateway to neighbouring Cambodia. Previous efforts at social marketing of condoms in traditional outlets such as pharmacies and non-traditional outlets such as restaurants had failed. But within two years of the "Condom Tunnel" use of condoms by men having sex with commercial sex workers has risen dramatically. Thirty-nine per cent of truck drivers and 9% of migrant workers had sex with commercial sex workers within the previous 12 months; of

those, 94 % and 78% respectively, used a condom the last time they engaged in commercial sex. (FHI, 2001)

Interventions based on *faith-based approach*, though few in HIV/AIDS literature is on the increase. For instance, in Cambodia the *Kienkes Temple* has been successfully used. Monks are revered in Cambodia and under this project, they were trained to lead communities, which they serve by showing compassion and respect for those infected and affected by AIDS. The monks mobilize the community to donate food and provide other support such as cloths, fertilizers, and land to plant vegetables or build a shelter as well as child-care services for families affected by HIV/AIDS (USAID, 2003c).

New technologies of communication have made I-E-C effective in **Africa**. Internet and mobile telecommunication are creating new opportunities that make this approach viable in amplifying marginalised voices in the continent where there is increasing media liberation, transforming both the print and electronic media from largely government-owned, monopolistic and uncreative media to a more popular democratic and complex one. (Akinfeleye, 2003).

Available literature on approaches employed in Africa suggests that *social marketing, counselling, Information-Education-Communication (I-E-C)* and *formal education* are more frequently used in HIV/AIDS interventions.

Gilluly and Moore (1985) reported the evaluation of a family planning radio programme in Egypt carried out by the University of Chicago. The result showed that radio "increased knowledge of family planning but did not necessarily increase use of contraception." (p.869).

In *Uganda*, national HIV prevalence survey among urban pregnant women from 1990-1993 and 1994-1995 indicate that there was a decrease by one-quarter (from 21% to 15%) and by one third (from 17%-11%) respectively. The surveys suggest that the changes could be due largely to reduction in numbers of sexual partners, condom use and delayed sexual debut.

Using the *partnership* and *social mobilization* approaches, the USAID and FHI set up a SCOPE –OVC project (Strengthening Community Partnerships for Empowerment of Orphans and Vulnerable Children) in Zambia to reach 137,521 orphans and other vulnerable children with life-sustaining care and support services, in 2003. The project maintained a focused strategy of partnership building and networking to sustain old linkages and then build new ones to community based organizations, churches, schools and other institutions that provide care and support to orphans and vulnerable children.

USAID adapted the successful Cambodian monk experience to the IDIRS (Traditional Ethiopian Community groups in Addis Ababa, Ethiopia). The IDIRS are burial societies dedicated to helping families bury their dead and assist the living and can be found in all parts of the country. Almost all Ethiopians are involved with one, personally or through their families. Members made monthly contributions and when death occurred, the *idirs* provided practical help all through the interment and mourning. The USAID and FHI empowered the *idirs* to carry out this traditional function and added one more: caring for PLHWA still alive, especially those already ill of HIV/AIDS. The fact that respected members of the local *idir* were involved reduced stigma suffered by PLWHA and the belief that HIV infection was a punishment for sin committed changed. (FHI, 2004a).

Similar to Project *Land of Promise* (Brazil) is the *Haruma Project* in *Nairobi*. The project, sponsored by the Elton John AIDS Foundation, which also funded the Brazilian project, gives hopes to PLWHA in Nairobi's slums. Haruma is a sprawling slum in the eastern part

of Nairobi. This locally grown approach teaches the inhabitants about nutrition. It educates clients on the role of good nutrition and proper hygiene to fight HIV/AIDS; group members learn how to cheaply grow vegetables and they also receive free immune booster kits, which costs US $22 monthly. The project has helped to develop a cadre of advocates for a society free from HIV-related stigma. (FHI, 2004c).

The *Education-Entertainment* (E-E) and *formal education* approaches have made positive impact in some African countries. For instance, in Ghana, Crown Talent Hunt, CTH, is a project of 'Preserve', a youth non-Governmental organization involved in HIV/AIDS prevention programmes. CTH seeks to discover youth with musical talents through a competition. This musical initiative aims not only harness the talent of young people but also to empower them economically. (Comminit.com, 2006)

A video soap opera was taped in 1992 for all in-coming secondary school students in Malawi. Titled 'Life is Precious', the video was later expanded to 30 episodes to be aired on radio in 2007. Malawi did not have a national television service. UNICEF provided the television sets for the programme (Mishra, 2005).

Perhaps the most frequently cited by scholars of successful E-E project on AIDS in Africa is 'Soul City'. Soul City is a South African organization, established by two medical doctors, which partnered with other NGOs, the government and the media to produce a television drama series on AIDS and violence on the heroine and her children and changes in attitude in the fictional community from silent acceptance of violence to open protest against it. Meanwhile, in the "real world", a helpline (telephone) was opened and media advocacy began. The impact of the drama and advocacy was seen when a man, arrested for the murder of his wife (in real life), was released on bail. Strong public protest against the bail was reported and was a factor in the passage in December 1999 of the Domestic Violence Act in

South Africa. Evaluation of Soul City confirmed that community action was critical (UNAIDS, 2002:49).

*Formal education* approach has been adopted by almost all East African countries. Mishra (2005) in his review of studies using the formal education approach noted, among others, that over two-thirds of primary schools students in *Malawi* identified teachers as one of their three most important sources of information on HIV/AIDS but this dropped to 50% for secondary school students. Girls were more likely to identify teachers.

In *Uganda*, teachers and the radio are the most common sources of information. The hospital and the home/parents are third and fourth for all outcomes. TV/movies are approximately assigned the same level of importance as newspapers. The latter may be because 60% of the sample is from rural areas where access to both newspapers and TV is relatively difficult. Teachers appear to be a particular important source of information for rural students.

Mishra reported further that, demographic and household survey data from 12 countries in Africa and Latin America found that participation in school was consistently lower for children who had lost both parents to HIV/AIDS. A subsequent analysis of such data from six African countries also showed that double orphans were substantially under-enrolled in Burkina Faso, Cote d'Ivoire and Kenya but not in Tanzania, Uganda or Zimbabwe. Female orphans have higher enrolment comparatively in Nigeria and Tanzania.

The *skills-based approach* (empowerment) in Uganda offers some important lessons. After a school health education programme yielded little progress in attitudes and behavioural change, a life skills programme for primary and secondary schools was piloted in 1994. A year later, no improvement had been realized because teachers lacked confidence in using

participatory teaching methods, were uneasy and afraid to cover topics of sexuality and condom use and perceived this subject to be relatively unimportant. "Realizing the need for greater commitment and cooperation, the ministry of education has responded with a new curriculum and improved teachers training approaches and Uganda's AIDS Commission reports a fall in the rate of new infections by almost 50% among 15-19-year-olds". (Mishra 2005:p.99)

In a literature survey of HIV/AIDS approaches in Africa, the "SiMchezo!" Project is worth mentioning. It is part of the Health Information Project, HIP; a multimedia *integrated communication approach*. SiMchezo! is an 'edutainment' technique which targets young people with information about a range of 'cool' and healthy lifestyle issues. Sexuality, reproductive health, HIV/AIDS, life skills career opportunities, violence and drugs are all topics communicated by using real life stories and testimonials, photo novels, advice columns are regular features. All HIP products whether print or electronic, outreach events or promotion campaigns complement and reinforce each other. They communicate similar content and messages in different ways to different segments of the audience.

> Feedback studies show that HIP products like SiMchezo! have succeeded in creating an empowering 'lifestyle brand' for young *Tanzanians* with clearly documented change effects. Not only have the different media products created forums for open talk about sensitive issues, stirring engagements and debate, they have with their long term recurring presence in the audiences' lives, become trendsetters, sources of comfort, critical thinking, knowledge as young people grow up and have to deal with a range of serious lifestyle issues. The edutainment methodology HIP has created and put to use is working.
>
> (Fuglesan, 2005:p. 85)

*Workplace Advocacy* is becoming popular in Africa although *Treatment and Care* appears to be the most dominant approach in recent times. Rau (2005) has reviewed many of the earliest work-place advocacy projects in Africa. Successes have been recorded, for instance after a

partnership project among companies, trade unions, public health officials and civic organizations in South Africa. STI prevalence reportedly went down by 85%. A 1996 study for the Makandi Tea Estate in Malawi showed a six-fold increase in mortality from 1991-1995 (four per 1,000 workers to 23 per 1,000); (Rau, 2005)

The biggest chunks of HIV/AIDS grants to African Countries are for *Awareness, Treatment and Care*, hinged on widespread use of anti-retroviral drugs and condoms, counselling and capacity building.

**Nigeria Perspective**

Most interventions have been on sero-prevalence of the disease, the spatial location, impact, treatment and care. Although most of these interventions (and studies on them) are grounded on NACA's BCC Framework, there has been no comprehensive attempt at studying the various approaches being used; especially for small-scale and community based interventions.

Further, the use of ante-natal attendees to arrive at national prevalence rates has been criticized by some stakeholders in terms of its validity and reliability. Mrs. Lydia Omenka a PLWHA and founder of the Organization for Positive Productivity (OPP), a support group for PLWHA, articulates this fundamental challenge in a newspaper interview:

> They said HIV prevalence has dropped from five per cent in 2003 to 4.4 per cent in 2005. But I tell you, go to laboratories, just visit the hospitals and find out how many cases that are reported daily; cases of new infections. Even on clinic days, the hospitals are filled up. I was at Asokoro General Hospital in Abuja and the place was filled up with people because it was HIV clinic day. So, if you say the rate of infection is decreasing, that means the clinics should not be overcrowded...The prevalence study of using only pregnant women is not right. They should use everybody's data. Go to the hospitals and use the data they have. Some NGOs go to the field to test people; use the data too. (NACA should) collect data from

> every organization that has done something and combine them to get a true figure. You cannot just use only pregnant women. How many pregnant women go for antenatal? What about those in communities that have no access to antenatal?
>
> ("HIV or not", 2007)

The Consultant-in-charge of Federal Staff Hospital, Abuja, Chinwe Igwilo recently confirmed Omenka's fears that new 20 cases of HIV/AIDS have continued to increase rapidly. New cases of HIV/AIDS are on the increase in the FCT. In December 2007, 101 new cases were detected and 128 cases (were discovered) in January 2008. ("New cases", 2008).

From available studies, *I-E-C* (mainly mass media publicity, conferences and workshops), *social marketing, empowerment, advocacy* and *faith-based* approaches appear to be the dominant approaches. The use of *edutainment* has been sporadic and no spectacular successes have been recorded through the approach.

In its 2000 Behavioural Surveillance Survey Nigeria, the FHI reported that "prevention methods was low and prevalence of incorrect beliefs about HIV/AIDS high, leading to very low comprehensive HIV knowledge indicators. Forty per cent of women in Jigawa State indicated that they had never used a condom with paying clients, compared to less than 1% of women in Lagos and Abia. Forty per cent of female sex workers in Lagos had non-paying partners use condom in the last sex. The study indicated that only 1% of Kebbi Adult Male Truckers had comprehensive knowledge about AIDS. The study concluded:

> Knowledge of the main prevention methods was poor in all high-risk and vulnerable target groups in all sites....it is clear that sexual behaviour and networking differ in the target groups sampled in the northern and southern portions of the country which have significant cultural and religious differences.
> (FHI, 2000).

Through *advocacy* and *agenda setting*, various issues such as acceptability of condom use, 'healing' of HIV victims, stigma and discrimination have dominated the Nigerian print and

electronic media – some national newspapers even have weekly columns on HIV/AIDS. However, this researcher could not find evidence on patterns of knowledge and awareness created through I-E-C, especially in rural areas. Most of Nigeria's newspaper readers are elites who live in the urban areas.

*Counselling* (including care and treatment) is now more widely adopted, according to the FMoH in its 2005 scale-up plan report on PMTCT. Counselling Centres are mostly located in tertiary health facilities with the belief that these facilities would serve as nodal centres for the expansion of services to lower levels of care in their vicinities. Service delivery of PMTCT Programme started in July 2002 in eight pilot sites and available data as at September 2004 showed that 38,630 women were booked for antenatal clinics. Of these, 90.7% were counseled, while 51.5% were tested for HIV. Of those tested, 8.5% were HIV – positive but only between 0.4% and 0.5% of total infected mothers were being reached. (FMoH, 2005).

Studies by Okoye (2003), Akinyemi *etal* (2004) [cited by FmoH, 2005:p.172] and Amoran (2004) found weak link between awareness and self-perception of HIV/AIDS risk. Okoye, in a survey of University of Lagos undergraduates (n=400), using a 90-item questionnaire, found a high awareness level of HIV/AIDS among respondents. But he also found that boys engaged in more casual sex than girls and that those at higher levels engage in more sex negotiation than those at lower levels. He recommends a strategy modification in HIV/AIDS campaigns that would encourage abstinence from sex because high level of awareness does not seem to lead to corresponding attitude and behavioural change.

Amoran, quoting a study of brothel-based sex workers in the FCT by Duby in 2004, suggested the use of *empowerment* approaches because poverty, mainly, is the reason why

the illicit business thrives: "it was evident that sex work is tolerated by the police because it provided a useful source of income" [for the police]. (Amoran: 2004:p.46).

Akinyemi, Ankomah, Clarke and Anyanti (2004:p.35) noted that "working with the commercial sex worker population takes time and trust, and unless the right approaches are used, it is unlikely that the number of NGOs able to reach sex workers and involve them in effective programmes will be significant." The challenge of *empowerment* is still very fundamental if behaviour change is to be achieved with respect to stigmatization. Trends of findings point to the need to take *social marketing* to the next level: *participation, negotiation* and *partnership*. For example, a study of 400 female sex workers found that while 75% reported condom use with clients, only 10 per cent used condoms with boyfriends. Reasons for this included skin-to-skin contact symbolizing the presence of love, care, trust, emotional well being and a sense of belonging because condom is seen as a kind of 'clothing' to be removed at the close of work. (Ojimba, 2005)

Some studies have recommended further research on the possibility of using *faith-based approaches*. NACA, learning from Senegal where huge success has been recorded in managing the HIV/AIDS pandemic through the faith-based approach, that is, involving Islamic and Christian organization in its BCC implementation programmes. (Jinung and Gotodok, 2007). (In Senegal where 93% of the 9 million populations are Muslim, HIV/AIDS became regular topic in mosques and senior religious figures talked about it on TV and radio). The Supreme Council for Islamic Affairs (the umbrella body for Muslim organizations and activities in Nigeria) has started an HIV/AIDS Desk and begun intensive community-based efforts to provide information and education on HIV/AIDS prevention, working in partnership with PLWHAs. There are also inter-faith forums for HIV/AIDS

programmes, such as the Islamic Medical Association of Nigeria (IMAN) and Federation of Muslim Women's Associations in Nigeria (FOMWAN).

Christian response to HIV/AIDS in Nigeria is a little complex. The ecumenical or denominational nature of the sect presents divergent responses – some of the traditional churches and missions. for instance believe condom use is sinful. The more 'evangelical' churches preach abstinence but claims to healing PLHWA by some of them have raised controversies on using the faith-based approach. Many Pentecostal denominations insist on HIV – test reports before joining new couples in wedlock for instance. For example, in 2007 the Covenant University owned by Living Faith Church, generated nationwide debate for making HIV/AIDS tests mandatory for its new and graduating students.

The FmoH, in the national situation analysis report, noted the activity of the Christian Health Association of Nigeria (CHAN) whose members have over 4,000 health facilities in Nigeria and provide up to 40 per cent of health services in some states. (FMoH 2005:p.159).

Traditional faith believers present a more complex scenario. A survey of 399 traditional healers in Lagos and Benue States found that many healers administer to 1,500-2000 clients from very wide catchments areas yearly. (Green, 1987). A more recent study of commercial sex workers by the Federal Ministry of Health and the World Health Organization, WHO, found that about 30% of respondents used services of traditional health providers. According the Federal Ministry of Health, influential leaders and 80% of people in low and middle income countries in sub-Saharan Africa patronize traditional healers. (FMoH, 2005:163). The above statistics about traditional medical practice justify further investigations on the traditional faith-based approach.

Jinung and Gotodok (2007) credited what they described as "the secret behind the success of Plateau State multi-sectoral approach to HIV/AIDS" to the "involvement of government institutions, local governments, and mass involvement of stakeholders such as CSOs, PSOs, FBOs and empowerment." The Plateau State AIDS Control Agency (PLACA) "ensured that the State HIV/AIDS programme is owned, driven and sustained by entering into working partnership with the CBOs right from its inception in 2003." (Jinung, J.K., and Gotodok, K.G., [2007]:. p;67).To underscore its use of the *faith based approach*, PLACA lists "prayer and fasting" as one of the secrets of its success. (Jinung, et al., p.9).

In a 2005 study, Idogho and Kio-Olayinka administered the WHO Quality of Life (WHOQoL) Questionnaire to 405 PLWHA drawn from Akwa Ibom, Benue , Enugu, Gombe, Kaduna and Lagos States. They found that 92.3% of respondents belonged to one support group or the other. Six domains of QoL were assessed in the study – physical, psychological, level of dependence, social relationship, environment and spirituality. Findings reveal that respondents recorded the highest mean score in the spirituality domain (13.1%), followed by the physical domain (12.1%) while the lowest scores were in the domains of social relationship (10.9%) and the environment (10.8%). The pattern was the same for both sexes: the study noted that "in terms of totality of support that PLWHA received, the society had provided very limited support for PLWHA; three out of every four PLWHA indicated that they had either not received any support at all or a low level of support". The researchers suggested the use of more *participatory techniques*. (Idogho and Kio-Olayinka, 2005)

The *E-E approach* is being encouraged by NACAs and SACAs lately. The FCT HIV/AIDS Committee (FACA) recently published a cartoon booklet targeted at 5-15 year-olds, in high quality colour print. The 24-page publication, titled ***Basic Facts About HIV/AIDS***, contains educational cross word puzzle and advertorials about HIV/AIDS. However, the concept

appears to be elitist and not contextualized. For instance, names, of key characters in it (Felix, Eric, Sophia, Mrs. Drucker) are not Nigerian. (FACA, 2006)

NACA also organized AIDS Musical Concert on Saturday March 14, 2006 at the International Conference Centre Abuja. Over 500 young people from 16 states attended the concert where I-E-C materials and condoms were distributed, when compared to E-E programmes successfully organized in other countries; this E-E effort is sporadic and non-systematic. (NACA News, 2006).

Oke (2001) found in an in-depth assessment of the HIV/AIDS situation in Lagos State that the *partnership community mobilization approach* offers opportunities for behavioural change.

Adebayo (2004) also found that community youths have the potentials to implement and sustain viable HIV/AIDS programmes, when such programmes are focused on addressing community specific experiences. Working under the Nigeria Youth AIDS Programme, the youths initiated community-based programmes in Aguda area of Surulere in Lagos State. The Community Youth developed the content of the programme conceptualized by them, mobilized participants, sourced funds and secured a central venue for implementation. About 310 community members, comprising 231 young people and 79 community leaders were reached.

According to Amobi (2008:pp.210-227), the dominant HIV/AIDS communication campaign approaches in Nigeria in the past five years include social marketing, news and public relations formats [I-E-C], edutainment, social learning theory-based approaches (for example HBM, Stages of Change, and BCC.)

Generally, HIV/AIDS communications approaches in Nigeria seem to evolve from the central strategic policies being used by multilateral and bilateral agencies that provide the bulk of funding for HIV/AIDS activities in the country. A summary of the strategic pattern

is outlined in the matrix next page. This pattern however, does not in any away suggest that NGOs, CSOs, FBOs, even SACAs and LACAs are restricted, teleguided or limited by the donor agencies in applying creative, effective and result-oriented communication approaches in their interventions.

**Table 2. Strategic HIV/AIDS Policies of Key Donor Agencies in Nigeria**

| S/N | MULTILATERAL AGENCIES | STRATEGIC POLICIES |
|---|---|---|
| 1 | UNAIDS. | Empowerment; Advocacy |
| 2. | WHO | Advocacy; Networking; care and counselling; Epidemiological surveillance |
| 3. | UNDP | Institutional capacity building; Leadership Development. |
| 4. | UNFPA | Advocacy, Interventions focused on pregnant women, youth and condom programmes; VCT; Institutional Capacity Building; BCC materials production |
| 5 | UNICEF | PMTCT (Preventing Mother to Child Transmission), VCT (Voluntary Counselling and Testing) |
| 6 | ILO | Workplace Policy Advocacy |
| 7. | UNIFEM | Technical and Financial support for projects addressing gender, stigma, discrimination against PLWHA |
| 8. | UNDC | Prevention programmes in tertiary institutions, prisons; I-E-C materials generation; community based partnership |
| 9. | WORLD BANK / IDA | Funding at National and State Levels |
| | BILATERAL AGENCIES | |
| 10. | DFID (Department of International Development) | Management Consulting; training; VCT, TB Control Funding; Social Marketing of condoms and contraceptives |
| 11 | CIDA (Canadian International Development Agency) | Funding of health education; Advocacy especially for gender, care and support |
| 12 | JICA (Japanese International Cooperation Agency) | Equipment and training for states with high prevalence |
| | **PRIVATE FOUNDATIONS** | **STRATEGIC POLICIES** |
| 13 | FORD FOUNDATION | Non-medical support, CBO/NGO capacity building; care and treatment, BCC; Advocacy with emphasis on grassroots outreach, impact mitigation. |
| 14 | Bill & Melinda Gates Foundation | PMTCT; equipment & training; surveillance and social mobilization. |
| 15 | PACKARD FOUNDATION | Family planning and reproductive health skills, prevention education and STI management |
| 16 | MACARTHUR FOUNDATION | Human rights; reproductive health; emphasis on universities / scholars |
| 17 | SOCIETY FOR FAMILY HEALTH (SFH) | Social marketing, private sector/workplace programmes |
| 18 | GEDE FOUNDATION | PMTCT and Advocacy |
| 19 | SOCIETY OF WOMAN AGAINST AIDS in NIGERIA (SWAAN) | Negotiation/Social Marketing; sex workers and youths; partnership with healthcare providers |

| | | |
|---|---|---|
| 20 | GHAIN | Research and capacity building |
| 21 | FAMILY HEALTH INTERNATIONAL FHI | Partnership, social marketing, empowerment |
| 22 | NACA | Capacity Building; Empowerment |
| 23 | SACAs, LACAs | Social Mobilization, capacity building |

Source: *Federal Ministry of Health, Abuja, 2005. National Situation Analysis of the Health Sector Response to HIV/AIDS.*

A Summary

Waisbord has noted regarding trends in development communication:

> The old paradigms may have passed in development communications as Everett Rogers had famously stated back the mid 1970s, but no single paradigm has replaced them. The theories may not have produced the desired results but they have given direction to pragmatic steps to get better results. The approaches which were initially discordant and irreconcilable are forming a budding consensus. (2005:p.80)

The consensuses are:

(1) Current thinking is that *power* should be at the forefront. Power is present in the idea that community empowerment should be the main goal of interventions; individuals and communities become empowered by gaining knowledge about specific issues, communicating about issues of common concern, making decisions for themselves and negotiating power relations;

(2) 'Top down' and 'bottom-up' approaches need to be integrated. Neither should be underestimated;

(3) The 'tool-kit' approach to communication is becoming popular. Practitioners have recognized the need for multiplicity of communication strategies. "Different techniques in different settings might be necessary to deal with specific problems and priorities." (Waisbord, 2005:p. 80);

(4) There is the need to combine interpersonal and participatory communication and multimedia activities. The media have proven to be successful in raising awareness and knowledge about HIV/AIDS, however, interpersonal communication is fundamental in persuading people about specific beliefs;

(5) It is important to incorporate approaches that focus on individual and environmental factors in understanding the role of behaviour change communication. Changes in behaviour and social conditions cannot be addressed by targeting personal or contextual factors only, but, rather, programmers need to be sensitive to both in order to understand problems and design solutions. Because environmental factors affect behaviour (in terms of both initiation and maintenance), they have to be addressed.

Seventy participants drawn from a wide range of UN agencies, bilateral organizations and donors, NGOs and communication specialists who participated at the UNFPA-organized Communication Roundtable, which focused on HIV/AIDS that took place in Managua, Nicaragua in 2001 concluded that shortcomings in theories of communication were not reasons for the unimpressive results at combating HIV/AIDS at the time. Rather, they were due to local context, fragmented and inadequate planning, poor message designs, poor management of programmes and lack of political commitment. (UNFPA, 2002: pp.29-30).

Communication scholars are now building a consensus that takes into consideration the relevance of the earlier paradigms and current challenges of culture, context, power, globalization and impact of technology and cultural hybridity and learning across boundaries. In other words, development communication practitioners are moving away from what

Waisbord (2005:p.82) described as "one-model-fits-all solutions" to inclusive approaches and openness to a diversity of programmatic insights and strategies

Narrowing down this perspective to the HIV/AIDS pandemic, Tufte submits:

> A key gap that is apparent in the field of practices of development communication (under which HIV/AIDS communication falls) pertains to advances in communication theory. The conceptual and methodical insights generated within qualitative audience analysis from the 1980s and onwards are, for example, not connected to the HIV/AIDS communication practices. In this context, the development of cultural studies as an inter-disciplinary field in academia still has limited romance with communication practice, despite the increased recognition of culture...the understanding of audience reception practices and the integrated approaches of political economy with cultural studies are all fields which could well contribute to redefining the field of HIV/AIDS communication within the framework of a social change agenda" (2005: p.118)

The literature on HIV/AIDS communication reveals that there is a gradual paradigm shift from top-down, large-scale interventions to tactical and small-scale community-based interventions. Available literature points to at least two major challenges: building capacity in communication and choosing the most appropriate approach from an array of suitable approaches in order to learn from the mistakes of failed programmes and replicating them on larger scales, successes attained on smaller scales. The literature indicates various theories, strategies and approaches have worked very well in some situations and poorly in some other situations mainly due to how well such theories, strategies and approaches have been adopted or adapted.

# CHAPTER THREE

# METHODOLOGY

## 3.1 Research Method

*Survey* (In-depth interview and Focus Group Discussion, FGD) was adopted as the method of this research, using the "quali-quan approach" – a combination of the qualitative and quantitative traditions. Creswell recommends this approach "because it is advantageous to a researcher to combine methods to better understand a concept being tested or explored". (Creswell, 1994:p.177)

The researcher adopted *Triangulated Instrumentation* in order to make results more credible and more dependable. "The concept of 'triangulation' is based on the assumption that any bias inherent in particular data sources, investigator, and method would be neutralized when used in conjunction with other sources, investigators and methods." (Creswell, 1004:p.174)
While the *qualitative* tradition helps to 'discover' and 'describe' the primary audience of a study, the *quantitative* framework helps to establish relationships sought and test their significance.

Creswell also notes:

> Qualitative research is concerned primarily with process rather than outcomes or products; ... the researcher physically goes to people, setting, site, or institution to observe or record behaviour in its natural setting; is descriptive; and is inductive in that the researcher builds abstractions, concepts, and theories from details". (p.145)

The *quantitative* approach would also be helpful in this kind of study because it uses the deductive form of logic, using the cause-effect order where concepts, variables and hypothesis are chosen before the study begins and remain fixed throughout the study. Quantitative framework is more suitable in establishing standardized and making valid inferences. (Orcher, 2005:p.40)

The Family Health International, FHI, USAID, FMoH and UNAIDS have used this design in investigating numerous HIV/AIDS communication approaches worldwide, many of which are cited in the review of relevant literature (Chapter 2) of this study. Examples: FHI (2004); FMoH (2005); FHI (2006); USAID (2005).

### 3.2 Population

Ondo, Lagos, Nasarawa and Cross River States were used as comparative case studies in this research. Interventionists that were executing or had executed HIV/AIDS campaigns in the aforementioned States from 2003-2007, constituted the population of the study.

Due to constraints of funds and time, only the afore-stated four states were covered in the study. However, the four states are reasonably representative of the Federation regarding the HIV/AIDS problem, in the sense that:

- *Prevalence rates average*: High (Nasarawa and Cross Rivers); Low (Lagos and Ondo);
- *Prevalence rates pattern*: Decreasing but still high (Cross Rivers); Increasing and still high (Nasarawa); Increasing but low (Ondo) and Decreasing and still low (Lagos).
- *Socio-economic characteristics:* They are representative of highly urban (Lagos); semi-urban (Cross River), semi-urban (Ondo) and rural (Nasarawa) stats;
- *Geo-political and cultural characteristics:*The four selected states were drawn from several geo-political locations.
- *Religious factor:* In terms of beliefs, Nasarawa State is predominantly Moslem although it has a large Christian population while Ondo is predominantly Christian although it has pockets of Moslem population; Lagos represents a complex mix of

Moslem, Christian, Traditional and other religions. Cross River is predominantly Christian.

The population selection was to make findings applicable to large segments of Nigeria and to give room for comparative evaluation. Idogho and Kio-Olayinka (2005) used a similar population segmentation approach in their study of the quality of life of PLWHA in Nigeria.

### 3.3 Sample Selection & Characteristics

The study covers interventionists in all local government areas in the selected states. Only organizations listed by the SACAs of Nasarawa, Ondo, Lagos and Cross River States officially, to have carried out HIV/AIDS programmes during the period 2003-2007 constitute the *sampling frame*. The researcher used the ***Random Purposive Sampling*** technique to determine interviewees. Orcher (2005:p.48) recommends this technique "where individuals needed to be handpicked to be participants because they have certain characteristics that are believed to make them especially good sources of information." In order to capture data that would be reliable and dependable, the researcher conducted a preliminary investigation into the number of active interventionists within each study location (in each of the four states) and found that many of the NGOs/FBOs/CBOs, PSOs were redundant. The researcher thus, requested from the State Action Committees on AIDS, a list of interventionists regarded by them as 'active programmers on HIV/AIDS' in the period under investigation.

Lagos State AIDS Control Agency, (LSACA) forwarded 41; Ondo, 40; Nasarawa 35; and while Cross River gave 45 names of interventionists. The 'dormant interventionists' whose names were not forwarded were left out of the study so that the outcome was not skewed. One out of every three active interventionists from the SACA lists was selected from each State randomly for this study.

*Sample size* for the study was thus: Ondo, 13; Lagos 13, Nasarawa, 11 and Cross River, 16, making a total of 53 NGOs. The sample size adopted was in line with a study of random sample of articles recently published in *The Journal of Counseling Psychology* which reported a median sample size of 14 in a range of 1-35 cases of qualitative studies (Orcher, 2005:p.106). Although Orcher (2005:p.106) notes that "unlike quantitative inquiry, qualitative study does not seek representative sampling in order to make a good comparative analysis and a largely generalisable impact as much as possible", this researcher adopted a relatively large sample size to ensure that the samples were representative of the study locations. As Babbie has noted, the larger the sample, the more representative of the population it becomes. (Babbie,1990).

Interventionists were limited to Faith-Based Organizations, FBOs; Civil Society Organizations, CSOs: Community Based Organizations, CBOs, and Non-Governmental Organizations, NGOs; that were officially recognized by the SACAs to have carried out interventions between 2003 and 2007 in the states. This was necessary to ensure a standardized parameter for delimitation.

For the **Focus Group Discussions**, *criterion sampling* (very clear specific yardsticks) were used to select participants. The participants were: a medical doctor/health worker experienced in handling HIV/AIDS cases; an HIV/AIDS communication specialist; a Monitoring and Evaluation Officer; Programme Manager/Executive Director of an HIV/AIDS organisation in the State; a Person Living With HIV/AIDS; and a member of the public.

## 3.4 Study Locations & Settings

*Ondo State*

One of the 36 States of the Federation (created in 1976), Ondo State has 18 local government areas. According to the 2006 Census, the State has 3.4 million inhabitants – 1.7 male and 1.6 female. It is located in the South West geo-political zone and the dominant occupation in the state is farming. Ondo State is largely rural and semi-urban.

HIV/AIDS prevalence rate in the state rose from 2.9% in 1999 to 6.7% in 2001. The figure dropped to 2.3% in 2003 (FMoH, 2005). The State Action Committee on AIDS began its activities in 2001 through awareness campaigns and capacity building workshops in collaboration with CSOs and CBOs. Lately, FBOs have been taking active roles in the State's SACA and LACA programmes.

Although the state has one of the lowest prevalent rates in the country, "there are indications of explosive epidemic in specific locations in neighbouring states hence it is not sufficient to conclude that the epidemic had stabilized on a downward trend". (Agagu, 2006). The major challenge faced by the State apart from funding, according to the State governor, is the 'relative absence' of development partners. The State's SACA aims at reducing the epidemic by 25% every four years through:

- Increasing access of PLWHA to qualitative clinical care and support services;
- Improving the knowledge, attitude, behaviour and practice related to HIV/AIDS in the general population;
- Increasing access of the general populace to qualitative sexually transmitted infections care services;
- Ensuring that the rights of PLWHA and PABA and Orphans and Vulnerable Children (OVC) are protected;

- Screening of blood and blood products;
- Gradual upgrading of the State's 15 HIV Screening Centres to Voluntary Counselling and Confidential Testing (VCCT) Centres.

*Lagos State*

Lagos is the second most populous state in Nigera (9,013,534 people according to the provisional figures of 2006 national population census). There may be much more people living in the state, as Lagos State has officially disputed the 2006 figures, claiming that the population of the state is about 17 million. The 1991 Census had projected the state's population to hit 15 million by 2006.

The state is cosmopolitan, with high cross-border activities, poverty, crime, drug abuse incidence, as well as many industries and military formations. Created on May 27, 1967, the state is the focal point of Nigeria's international trade and the political capital of the country until 1992. With 20 local governments, Lagos State is located on the South-West coast and is the smallest in size, of the 36 states of Nigerian Federation.

Rapid assessment studies of HIV/AIDS in the state by Family Health International, FHI in 2000 and 2001, found many high risk and vulnerable populations, including: transport workers, female sex workers, drug users, youth in-school, touts, youth out-of-school and apprentice traders. One of the studies found that "there is a poor working relationship between state and local governments and NGOs in the state" stressing that "there is generally a high level of awareness of HIV/AIDS among the population but a very low level of response in terms of behaviour change. (Oke, *et al.*, 2001).

The official prevalence rates in Lagos were 6.7% in 2000 (Oke, *et al.*, 2001); 4.7% in 2004 (USAID, 2004); 3.3% in 2005 (FMoH, 2005) and 3.3% in 2006 (Desalu, 2006). The State has an agency for the control of HIV/ AIDS (LSACA), and HIV/AIDS committees in every local government area.

*Nasarawa State*

The State was carved out of Plateau State in the North Central Zone in October 1996. According to the 2006 provisional census figures, Nasarawa has 1.8 million people.

A largely agrarian state (80% of the population are farmers), the state, made up of 13 local government areas, boasts of commercial deposits of solid minerals. Nasarawa State is a link state between the FCT, East Central region and the North. Its capital town, Lafia had only 350,000 people in 2000 but the state is rapidly urbanizing with the influx of people, particularly into Karu (Mararaba) and Keffi Local Government Areas, LGAs, due to thei proximities to the FCT, Abuja, the nation's capital. The state has a rich cultural heritage with over 30 ethnic groups. Males constitute 51% of the population. (NASEEDS, 2005).

The rapid assessment by Family Health International in selected LGAs of the state in 2000 found that "very few NGOs/CBOs programming in HIV/AIDS/STI were active on the ground" and that "out of those, only a very few have any technical or programmatic capacity." In other words, skills and knowledge of healthcare providers were observed to be limited.

The study also indicated that there was a rising HIV-positive trend and this was attributed to implementation of sharia law in some adjoining states, which was perceived to have influenced the influx of sex workers into the state; proximity to the FCT and Benue State may have also complicated the HIV/AIDS situation in the state. (Imam, *et al*, 2000).

HIV/AIDS prevalence rate in the state was 6.5% in 2003 (SFH/NACA, 2005) and 6.7% in 2005 (FMoH/HSS, 2005). The State's Action Committee on AIDS coordinates HIV/AIDS activities in Nasarawa State.

### Cross River State

Created in 1987, when Akwa Ibom State was carved out of the then Cross River State, Cross River State has a population of 2.5 million people, according to the 2006 national population census. It shares international boundary with the Republic of Cameroon and has Benue, Ebonyi, Akwa Ibom and Abia as neigbouring states. The State has potentials for tourism and international trade but major occupations currently are farming, fishing and petty trading.

The HIV Sentinel Surveillance Survey puts HIV/AIDS prevalence in the state at 5.8% in 1999; 8.0% in 2001 and 12.0% in 2003. By 2005, the rate significantly dropped to 6.1%. Calabar and Ikom have the highest sero-prevalence rates among urban towns (6.3% and 7.0% respectively). Akampka has the highest prevalence rate among rural towns (8.0%). The HIV prevalence among women age 15-24 years is 8.9% (for urban) and 6.8% (for rural location). (CRSACA, 2006).Reasons for the rapid increase were: neighbourhood with states with high prevalence; location in international boundary; high presence of commercial sex workers, long distance truck drivers, members of the uniformed services, and out-of-school youth; poverty and cultural factors. (NACA/FHI, 2005).

Because of increasing HIV/AIDS cases – prevalence in the State was more than twice the national average and almost doubled the South-South zonal average in 2003 – response to HIV/AIDS in Cross River has been rapid, (NACA/FHI, 2005). Local Government Action Committees on HIV/AIDS (LACAs) were inaugurated in the 18 LGAs in 2004. Technical

responses (mostly medical, capacity building, treatment and prevention) were located across the state although they were concentrated in urban areas.

NACA/FHI reported the presence of three networks of NGOs in the State: Cross River AIDS Network (CRAN), a coalition of AIDSCAP-supported NGOs with 20 members; Cross River Network (CRINET) with 50 NGOs as members and the State Branch of CiSNHAN (Civil Society Network for HIV and AIDS in Nigeria) with 41 registered members. (2005:p.17). By the end of 2006, more networks (CRCSC [Cross River Civil Society Coalition], CRS NEPWHAN [Cross River State Network of People with HIV/AIDS in Nigeria] and Interfaith Coalition have carried out interventions and key partners such as Actionaid International, FHI, MTN Foundation, Society for Family Health [SFH], UNAIDS, John Snow Inc. [JSI], UNICEF, World Bank and NACA have funded interventions in the State. (CRSACA, 2006).

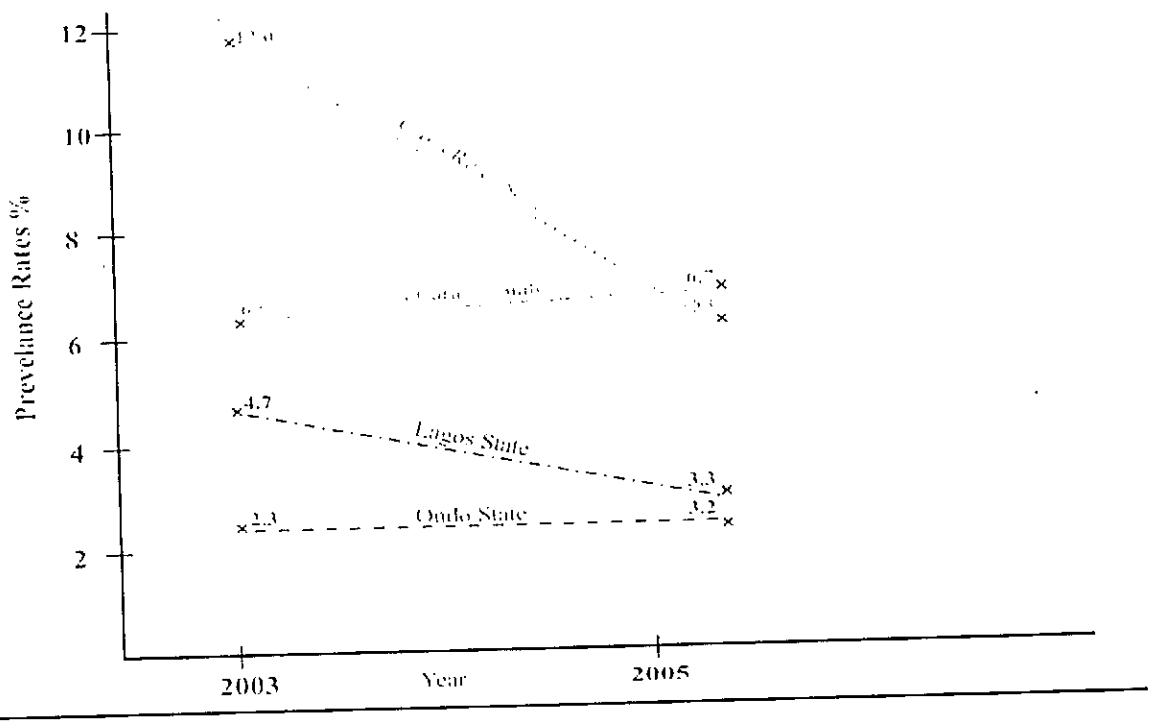



*Figure 5. Comparison of 2003 and 2005 HIV/AIDS Prevalence Rates in Study Locations. Cross River and Lagos States recorded drops while Ondo and Nasarawa States experienced increases in prevalence rates during the period.*

## 3.5 Scope (Delimitations and Limitations)

*Delimitations*

This study confined itself to interventionists located in the four aforementioned states. Organizations not recognized by SACAs to have implemented at least one HIV/AIDS programme between January 2003 and December 2007 were excluded from the study because the researcher believed organisations with rich or extensive experiences and more activity in HIV/AIDS programming should be well-known to the respective SACAs . The time frame was limited to 2003-2007, being the first phase of the multi-sectoral response that witnessed unprecedented HIV/AIDS interventions and increased funding in the country.

*Limitations*

1. The fact that only Non-Governmental Organizations (NGOs) registered with the State AIDS Programme offices were sampled for this study could limit the wide application of its findings because health institutions (public and private), private sector organizations (PSOs) and International Organizations which also also engaged in direct interventions were excluded from the sample. However, findings could still be applied to the latter category of interventionists with caution.
2. It is expected that some limitations of the survey method would intervene in this study. For instance, it was difficult or impossible to authenticate the outcome/success rate of interventions and some other information provided by the respondents. The researcher, in such situations, relied on information provided by the respondents. The possibility of some of them exaggerating, misplacing facts or giving inaccurate information cannot be ruled out.

## 3.6 Research Instruments

The researcher used "Triangulated Instrumentation" (used more than one instrument to collect data from the same type of audience) and "Triangulated Data Sources" (used multiple sources of information to provide answers to the questions). This approach makes results more credible and more dependable, according to Creswell (1994:p.174) and Orcher (2005:p.129).

The triangulated instruments were:

(i) In-depth Interviews with interventionists (comprising open-ended questions);

(ii) Focus Group Discussions (FGD)

The triangulated data sources were:

(i) The Programme Officer or Chief Executive of the organization carrying out HIV/AIDS interventions (who responded to the questions for the in-depth interview);

(ii) Five stakeholders drawn from amongst donors; treatment, care and counselling; the communication field; member of the general public; PLWHAs; interventionists, were purposively selected randomly from each Study Location to participate in the Focus Group Discussion for the respective location.

## 3.7 Validation of Research Instruments

The researcher had conducted a pilot study in Nasarawa State to test the instruments – in-depth interviews with *five* NASACA-recognized interventionists systematically drawn from the population and representative samples of discussants (from the mass media, PLWHA, Interventionist, NASACA, medical/general publics) for the FGD at Lafia, Nasarawa State.

Results of the pre-test helped in determining the eventual sample size, conduct of the FGDs and uniform format for the interviews.

*Reliability of Instruments*

The researcher adopted standardized format for the indepth interviews in all study locations, using Canary and Cody's six criteria for assessing communication in constructing the interview schedules. (Canary & Cody, 2000). These are: adaptability or flexibility; conversation involvement; conversational management; empathy; effectiveness; and appropriateness. The research is more about 'what are the means available,' 'how have they been employed in various situations' and 'which ones have the highest levels of success in the assessment of the NGOs, in given situations'. Respondents were asked the same questions and the FGD participants also dealt with the same issues. A professional statistician assisted in re-testing the instruments and conducting significant tests on the relationships among some variables as additional safeguard for reliability of instruments.

### 3.8 Data Collection & Recording Procedures

Data generated through survey instruments were analyzed qualitatively and quantitatively. Miles and Huberman's four data collection materials were used in data collection for this study. These were the **setting**, the **actors**, the **events**, and the **process**. (Miles & Huberman, 1984).

*Training of Research Assistants*

Three (3) interviewers assisted in gathering data in each Study Location. Five (5) Pre-test Interviewers had been inducted through a one-week workshop and they later participated in the Pilot Study in Nasarawa State to further sharpen their knowledge-skills and enrich their practical experience. The Research Assistants used for the

Nasarawa pre-test served as Interview Team Leaders (one-in-each) while the researcher himself served as Team Leader in all the four Study Locations.

*Interviews:*

All interviews were semi-structured and guided by consistent questions but allowing opportunity for digression where necessary. (A copy of the Interview Schedule is attached to this report as *Appendix I*)

*Focus Group Discussions*

Because the major reason for including FGD in the instrumentation of this research was to generate meanings through conversations and social interaction, the researcher paid particular attention to group dynamics. The Pilot FGD in Nasarawa State had taken place in a neutral, convenient location - the meeting room of a hotel. The researcher, who served as moderator, ensured robust discussion. A similar approach was adopted during the actual FGDs. For convenience, the researcher generated 'headings', with slight modifications as we moved from one study location to another, to suit local situations. As recommended by Hansen, A., Cottle, S., Negrine, R., and Newbold, C., (1998, p.143), the researcher made observational notes during the interviews as further inputs in the development of analytical categories. (A transcript of the Focus Group Discussions is attached to this report as *Appendix III*).

*Documents*

The researcher also examined documents such as publications, posters and other audio-visuals relevant to the research questions to double-check the accuracy of responses. For instance, an executive director claimed to have used radio/TV mostly but could not produce a copy of the jingle or recall the contents of the copy.

*Recording FGD Data*

The entire FGD was recorded on audiotapes. The Nasarawa Pilot helped in the redesign of the Interview Schedule and the conduct of the FGDs. For instance, it had revealed that the NGOs would not be easily located (many of them did not have visible offices and their key officer(s) travelled out of town frequently; some Executive Directors of NGOs operating in Lafia resided in Abuja.) Also, we found during the pilot that we would need clearances from higher authorities to have effective cooperation of the NGOs. The researcher as a result adjusted the sample and increased personnel for the interviews.

## 3.9 Data Analysis Procedure

*Coding of FGDs*

The researcher applied the three FGD coding steps recommended by Orcher (2005) – open coding, axial coding, and selective coding - in this study as follow:

Step I – ***Close examination of the data***; we labelled ideas and concepts expressed during the FGD. This involved breaking the transcripts into small discrete parts. (*Open Coding*)

Step II – ***Creation of Categories***; the researcher grouped similar concepts. (*Axial coding*).

Step III – ***Determination of how multiple categories are related***; (*Selective coding*) Core categories were related to other categories; the researcher then defined and explained their relationships.

*Coding In-depth Interviews*

We generated Content Categories from the indepth interviews, coded and subjected the data to computer analyses.

*Data Analysis Techniques*

Data generated from the Indepth Interviews and the Focus Group Discussion were analyzed from three broad perspectives:

(a) *General/Composite Profile Analysis of data obtained from the study locations.* This was to provide a general overview of findings across study locations. The techniques applied were descriptive statistics (measures of central tendencies such as mean, mode median – and measures of dispersion, such as standard deviation).

(b) Inferential statistics based on the seven (7) research questions of the study.

(c) Analysis of other findings that the researcher considered to be important although they were not the primary focus of the study.

*Data Presentation Techniques*

The researcher constructed univariate, bivariate and multivariate tables while also generously using bar, line and pie charts to aid analyses of textual data. Word table was built to summarize the outcome of the FGDs. The researcher separated FGD data from the in-depth interviews data. Both FGD and Interview Schedule Data are presented in line with the research questions for analytical coherence.

# CHAPTER FOUR

## DATA PRESENTATION AND ANALYSIS

### Profile Analysis of Interventionists

Seventy per cent of interventionists studied are over five years old (out of which 59.3%; n=32 have been in existence for up to 14 years). This means that most of the interventionists had existed for at least four years prior to the period under study and should certainly be fully on ground. The interventionists are generally moderate in size; almost one-third have less than 10 members of staff (57.4%) and only 29.6 per cent operate an annual budget of over N5 million. Half of the respondents (51.9%) operate in well-established offices while the others have no well-established offices or no business offices.

*Hypothesis 1: Interventionists will not differ significantly in major programming areas.*

A large majority of interventionists concentrated on arresting the HIV/AIDS scourge through various initiatives while the rest focused on caring for PLWHA (People Living With HIV/AIDS) or PABAs (People Affected By AIDS). This finding is consistent with the fact that the emphasis of the government and donors during the time of the study was awareness and education.

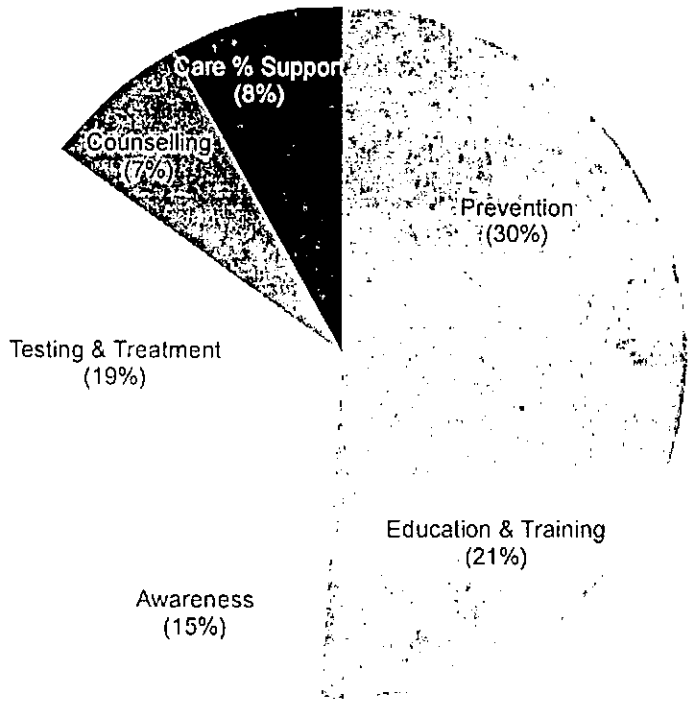



*Figure 6.*

***Programming focus of interventionists. Sixty-six per cent of respondents are into awareness, education and treatment while the rest are into care, testing and counselling.***

Statistical tests reveal that all the study locations did not engage in significantly different programming areas across study locations. As Table 3 shows, there is no statistically significant relationship between study locations and organisations' major programming areas in the past four years ($x^2$= 20.579, df = 15, P >0.05). This implies that all study locations were doing similar programmes during the period under study. Hypothesis 1, which says interventionists will not differ significantly in major programming areas, is upheld.

*Table 3. A comparison of major programming areas across study locations*

| | Programming areas (n) | | | | | | |
|---|---|---|---|---|---|---|---|
| | Prevention | Awareness | Treatment | Counselling | Care | Education | **Total** |
| Study Location | | | | | | | |
| Ondo | 6 | 1 | 4 | - | 1 | 1 | 13 |
| Lagos | 2 | 5 | 1 | - | - | 4 | 12 |
| Cross River | 5 | 1 | 3 | 2 | 1 | 3 | 15 |
| Nasarawa | 2 | - | 2 | 1 | 2 | 2 | 9 |
| **Total** | **15** | **7** | **10** | **3** | **4** | **10** | **49** |
| **Percentage** | **(30.6)** | **(14.3)** | **(20.4)** | **(6.1)** | **(8.2)** | **(2.04)** | **(100)** |

**Findings to Research Questions**

*Question 1:*

***What influences do communication approaches have on the outcome of HIV/AIDS interventions?***

*Hypothesis 2:*

***There is no significant relationship between communication approaches and the outcome of interventions.***

Generally, an overwhelming majority of interventionists (80.6%; n=44) attained the goals they had set for their interventionists while the rest performed poorly or very poorly (18.4%;n=9). The researcher assessed interventionists in terms of attainment of set goals for specific interventions that they had carried out between 2003 and 2007 along the following scales:

| | |
|---|---|
| Excellent | (over 90 per cent of set goals attained) |
| Very Successful | (between 70-89 per cent of set goals attained) |
| Successful | (between 50-69 per cent of set goals attained) |

Poor (between 40-59 per cent of set goals attained)

Very Poor (less than 40 per cent of set goals attained)

As shown on Table 4, Counselling and Faith-based Approaches accompanied the least successes in terms of performance. On the other hand, Social Marketing, Peer Education, Edutainment, Advocacy, Empowerment and I-E-C associated with "Excellent" and "Very Successful" outcomes.

*Table 4.*
*Relationship between dominant communication approaches and outcomes of interventions*

| | Description of outcomes(n) | | | | | |
|---|---|---|---|---|---|---|
| | Excellent | Very Successful | Successful | Poor | Very Poor | Total n(%) |
| Dominant approaches | | | | | | |
| Advocacy | 1 | 7 | 2 | - | 1 | 11 (20.7%) |
| Social Marketing | 1 | 1 | 1 | - | - | 3 (5.6%) |
| Counselling | - | 2 | 1 | 1 | - | 4 (7.5%) |
| Formal Education | - | 1 | - | - | - | 1 (1.8%) |
| I-E-C | - | 3 | 5 | 2 | - | 10 (18.8) |
| Edutainment | 1 | 1 | - | - | - | 2 (3.7%) |
| Peer Education | 3 | 3 | - | - | - | 6 (11.3%) |
| Empowerment | 1 | 1 | 2 | - | - | 4 (7.5%) |
| Participatory comm | - | 2 | 2 | - | - | 4 (7.5%) |
| Faithbased Xtianity | - | - | 1 | 2 | 1 | 4 (7.5%) |
| Faithbased Islam | - | 1 | - | 2 | - | 3 (5.6%) |
| Other | - | - | 1 | - | - | 1 (1.8%) |
| **Total count** | **7** | **22** | **15** | **7** | **2** | **53** |
| **Percentage** | **(13.2)** | **(4.5)** | **(28.3)** | **(13.2)** | **(3.8)** | **(100)** |

Chi-square test based on Table 3 indicates no significant difference in dominant communication approaches used by Interventionists and the outcome of interventionists. ($x^2$ = 49.868, df =44, P > 0.05). In other words, the communication approaches applied by the programmers produced more or less the same outcome.

Thus. Hypothesis 2. which says there is no significant relationship between communication approaches and the outcome of interventionists' is upheld.

This finding may have resulted from the fact that in the initial phase of the multi-sectoral response (2003-2005) when many interventionists emphasized awareness creation. Perhaps the most crucial requirement for attaining awareness about HIV/AIDS was funds to buy media space, not essentially the approach.

*Hypothesis 3*
***There is no significant difference in the reasons attributed for success attained by interventionists.***

When asked the question: "What was the most important reason for the success level attained in your intervention", most of the respondents believed that good funding (n=16) and good technical support (n=12) were the strongest factors. Communication, though important success factor, comes only after the above two critical areas, according to respondents. (See Table 5)

*Table 5.*
***Test of significance of most important reasons for success***

| | Observed N | Expected N | Residual |
|---|---|---|---|
| Good funding | 16 | 8.8 | 7.2 |
| Good technical support | 12 | 8.8 | 3.2 |
| Communication approach | 11 | 8.8 | 2.2 |
| Audience attitude | 5 | 8.8 | -3.8 |
| Determination and hardwork | 6 | 8.8 | -2.8 |
| Reason not clear | 3 | 8.8 | -5.8 |
| **Total** | **53** | | |

The observed frequency of respondents that attributed success attained to good funding (16) and good technical support such as monitoring, supervision, support in kind (11) was greater than expected frequency of 8.8. However, the observed frequency of those that attributed success to cooperative attitude of the target audience (5), determination and hardwork (6) and reason not clear (3) were less than the expected frequency of 8.8. Further statistics show that the calculated chi-square of 13.91 was greater than the critical chi-square of 11.06. This was significant at 95% confidence interval. Thus, a statistically significant difference exists in the reasons attributed for the success attained by the respondents ($P<0.05$), with 'audience attitude', 'determination and hardwork', and 'reason not clear' reporting lower importance in terms of *most important reason for success.*

*Question 2:*

***Do interventionists possess communication competence for the successful implementation of HIV/AIDS programmes?***

*Hypothesis 4:*

***Interventionists have low communication competence for HIV/AIDS programming.***

The researcher investigated the 'use of communication specialist' as a measure of the communication competence of interventionists. Such specialist(s) could be consultants, directors or members of staff of the respective organisations.

Results show that over one-third (66.0%) of the interventionists did not engage the services of someone very knowledgeable in communication, either as consultant or staff. (See Table 6).The hypothesis that interventionists have low communication competence for

HIV/AIDS programming is validated by data generated from the in-depth interviews.

Of the 37.0 % who used communication specialists, 20.4% acquired their communication skills mostly through formal academic training such as university degree in communication; 13% through seminars, conferences and workshops; 1.9% by reading books, journals, the Internet, audio-visual recordings while 1.9% acquired their communication skills through other means such as on-the-job training and intuition.

*Table 6.*
***Relationship between success level and communication expertise***

| | Use of communication specialist (%) | | |
|---|---|---|---|
| | Yes | No | Cummulative % |
| Set goals attained | | | |
| Over 90% (Excellent) | 85.7 | 14.3 | 100 |
| 70-90% (Very Successful) | 45.5 | 54.5 | 100 |
| 50-69% (Successful) | 6.7 | 93.3 | 100 |
| 40-49% (Poor) | - | 100.0 | 100 |
| Below 40% (Very Poor) | 50.0 | 50.0 | 100 |
| **Total** | **34.0% (n=18)** | **66.0% (n=35)** | **100% (n=53)** |

In addition, findings reveal that only 20.4% of interventionists (n=11) demonstrated 'very good' knowledge of popular HIV/AIDS communication approaches. Almost half of them (48.3%) showed poor knowledge of such approaches while the rest 24.1 per cent scored just above average in terms of their knowledge of HIV/AIDS communication approaches.

Generally, therefore, findings strongly suggest that most NGOs, CBOs, and FBOs carrying out HIV/AIDS programmes in the study locations do not possess communication competence (i.e. be able to set and achieve realistic communication goals using knowledge of

communication theory, adapting relevant theories to local project setting to enhance project performance) .

*Question 3:*

***What is the relationship between knowledge of communication approaches and the results of interventions?***

*Hypothesis 5:*

***There is no significant relationship between interventionists' knowledge of approaches and the results of their interventions.***

The researcher asked the Chief Executive Officers of organisations into HIV/AIDS programming the human communication methods perceived by them to be most effective in terms of contributions to the attainment of set goals. Over one-quarter (27.8%) considered participatory communication (i.e. a communication scenario in which both the communicator and the audience play very active mutual roles) to be the most effective. Information-Education-Communication (basically, the use of TV, radio, newspapers, magazines, posters and other mass communication media) came next in the view of interventionists.

The above finding suggests that communication in which the audience plays a passive role would be less effective than those in which the audience plays an active role, all other things being equal.

When related with levels of success attained for programmes, those which employed the services of communication specialists recorded higher success rates than those who did not. As Table 6 indicates, although most programmers succeeded generally, 'poor' and 'very poor' results were highly associated with those who did not use communication specialists. Hypothesis 5 which states that there is no significant relationship between knowledge of communication approaches and results of interventions is therefore rejected.

*Table 7.*

*Relationship between knowledge of communication approaches and results of interventions.*

| | Knowledge of communication approaches (n) | | |
|---|---|---|---|
| | Yes | No | Total n(%) |
| Results of Interventions | | | |
| Excellent (Over 90% goals attained) | 6 | 1 | 7 (13.2%) |
| Very Successful (Between 70-90% goals attained) | 10 | 12 | 22(41.5%) |
| Successful (Between 50-69% goals attained) | 1 | 14 | 15(28.3%) |
| Poor (Between 40-45% goals attained) | - | 7 | 7 (13.2%) |
| Very Poor (Below 40% goals attained) | 1 | 1 | 2 (3.7%) |
| Total | 18 | 35 | 53 |
| | (34.0%) | (66.0%) | (100.0%) |

From Table 6, the calculated Pearson Chi-square ($x^2$) is 18.467 while the degree of freedom (df) is 4. It is therefore very unlikely that the Null Hypothesis is true at 95% confidence level. This means there is a significant relationship between Interventionists' knowledge of approaches and the results of their interventions. (P= <0.05).

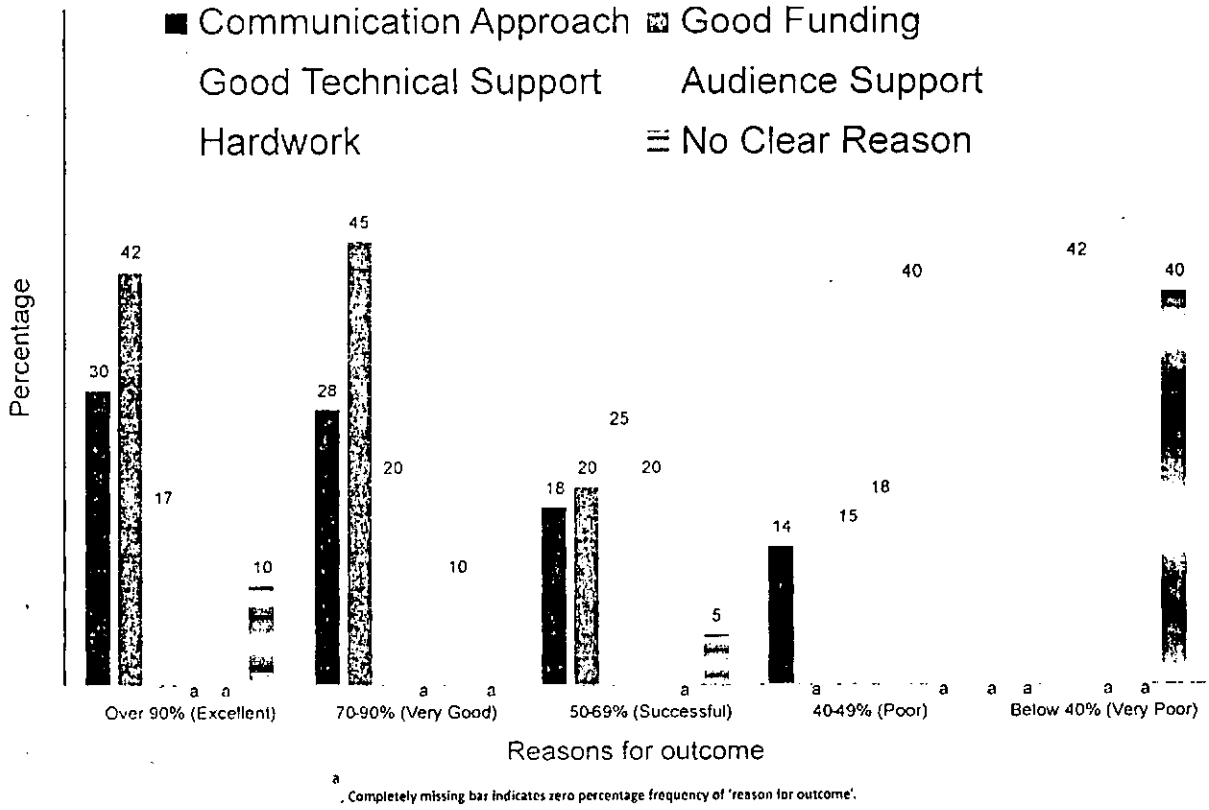



*Figure 7. A comparison of the most important reason for various levels of success. "a indicates a completely missing bar, which shows zero per cent frequency reasons for success. All interventionists claim that good funding is very crucial for success, followed by good communication skills. Organisation which attained low levels of success generally had no idea why their programmes failed (apart of complaining of lack of enough funds).*

*Question 4:*

*What is the relationship between knowledge of communication approaches and patterns of HIV/AIDS prevalence?*

*Hypothesis 6:*

*There is no significant relationship between knowledge of communication approaches and patterns of HIV/AIDS prevalence.*

The researcher compared knowledge of current popularly-used communication approach(es) across study locations. Programmers were asked to recall any theories and approaches of communication known to them or which they had used in their interventions. Data reveal that in regions where knowledge of popularly-used communication approaches was high, level of success was higher. (See Table 7)

Further statistics show that there is a significant relationship between study location and knowledge of current popularly used HIV/AIDS communication approaches ($x^2$ =26.656, df= 12;P<0.05) (See Table 8). In other words, interventionists in some locations were aware of the current popularly used communication approaches (such as peer group, health belief model, advocacy, empowerment and many others) while their counterparts in other locations, where prevalence rates differ, were not. Thus, the hypothesis that there is no significant relationship between knowledge of communication approaches and patterns of prevalence is rejected.

*Table 8.*
***Comparison of knowledge of communication approaches and patterns of prevalence***

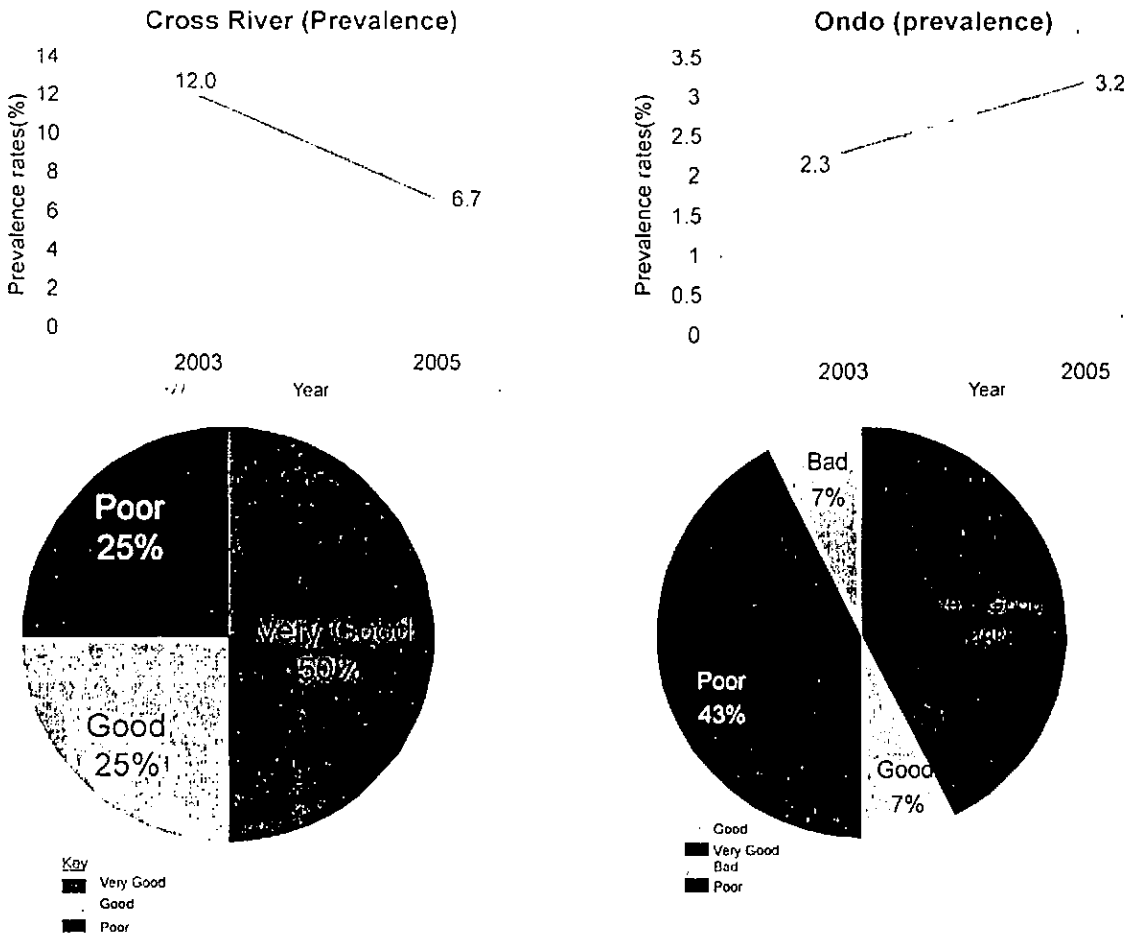
| State prevalence (%) | Knowledge of popularly-used communication approaches (n)[a] | | | | | |
|---|---|---|---|---|---|---|
| | Very Good | Good | Poor | Very Poor | Bad | Total |
| Ondo (3.3) | - | 1 | 5 | 5 | 5 | 12 |
| Lagos (3.3) | 12 | 5 | 5 | - | - | 12 |
| Cross River (6.1) | 8 | 4 | 4 | - | - | 16 |
| Nasarawa (6.7) | 1 | 3 | 2 | 3 | - | 9 |
| **Total** | **11** | **13** | **16** | **8** | **1** | **49** |
| **Percentage** | **(22.4)** | **(26.5)** | **(32.7)** | **(16.3)** | **(2.0)** | **(100)** |

[a]The researcher asked the respondents to name and explain the communication approaches and theories they are aware of. Many of the respondents who were knowledgeable about approaches and theories could not recall them in detail but demonstrated sufficient understanding of the concepts.

**Chi-square test:**
Pearson chi-square value: 26.656
Degree of Freedom: 12
Assum.Sign (2-.sided): .009
P= <0.05

Table 8 shows that there is an inverse positive relationship between knowledge of current popular HIV/AIDS communication approaches and the prevalence rate movement in Cross River State. In this study location, prevalent rate dropped from 12.0% in 2003 to 6.1% in 2005.

Generally, findings suggest that good knowledge of widely-used HIV/AIDS communication approaches has a strong association with areas where prevalent rates have been decreasing. The opposite is the scenario in states where knowledge of widely-accepted HIV/AIDS communication approaches was poor. (Figure 8 depicts this result graphically).




**Communication competence**

*Figure 8. Comparison of 2003 and 2005 HIV/AIDS prevalence rates and communication competence in Cross River and Ondo States. In Cross River State, where prevalence rates dropped during the period, there is a high level of communication competence whereas in Ondo State where prevalence rates increased, communication competence was poor. Lagos and Nasarawa State showed a similar pattern respectively.*

*Question 5:*

*To what extent do HIV/AIDS interventionists contextualize their communication approaches?*

*Hypothesis. 7:*

*There is no significant difference among interventionists regarding contextualization of programmes.*

The research investigated the extent to which HIV/AIDS interventionists contextualized their communication approaches, a pre-condition by most experts for successful intervention in HIV/AIDS programming (UNFPA, 2002: p.29-30).

All interventionists took actions to contextualize their programmes in one way or the other – use of local languages, use of influential opinion leaders, etc. However, in terms of deliberate contextual plans, about half of respondents (48.1%, n=26) more often factored in the local culture (such as language, norms, tradition) in designing their programmes while about one-sixth (16.9%,=9) considered user-friendly I-E-C materials as most significant effort to contextualize their programmes. Another 16.9% (n=9) considered use of PLWHA/local staff as the most important action to contextualize their programmes. The rest 14.8% (n=8) did not take any significant deliberate effort to contextualize programmes. A probable reason for this

is that awareness creation, which was the main focus of programming during the period, required lesser need for contextualisation than, for instance, attitude and behavioural change campaign. (See also FGD data analysis on 'contextualisation of programmes).

**Table 9. Chi-square test of most significant steps adopted to contextualize programme.**

| | Observed N | Expected N | Residual |
|---|---|---|---|
| Stopped non-user-friendly I-E-C materials | 9 | 13.0 | -4.0 |
| Consideration for local culture | 26 | 13.0 | 13.0 |
| Use of PLWHA and local staff | 9 | 13.0 | -4.0 |
| Programme not contextualized | 8 | 13.0 | -5.0 |
| Total | 52 | | |

$x^2 = 17.39$, df = 3, $P < 0.05$

The observed frequency of the respondents that said that the most significant action they adopted to contextualize HIV/AIDS programmes, 'consideration for local culture' (26), was higher than the observed frequency of 13.0. However, the observed frequency for those that adopted stoppage of none-user friendly I-E-C materials - such as materials having foreigners – (9) and those that used PLWHA and local staff as a way of contextualizing their programmes (9) were less than the expected frequency of 13.0. In addition, the observed frequency of those that did not make definitive steps to contextualize their programmes (8) was less than the expected frequency of 13.0. Further statistics show that a significant difference exists in how respondents contextualized their programmes ($P< 0.05$). Hypothesis 7 which says there is no significant difference among interventionists regarding contextualization of programmes is thus rejected.

*Question 6*

***What challenges (apart from those related to communication) do interventionists face in attaining their goals?***

Data suggest that funding is the most crucial challenge facing HIV/AIDS interventionists in all study locations. One-third of the organisations (33.3%, n=18)) financed most of their projects by themselves while 16 .7% (n=9) and 33.3% (n=18) relied mainly on SACA and international organisations respectively for the bulk of their funds. An overwhelming majority of respondents (71.4%, n=36) operated an annual budget of less than N5million.

General programmatic challenges are: general empowerment (22.2%, n=12); training in communication skills (22.2%, n=12); communication equipment (20.4%, n=11); funding (16.70%, n=9); engagement of communication professionals (5.60%, n=11) and inadequate monitoring by the State government (11.1%, n=6). The researcher asked the respondents: What is your organisation's most crucial programmatic problem? Their responses are shown in Figure 9. These challenges are analysed in greater detail in the FGD report in the latter part of this chapter.

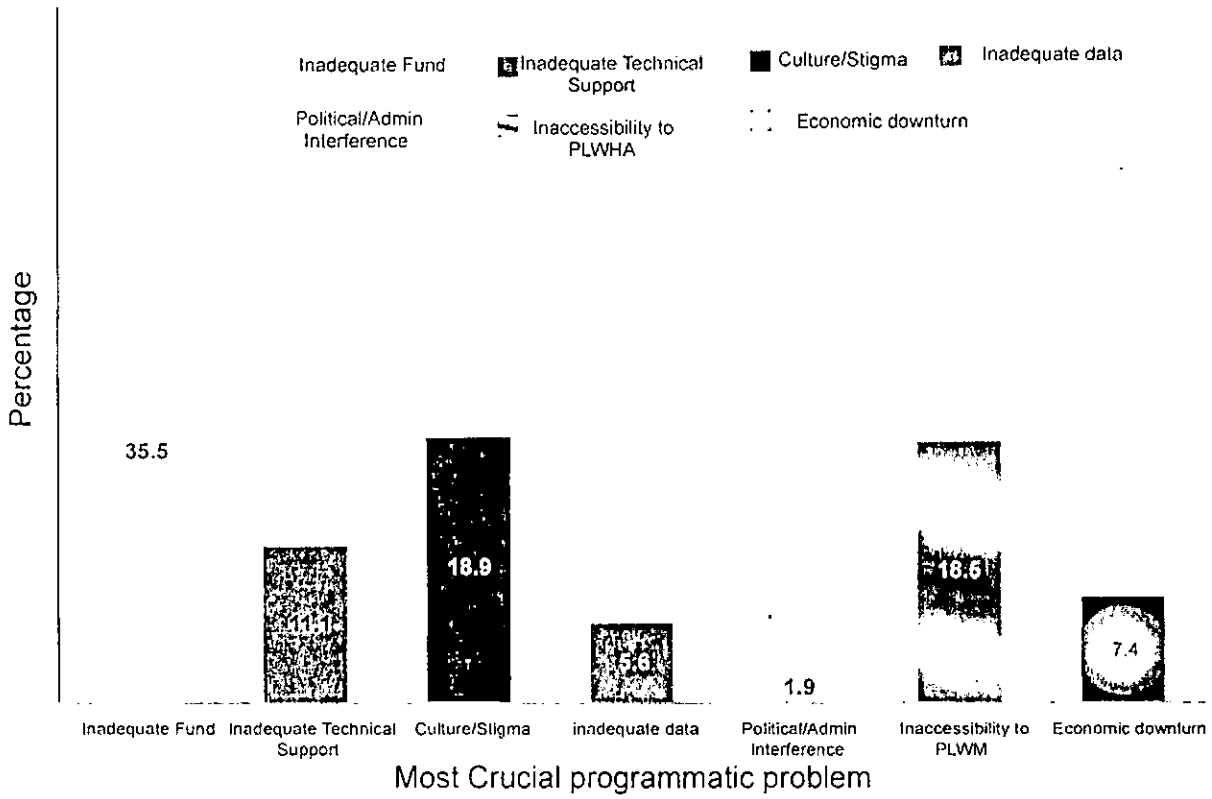


*Figure 9. Respondents' views about the most crucial programmatic problems, showing inadequate and inconsistent funding as the most crucial problem (35.2%, n=9) while the factor considered least crucial being political and administrative interference (1.9, n=1). However, participants in the Focus Group Discussions identified political and administrative interference as the second most crucial problem after funding.*

*Question 7:*

***What factors may be responsible for successful and failed interventions?***

Findings appear to be insufficient to determine the causal factors for successful and failed interventions. In the opinion of respondents, factors responsible for successes are good funding, good technical support, communication approach, determination and hardwork, while the reasons for failure are culture/stigma, inadequate information and facts, inadequate funding, inappropriate communication approach and general paucity of programmatic skills. (Figure 7 offers a graphical insight).

Some organisations were not certain of the *most important reasons* for the success of their programmes, saying such was difficult to determine by them. This category of respondents (5.6%) however could readily pin-point success factors in their programmes. It might require a true experiment in which internal and external validity variables can be controlled to determine specific 'most important reasons' for success or failure of programmes.

Supervision by donor agencies and SACAs may have been responsible for the generally successful intervention ('good technical support', 22.2%), coming only second to 'good funding' (29.6%) as the most important reason for success. Respondents who attributed their successes mainly to 'determination and hardwork' were generally those who had difficulty in funding their programmes (11.5%).

Reasons attributed for success and failure are similar. As shown in Figure 9, inadequate funding (24.1%), Culture/stigma (16.7%), poor technical skills (11.1%) and communication approach (5.6%) are leading factors in this regard. However, 'cannot say' (27.8%) is the mode among most reasons given for failure of programmes. This implies that over a quarter of interventionists could not categorically attribute the *most important reason* for failures of interventions, though they readily outlined failure factors.

*Table 10.*
*Reasons for successes and failures of interventions*

| | Percentage Frequency |
|---|---|
| Successful Interventions | |
| Most important reasons for success | |
| Good funding | 29.6 (n=16) |
| Good technical support | 22.2 (n=12) |
| Communication approach | 20.4 (n=11) |
| Audience cooperation | 9.3 (n=5) |
| Determination and hardwork | 11.5 (n=6) |
| Reason not clear | 5.6 (n=3) |
| **Total** | **100.0 (n=53)** |
| Failed Interventions | |
| Most important reasons for failure | |
| Cannot say | 27.8 (n=15) |
| Inadequate funding | 24.1 (n=13) |
| Culture/Stigma | 16.7 (n=9) |
| General paucity of programmatic skills | 11.1 (n=6) |
| Inadequate information/facts | 9.3 (n=5) |
| Poor communication approach | 5.6 (n=3) |
| **Total** | **100.0 (n=53)** |

## DATA FROM FOCUS GROUP DISCUSSIONS

### General findings

Table 11 summarizes the outcome of the Focus Group Discussions in all four study locations. Participants did not hold fundamentally divergent opinions on the research problem across study locations. Also, findings from the FGD generally corroborate data generated from the Indepth Interviews (although there are few exceptions).

Table 11.
*A summary of the outcomes of the FGDs in all study locations*

| FGD locations | Most important success factor | Influence of communication approach on outcome | Communication competence of interventionists | Approaches and prevalence rates | Contextalization | Major challenges |
|---|---|---|---|---|---|---|
| Ondo | Consistent funding; commitment and specialisation or focus | Important but secondary to funding | Poor among programmers | Rates are dropping but enthusiasm is exaggerated | Good | Funding; political interference and capacity building |
| Lagos | Technical skills or organisational ability of interventionists; empowerment of interventionists | Very important; saves funds | Good among programmers | Rates are dropping due to holistic response, not mainly due to communication approach | Good | Capacity building and empowerment (self-funding challenges) |
| Cross River | Local culture and context and communication expertise | Funding and skills acquisition different; NGOs must apply the right approaches to succeed | Very good among programmers, especially human communication techniques | Strategic interventions and good funding are the main reasons for drop in prevalence | Very good | Capacity building and empowerment (self-funding challenges); contextualizing programmes |
| Nasarawa | Consistent funding; context | Contextualized communication leads to success | Fair; interpersonal techniques more dominant | Rate still high due to funding problems but satisfactory | Very good | Political interference; funding and capacity building |

**Consensus of participants on research problems**[a]

[a]. Full transcripts of Focus Group Discussions in all study locations are reproduced as *Appendix III*.

**Ondo State**

Participants believe that funding is very fundamental to the success of HIV/AIDS interventions. Many of the interventionists do not have good administrative set-ups to

organise meaningful projects. Some of them are one-man or one-woman NGOs although quite a few are well-organised. Discussants reasoned that most interventionists in the state were very committed although they seemed to lack communication competence. The panelists believed that programmatic skill is a matter of having good funds. Once funding is available and people who are willing to do the work are ready, skills can be built. One of the panelists, Mrs. C.O. Awe, a medical laboratory scientist put it aptly:

> The NGOs are trying but you know the poverty level is high...and the problems keep coming. Quite a lot of people are into HIV/AIDS programming because they have found there is a lot of a fund there: let's put our pipes there and let's drain something. For the ones that are really working, they need further support. Unfortunately, the way we appreciate our rich men in this society is defective...including what we appreciate them for. When people are rich in this environment, we don't ask them what they put back to the society. We should encourage more philanthropists. We have people in this country that say they are third or thirtieth richest people in the world. For God's sake, what are they doing about making the society better? We have corporate organisations netting billions after tax in their annual reports published in newspapers, what are they putting back to society?

The discussants agreed that communication competence among interventionists in the state is poor and that this area needs to be addressed. Said Mrs. Awe:

> Behaviour change is almost a life time thing for most people. You are talking of people who have been engaging in a life style...you are not talking of ten years, you are not talking of fifteen years, not even 20 years. Look at the age people experience their first sexual intercourse. You find out that many girls had their first experiences about age 10. Little boys in primary schools are already having sex. When these boys and girls are now in their 20s and having tasted so much of it, you now want to change their attitude and behaviour. It has become their whole way of life... and you cannot change them unless you ***engage their will***.

Political considerations in funding, support and administration of HIV/AIDS programmes in Ondo State have not helped in accelerating success, according to the participants. This hampers those who are genuinely interested in carrying out interventions from getting the right support.

In terms of home-grown approach in communication programming, the panelists recommend a systematic approach (which this researcher has conceptualized as **'the Octopus Model'** (see \Chapter Six). This involves everybody, not just NGOs, getting involved. Attitude and behaviour change can only take place when everybody in the society plays his/her/its roles very well – teachers, parents, philanthropists, government, NGOs, institutions such as churches, schools, media and so on. When one part of a system fails, (for instance, if a mother does not discipline her daughter) behaviour change would not be sustainable. No one has a 'permanent behaviour' for life and when parts of the 'system' fail, it ultimately leads to a relapse in the (behaviour of the) system.

**Lagos State**

Participants at the Lagos GGD viewed the problem of funding from a different perspective. Their views were very similar to those who participated in the Cross River State FGD: interventionists should develop self-funding capacity and stop expecting that funds would continue to come in droves as it was when the scourge attracted worldwide attention to Nigeria a few years back.

A member of the panel, Mrs. Nike Alaka, who is an Executive Director of an NGO in the state, commented on the challenge of funding thus:

> My understanding of empowerment is to teach the NGO how to fish rather than give them fish and they would be able to generate their funds. LSACA should spend what it gets from the government and the World Bank on this area such that we can have over 1,000 organisations empowered. When these 1,000 organisations can fend for themselves, they go to the nooks and crannies of the state doing one intervention or the other and the entire state is covered.

A key concept generated from the Lagos FGD is what this researcher has termed the '**Mustard Seed Approach**'. This entails the development of small, rather than big or broad-based interventions. There could be an HIV/AIDS programmer whose scope is just five streets or just two secondary schools. The programmer concentrates on this little scope and generates his or her funds from within that coverage. The challenge of bigger interventionists of the relevant SACA would now be how to 'scale up' and grow the little mustard seeds.

The panelists saw this approach as a potentially effective way to contextualize programmes in a highly urbanized and highly complex state such as Lagos. Political interference is not a significant problem for interventionists in Lagos State, according to the panelists.

**Cross River State**

Although the discussants regard funding as an important success factor in the state, they believe the challenge of contextualizing programmes is more serious. Before 2003, Cross River State had the highest prevalence rate in the country and this led to more interest by the World Bank and many international organisations, which moved in to build capacity in programming. Cross River has built a high level of awareness and the greater challenge now (during the period under study) was how to bring about attitude and behaviour change. Two big hurdles against this was the heterogeneous nature of the society and the difficulty in accessing people in rural areas due to the coastal terrain. Like Lagos, political interference is not a major problem for interventionists in Cross River State.

Programmers in Cross River State face different cultures (and different interpretations to sexuality and sex). Therefore, in the view of panelists, capacity building in programming is the greatest need of NGOs in the state at the moment. The panelists agree that communication is key to the success of HIV/AIDS interventions and that interventionists in

the state have good knowledge of communication or access to those who possess the skills. This may have helped in scaling down the prevalence rates in the state, according to them. What the participants recommend as the pragmatic communication approach for HIV/AIDS programming in the state is similar to Ugboajah's **'Oramedia'** – creative and localized combination of modern mass media and traditional media channels. (Jefkins & Ugboajah, 1986).

Martins Akpan, a communication specialist with CRSACA, said the following during the FGD:

> You are in a community where someone entertains a guest with her daughter, i.e. offers her to satisfy the sexual pleasure of an important guest. Consider another community in which keeping virginity is considered a taboo for a young girl. You need more than putting advertisements on radio or TV to bring about change in that kind of society. And this is the situation we face in Cross River. Without **engaging the will** of the entire society, I am afraid; we will not be able to do much. That's why we strongly recommend participatory communication approaches to NGOs working with us.

One of the participants, Miss Kate Amaechi, described the importance of using appropriate communication technique thus:

> We continue to say the youths are the most vulnerable, but why are we not reaching the youths? Part of the reason [why HIV/AIDS interventions fail] is that we are not negotiating with the youths. That's where the mistake lies. We want them to see things from our view point but we don't want to see things from their own view points.

**Nasarawa State**

The problem of funding was seen as 'acute' in Nasarawa State by panelists. Most of the funds available for programming come from international organisations and the State Government, which participants accused of politicizing the administration of such funds.

Like Ondo State, NGOs in Nasarawa State are ready to do the work but those who are committed to the work do not often get the funds. There was disagreement among panelists on the appropriateness of the choices of NGOs being supported with funds but it was the consensus that NGOs must graduate from the levels of being infants who are fed with milk to adults who can fend for themselves. The position of Mr. Daniel Sagbeda, Director of Monitoring and Evaluation of NASACA reveals the tone of the discussion on this issue:

> I think my colleagues [panelists] are misrepresenting the facts. The government gets funds and the disbursement is based on certain conditions which we must follow. I think an NGO worth its calling should be able to generate funds on their (*sic*) own if they are (*sic*) really committed to their volitional calling...

The discussants pointed out that what led to the formations of organisations in the fight against HIV/AIDS was the possibility of getting consistent funding but which was not forthcoming as soon as such organisations were set up. Lack of funds directly led to low level of activities by the organisations and this may have led to the marginal increase in prevalence rates in the state.

In terms of communication approach, participants agreed that traditional interpersonal and group networks of communication should be emphasized over modern mass media channels since the state is largely rural and poor. Most of the target audiences for HIV/AIDS campaigns do not have access to the modern mass media.

The panelists considered the level of communication competence by interventionists as 'fair', in the sense that their (knowledge of) communication skills were good enough to bring good results, all other things being equal.

The discussants could not draw a direct link between communication approach and the prevalence rate in the state. Dr. Hassan Ibrahim (a medical doctor with the State Health Management Board) explained the reason for this during the FGD:

I think we have to be careful in drawing conclusions. Personally, I look at the national SSP [State Sero-Prevalence] with caution. This rate was produced using figures collated from tests on pregnant women who visited hospitals and health centres. We all know that in our society quite a lot of these women do not go to conventional hospitals. So, even if we say it is okay to use pregnant women, we have a problem there. Second, we have quite a lot of people who are vulnerable outside the bracket. So, to me, quite a lot of figures are not tracked into the SSP. It does not truly represent what is on ground when you talk of patterns of prevalence. But for our purpose here, let me use the data you have described. Let me accept it as okay. Now, comparatively to how serious the problem was, although we have a high rate, I think it is satisfactory. We should not expect magical results when it comes to a social problem such as AIDS. The good thing is that things are getting better. Where I have problems is saying this and that are responsible for it.

# CHAPTER FIVE
# FINDINGS AND DISCUSSIONS

This research. A Study of HIV/AIDS Communication Approaches by Interventionists in Selected Nigerian States, provides some enlightening results.

**A summary of findings to research questions/hypotheses**

1. Data suggest all study locations were doing similar programmes during the period under study and their areas of focus (education/prevention/care support, counselling, and treatment) did not differ significantly. Communication approach is a major influence but not the sole overriding influence on success of programmes. (Waisbord, 2005:p.80). There is no significant difference in dominant approaches used by Interventionists and the outcome of interventions. ($x^2$ =49.686, df =44,P> 0.05).
2. A statistically significant difference exists in the reasons attributed for the success attained by the respondents, (P<0.05), with 'audience attitude', 'determination and hard work', and 'reason not clear' reporting lower importance in most important reasons for success.
3. Most programmers neither trained in the use of communication skills nor engaged the services of communication specialists. When communication skills of programmers and use of communication specialists were examined across study locations, programmers in Ondo and Nasarawa States showed much less communication competence than their counterparts in Lagos and Cross River States.
4. Findings support previous evidence that good knowledge of widely-used HIV/AIDS communication approaches and communication skills enhance the success of interventions. (Arhihenbuwa, 2005). The Null Hypothesis that there is no relationship between interventionists' knowledge of approaches and the results of their interventions was rejected. This implies that communication skill/competence is very important in HIV/AIDS programming.

5. About two-thirds of interventionists made deliberate attempts to contextualize their interventions. When subjected to chi-square test, the differences in the contextualization of programmes was significant – interventionists which made efforts to adapt their communication models to local situations reported higher successes.
6. There is a statistical relationship between study location and knowledge of current popularly used HIV/AIDS approaches. NGOs exhibited remarkably different methods of contextualizing their programmes.
7. Data generated from this study are insufficient to establish causes of successful and failed interventions. In the opinion of respondents, factors likely responsible for successes are good funding, good technical support, communication approach, determination and hardwork. Reasons for failure could be stigma/culture, inadequate information and facts, inadequate funding and paucity of programmatic skills.
8. Data strongly suggest that funding is the most crucial challenge facing HIV/AIDS interventionists in all study locations. Technical support comes next, after which communication skills follow.

**Discussions**

In previous research on successful communication approaches in Vietnam, Brazil, Cambodia, *social marketing* and *peer education* were found to be the dominant communication approaches. (USAID, 2003a; USAID, 2003b; USAID, 2005; FHI, 2006). Studies in East Africa by Mishra (2005) found *formal education, empowerment* and *participatory communication* to be the most effective successful approaches. In Senegal where prevalence rates dropped very sharply in the past six years, *faith-based* communication approach was found to be dominant. This research did not confirm these approaches as highly effective in Nigeria. Rather, it shows that most interventionists relied on I-E-C through the modern mass

media as principal communication techniques for their most successful interventions. *Social marketing* is the next dominant method, however, confirming earlier findings on the potentials of the technique for prevention. This finding however does not mean that the approaches found to be effective elsewhere could not be successfully applied in Nigeria. Most Interventionists do not have working knowledge of these approaches and until they are tried out, their effectiveness cannot be established.

The Family Health International, in a 2000 study in Kebbi State (North West Nigeria), found that "knowledge of main prevention methods was poor in all high-risk and vulnerable areas." (FHI, 2000). The outcome of the this study in Ondo and Nasarawa States were similar to what the FHI found in the its study. In Ondo and Nasarawa states prevalence rates increased during the period of the study and knowledge of prevention methods was also poor.

In terms of possession of programmatic skills by interventionists, this study suggests that there has been an improvement in the past several years. For instance, in their 2000 study in Nasarawa, Imam *et al*., had found that "skills and knowledge of healthcare providers were limited and only a few have any technical or programmatic capacity." (Imam *et al*., 2000). This study found that programmers in Nasarawa State, though still low in terms of communication competence, have since acquired reasonably sufficient communication knowledge to carry out meaningful interventions.

Findings from this investigation imply that there is still a wide gap between theory and practice in some aspects and also some areas of convergence between theory and practice in other aspects of HIV/AIDS interventions in Nigeria.

The study confirms that HIV/AIDS in Nigeria have begun to use the most recent paradigms in development communication such as integration of psychological, sociological and communication theories; viewing 'communication' as sharing, meeting of minds or simply

'bringing about understanding' (unlike the old misconception of viewing communication as a one-way linear traffic to enlighten a supposedly ignorant audience). There is a gradual shift by Interventionists towards human and participatory techniques.

These findings affirm Waisbord's view that "the old paradigms may have passed in development communication as Everett Rogers had famously stated back in the mid-70s but no one single paradigm has replaced it...but the approaches which were initially discordant and irreconcilable are now forming a budding consensus." (Waisbord, 2005: p.80). Data from this research indicate that there is no significant difference in the approaches employed by Interventionists to attain their generally successful interventions across the four states studied. The study also corroborates previous research finding (UNFPA, 2002) that programmers were increasingly paying more attention to environmental factors and context in their interventions.

However, the findings also appear to contradict the theoretical postulation that 'power' was at the heart of most successful interventions. Over two-thirds of the respondents complained of lack of empowerment (human, financial, technical), yet they succeeded in their programmes. This finding may have resulted from the fact that in 2003/2004, most of the organisations benefited generously from international donations, probably due to the huge outcry on the AIDS scourge at the time. Funding has reduced since then. The above assumption is strengthened by the participants' views in all the four FGDs that the greatest need of Interventionists was empowerment. In addition, experts have defined power in the context of development communication to mean much more that money. It means 'money' plus 'educating people through necessary information that could enable then fend for themselves and liberate themselves from poverty and ignorance.'

> Self-management is the most advanced form of participation. In this case the public exercises the power of decision making within communication enterprises as is also fully involved in the formulation of communication policies and plans...Participation implies a higher level of public involvement in community systems. It includes the involvement of the public in the production process and also in the management and planning of communication systems: May be no more than representation and consultation of the public in decision-making.
> (Servaes and Malikhao, 2005:p.96).

Family Health International had found that most recent HIV/AIDS interventions succeeded elsewhere in the world due to "diversity of programmatic insights and strategies." (FHI, 2006). This study did not replicate this position. Rather than creatively designing home-grown, localized approaches to address particular problems, most organisations still use the essentially mass media strategies. This strategy may have produced good results in awareness creation but may fail dismally in attitude and behaviour change campaigns.

It is surprising that faith-based approaches were not used frequently by Interventionists, going by statistics generated from this study. The fact that application of faith-based Christian and faith-based Islamic approaches in Cross River and Nasarawa States respectively accompanied good outcomes is an indication that the faith-based approach could be very effective. The religious knowledge and compassion of those who employ the faith-based approach only need to be complemented with acquisition of communication skills. Many people who commit sins know that they do commit sins; what is missing is probably a communication approach to help people stop sinning (stop doing what they don't enjoy doing).

The structures to support faith-based methods are already there in Nigeria. There is a church or a mosque almost on every street in the cities and every rural town has either a mosque or a church or both, at least. The church and mosque leadership and administration are already in

place. The enthusiasm to work for humanity is also probably also present in these religious organisations and many of them do not complain of funds. What remains to be done in deploying the faith-based approach might just be some re-orientation and the entire nation is networked for effective HIV/AIDS intervention.

When related to current theoretical frameworks of HIV/AIDS communication, findings from this study of HIV/AIDS communication approaches in four states of the Nigerian Federation show that theories borrowed from the Communication Framework were preferred to the Psychologically-rooted Frameworks. Sociologically-rooted theories and approaches were least frequently applied by Interventionists. None of the Interventionists was aware of the Activity Systems Theory and the ACADA Model, two of the very popular models widely applied in health communication.

It is evident from findings that sound theoretical foundation in communication would help Interventionists in understanding which communication approaches to adopt and in what circumstances or situations such should be adopted. Future HIV/AIDS interventions in Nigeria, especially those aimed at attitude and behaviour change may not succeed very well unless organisations carrying out the interventions have access to communication skills, especially now that the major challenge is attitude and behavioural change communication. It should be a source of concern to NACA and SACAs that over seven years after the Family Health International found in a study in Kebbi State that knowledge of main HIV.AIDS prevention methods was poor in the state, situations have not improved dramatically, going by findings to this study. (FHI, 2000).

The study reveals that traditional communication approaches are not in effective use in HIV/AIDS programming. The paradigm shift to context, culture and engagement of the

audience would logically require a similar shift in communication approach. In this regard, traditional communication methods have to be revisited and applied to the HIV/AIDS problem.

# CHAPTER SIX

# CONCLUSION AND RECOMMENDATIONS

## Conclusion

This study set out to discover and describe the HIV/AIDS communication methods being used by Interventionists in Nigeria between 2003 and 2007, using Ondo, Lagos, Cross River and Nasarawa States as case studies. It also sought to know the communication competence of Interventionists, challenges being faced by Interventionists and the implications of findings on HIV/AIDS programming.

The study came on the heels of drops in national prevalence rates generally in the country although some states were experiencing sporadic rises in prevalence rates. The focus of the National HIV/AIDS Behaviour Change Communication Strategy 2004-2008 was "advancing beyond awareness creation and addressing the issues underpinning behaviour change through strategic, evidence-based, theory-driven and result-oriented interventions." (Osotimehin, 2004). This period was thus ideal to evaluate the efforts and challenges of interventionists. The bulk of direct interventions in Nigeria take place through organisations and private/public institutions. Most health institutions are involved mostly in clinical services while other levels of direct interventions were mainly supervisory. (FMoH/SSP, 2005).

Findings of a pre-test had revealed that many among the plethora of 'organisations' carrying out HIV/AIDS interventions were not on ground. This researcher therefore adopted only organisations recognized by SACAs in the respective study locations. Fifty-three out of a list 174 organisations of sampled for the study.

Below is a summary of research questions and answers to them from data generated from the study:

*Main Questions:*

1. **What influences do application of 'communication approaches' have on the outcome on HIV/AIDS Interventions?**

   Communication approach is one of the major contributory determinants of the outcome of HIV/AIDS interventions. Although many interventions succeeded irrespective of particular approaches employed, statistics show that organisations whose personnel had good communication skills succeeded more than those which did not.

2. **Do Interventionists possess communication competence for the successful implementation of HIV/AIDS programmes?**

   Generally, findings strongly suggest that most organisations carrying out HIV/AIDS programmes in the study locations do not possess communication competence. Interventionists in Cross River and Lagos States possess better communication competence.

3. **What is the relationship between Interventionists' knowledge of communication approaches and the results of their interventions?**

   When related with levels of success attained for programmes, organisations that demonstrated knowledge of communication approaches and general communication skills recorded higher success rates than those who lack such skills. This implies that knowledge of communication skills, other things being equal, would bring about better outcome of programmes.

4. **What is the relationship between knowledge of communication approaches and patterns of HIV/AIDS prevalence?**

   There was a significant relationship between knowledge of widely-used approaches and the patterns of prevalence. In areas where HIV/AIDS prevalence had been decreasing (Lagos and Cross River) there was good knowledge of widely-used communication approaches. In Ondo and Nasarawa States where prevalence rates had been increasing, there was poor knowledge of widely-used communication approaches.

5. **To what extent do HIV/AIDS Interventionists contextualize their communication approaches?**

   About two-thirds of Interventionists made deliberate efforts to contextualize their programmes. The differences in approaches used in contextualizing programmes were significant, with local culture being the dominant consideration in contextualization of programmes.

6. **What challenges (apart from communication) do Interventionists face in attaining their goals?**

   Funding is the major challenge facing Interventionists. Next to funding is technical programmatic skills and communication skills respectively.

7. **What factors may be responsible for successful and failed interventions?**

   Data from findings are insufficient to determine the causal factors for successful and failed interventions. Good funding, good technical support, communication approach, determination, hardwork and context are however contributory factors to successes or failures.

## Recommendations & Contributions to Knowledge

This study has generated new information in the sphere of HIV/AIDS communication. Below are the specific contributions to knowledge and recommendations based on data generated from the research.

*Contributions to Knowledge.*

1. This study has narrowed the wide gap between theory and practice in the field of HIV/AIDS communications programming. Being perhaps the first scientific comparative study on the communication competence of those directly involved in HIV/AIDS programmes in Lagos, Ondo, Nasarawa States and the Cross River States, the study has provided helpful information on the communication-knowledge skills of programmers in these states which would assist in enhancing the success of future interventions.
2. This research has offered scientific explanations for the recent drops and increases in prevalence rates of HIV/AIDS in some states in Nigeria.
3. The study provides theoretical and practical suggestions in managing the HIV/AIDS problem in Nigeria. It has discovered, explained and assessed some of the major approaches currently in use, the relative outcomes associated with them and limitations of their usage.
4. The bulk of the literature on HIV/AIDS in Nigeria is on sero-prevalence, effects of the scourge and generally clinical studies. This study has expanded and refined the literature on HIV/AIDS in the country regarding methods, techniques and tactics employed in previous and current interventions.
5. The NACA, SACAs, LACAs, local and international donor agencies and other stakeholders will through this study be able to make more result-oriented policy

on funding and capacity building for interventionists especially in Ondo, Lagos, Cross River and Nasarawa States where currently scientific data on communication approaches are not readily available.

6. Communication scholars will benefit immensely from this study because it has discovered new development communication concepts and constructs and shed more light on emerging ones. These include:

- **Political Interference**

  Biased and unprofessional decisions by SACAs and donors, based on political considerations as against programme necessities are new challenges facing NGOs.

- **Empowerment**

  Discussants used this expression to explain ability of NGOs, other programmers and the target audience to stand on their own financially.

- **Engaging the Will**

  This was a common phrase amongst participants. It means, interventionists must negotiate with their audience in order to persuade such audience.

- **Persuasion from the Audience's point of view**

  Attitude change campaign often becomes successful when we persuade people from their (audience's) own point of view, not necessarily the communicator's point of view. If we try to understand what a lady enjoys by having multiple sexual partners, we may be able to help her satisfy that gratification in such a way that she would not have multiple sexual partners.

- **Active Audience**

  The audience of an HIV/AIDS intervention must play an active role in the intervention process, not just to receive a message or idea.

- **Localised programming**

This involves the establishment of small community-based interventions instead of broad elaborate programmes, (*Mustard Seed Approach).* The concept of Mustard Seed is based on evidence that it is effective to solve the problem that affects a whole by carefully paying close attention to the parts of that whole. It has been successfully used in fast-growing economies such as Malaysia, Singapore and China, where small-medium industries were used to transform such economies. The approach has also been successfully used in Christian church development through a system known as 'Cell Development.' This involves small households constituted into small churches (the church in the house). Several small home churches are grouped into community centres. The Redeemed Christian Church of God and the Foursquare Gospel Church in Nigeria have used the Mustard Seed Approach to plant churches virtually on every other street in many cities in Nigeria. Many of these little churches survived foundational difficulties to become big churches today. The idea is to plant a church (or plant an NGO). For every three streets, SACA and LACA can initiate an NGO (similar to Community Development Associations often established by house owners in the city). Once foundational empowerment is ensured, the NGO would progressively expand to serve the small community vibrantly regarding its aims and objectives.

*Recommendations*

Based on previous findings by other researchers and the results of this investigation, this researcher recommends as follow:

1. Government and donors should concentrate efforts in helping interventionists in HIV/AIDS interventions to fend for themselves (teach them how to fish rather than

give them fish). Programmers cannot succeed without consistent funding but complete reliance on government and international agencies for running of NGOs foretells programmatic failure regarding HIV/AIDS in Nigeria in the near future.

2. Government should encourage rapid establishment of community-based NGOs to make contextualization of programmes more easily attainable: The Mustard Seed Approach. Government agencies do not need to engage in direct interventions as there are numerous NGOs and interventionists at other levels who are currently under-utilized due to incapacitation. Government should concentrate on offering technical and financial support for small but effective organisations who are serving well-defined audiences.
3. International donor agencies need to adopt a more realistic pre-qualification procedure for grants and also diversify strategies in the administration of grants. Active and serious NGOs, FBOs, CBOs and other organisations should be able to access funds from such donors without recourse to local or state governments.
4. Interventionists must make independent efforts to build their communication and other technical capacity – possibly have areas of programming specialization/areas in which they have comparative advantage. Such expertise will probably engender better results as well as open regular streams of income. The current preponderance of 'jack of all trades' has made interventionists 'master of none', making them low in programmatic skills.
5. Interventionists should carefully choose appropriate techniques based on programme mission and goals. Creative combination of mass media, interpersonal, group and indigenous communication systems is crucial to programmatic success. This researcher reiterates Akinfeleye's suggestion that I-E-C should be expanded to include 'Participation'; **I-E-C-P,** especially in development communication campaigns. In other words, the audience should be involved in developing

Information, Education and Communication materials as well as be involved in the communication process. (Akinfeleye, 2008b).

6. Communication proficiency should be a pre-condition for support, set by NACA, SACA and donors for interventionists.
7. Faith-based approaches might turn out very effective if properly deployed to HIV/AIDS programming. The preponderance of churches and mosques which have structures that are already up and running provides a veritable opportunity for HIV/AIDS programming in Nigeria. With a little orientation, training and support (as was the case in Senegal and Cambodia) these religious organisations could serve as engine rooms of HIV/AIDS interventions, especially since research has confirmed that funding, commitment and belief systems are very crucial in attitude and behavioural change communication. Pilot studies are required in this area.
8. Political bias and interference should be removed from HIV/AIDS programming in Nigeria. Political biases of Interventionists should not be used as yardsticks to determine which Interventionists get funds or how much they get.
9. There is a need for further research on the effectiveness of some of the approaches specifically, and *causes* of successes and failures of interventions.
10. This researcher, based on data generated from this study has developed the **Octopus HIV/AIDS Communication Model**, for use by all interventionists In HIV/AIDS in Nigeria. This Model is hereby recommended for adoption by all interventionists in Nigeria.

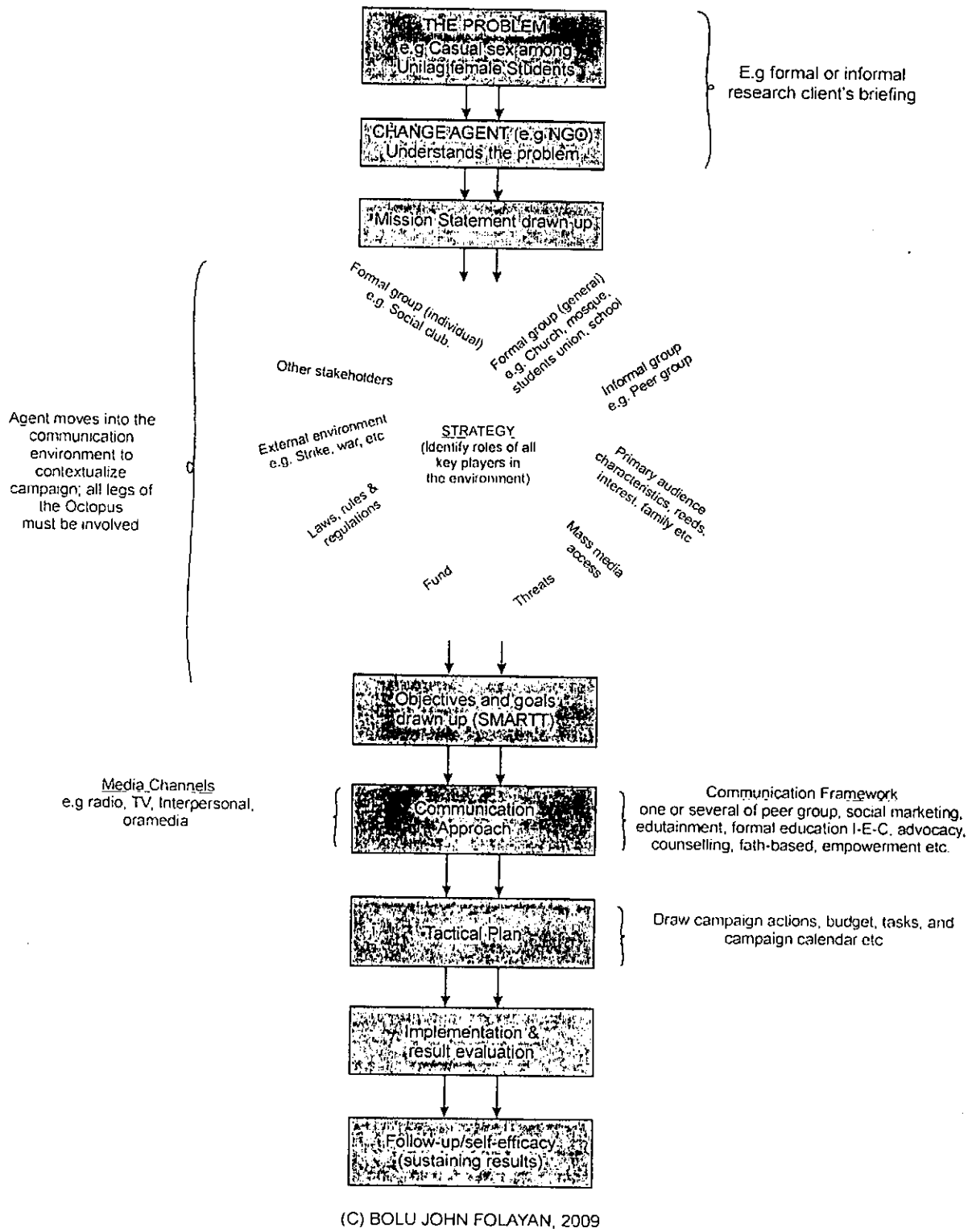



*Fig. 11. The Octopus HIV/AIDS Communication Model*

*Key Concepts & Metatheoretical Assumptions of the MODEL*

'MUSTARD SEED'

This entails development of small audience-specific rather than big or broad-based organisations/interventions. A programme's scope could be just three streets, an entire village or two secondary schools. In this form, the NGO is 'localised'. The programmer, through this technique, will be able to build local credibility and goodwill such that it can become empowered by the local community. What begins like a mustard seed now grows outwards, covering adjoining villages or additional secondary schools. Most success stories reported in recent times in HIV/AIDS literature are small scale interventions which are now being scaled up.

'SYSTEMS'

A system consists of components that are inter-related, inter-subjective and inter-dependent. Human beings do not exist as islands. They affect their immediate and remote environments and they are also affected by their immediate and remote environments. Communication change in HIV/AIDS cannot take place unless we factor in this reality. AIDS is a problem about sex, gender, poverty, culture, etc. and it is better when the problem is tackled through the functional parts of the society.

'CONTEXTUALIZATION'

An African adage says, 'you cannot step into the same rive twice.' Behaviour communication must take into consideration the local situation. What works perfectly in Community A may not work in Community B in another location. Contextualization is an attempt to as much as possible consider local influences and events that can affect the outcome of the programme.

## 'PARTICIPATORY DEVEOPMENT COMMUNICATION'

Contemporary paradigms in development communication states that the audience must be actively involved in the communication effort. We cannot change a people when we *think for them.* But we can 'prime them up' or 'trigger them to think or do things for and by themselves through giving them material, economic, moral and other support. The audience in an attitude change campaign must be involved in (and often they are to initiate) the change desired. Yet, they cannot do it alone. They need their fellow citizens and sometimes people 'outside' to attain change. Their *will must be engaged* for an enduring change to occur.

## 'SELF EFFICACY/EMPOWERMENT'

What distinguishes 'behaviour modification' from 'behaviour change' is time frame. When change in behaviour occurs in the short run, it is known as behaviour modification. If the new behaviour is sustained beyond six months, behaviour change has taken place. Self-efficacy means 'I can do it by myself'. The object of change must be able to sustain the new behaviour well after the change agent had gone. We can get a prostitute off the streets to learn tailoring and open a shop for her to begin a new life as a way of reducing HIV/AIDS transmission. The above example illustrates 'empowerment'. What guarantees that the prostitute is unlikely to come back to the streets is the component 'self-efficacy.'

## 'THEORY'

Every HIV/AIDS communication campaign must be footed on one or several relevant theoretical frameworks, to guide the interventionist. A working theory can then be adapted by the Interventionists for the specific projects being implemented. A theory attempts to explain, describe or predict the outcome of an effort.

The Interventionist can adopt and adapt one or more theories of communication for their programmes. These theories or models rooted in various disciplines but notably in the humanities and social sciences have been helpful in understanding and situating the HIV/AIDS problem although they have produced varying degrees of successes in terms of providing the desired results of interventions (Airhihenbuwa, 1995; UNFPA, 2002). Some of the widely used theories in development communication are: **Meaning of meaning Theory** (Richards 1936); **Balance Theory** (Heider and Newcomb 1946); **Congruity Theory** (Osgood and Tinnebaum, 1955); **Health Belief Model** (Hochbaum, 1958); **Attribution Theory** (Heider, 1958); **Inoculation Theory** (McGuire, 1961); **Social Judgment Theory** (Sherif, M., and Hovland, C.I., 1961); **Cognitive Dissonance** (Festinger, 1962); **Belief Congruency** (Rokeach, 1965); **Source Credibility Theory** (Hovland, Janis and Kelly, 1967); **Social Penetration Theory** (Altman and Taylor 1973); **Theory of Reasoned Action** (Fishbein and Azjen, 1975); **Elaboration of Likelihood Model** (Petty, R.E., and Cacioppo, J.T., 1979); **Sensation Seeking** (Zukerman, 1979); **Activation Theory of Information Exposure** (Donohew, L., Palmgreen, P., and Duncan, J., 1980); **Communication Competence** (Spitzberg and Compach, 1984); **Fear Appeals** (Witte, 1992); **Tran theoretical Model [Stages of Change]** (Prochaska, .O., DiClemente, C.C., and Norcross, J.C.,1992); **Information-Motivation-Behavioral Skills** (IMB) Model, (McKee, 2000) **Activity Theory** (Kelly et al., 2003); and the **Extended Parallel Process Model**, EPPM, (Witte, K., Cameron, K.A., Lapinski, M.K. and Nzyuko, S., 2000). Major relevant theories from the field of mass communication that have been used for HIV/AIDS programmes include: **Diffusion Theory** (Lazarsfeld, Berelson and Gaudet, 1944); **Functional Approach** (Lasswell, 1948); **Agenda Setting** (Newcomb and Shaw, 1973); **Uses and Gratifications Theory,** (Blumler and Katz, 1974).**Cultivation Theory** (Gerbner and Gross, 1976); and **Spiral of Silence Theory** (Noelle-Newman, 1984).

*Application of the Octopus Model*

*Note:* This model is adapted from the ACADA Model and the Activity System Theory.

Step 1 : The Change Agent (e.g.NGO) understands the problem through formal or informal research;

Step 2: The NGO draws up a broad mission for the intervention.

Step 3: The agent identifies and assigns roles to all key stakeholders in the attainment of the mission/goals; every leg of the Octopus is important because when one leg falters, effectiveness is hampered. (Participation/Interdependency/Systems). It chooses the theoretical and conceptual frameworks that would be very appropriate to realize the set goals.

Step 4: The agent now draws communication objectives and goals which are Specific, Measurable, Attainable, Realistic, Targeted, and Timed, SMARTT. (Contextualization)

Step 5: Next, the Agent chooses one or more of several tested communication frameworks that he or she deems appropriate to attain the goals set along side the complementary media channels. The NGO may develop its own 'working theory' (adapt an approach to suit its programme) based on what it believes could work in the context of the intervention. No two interventions are exactly the same.

Step 6: The NGO chooses appropriate media suitable for the communication approach selected. Communication approach and media channels are not the same, although the media channels are usually apparent in the approach. For instance, peer education uses interpersonal channels, but can also be effective using radio and TV channels.

Step 7: The Interventionist draws a budget and implements day-by-day and week-by-week actions.

Step 8: At the end of the campaign, the NGO evaluates and builds on self-efficacy (how the achievements would continue to be sustained and setbacks could be avoided in future interventions).

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*APPENDIX I*

## IN-DEPTH INTERVIEW SCHEDULE COPY

*Dear Sir/Madam*

*My name is Bolu John Folayan, a PhD Mass Communication candidate of the University of Lagos. I require your inputs to provide data for my Thesis: AN EVALUATION OF HIV/AIDS COMMUNICATION APPROACHES IN FOUR NIGERIAN STATES: 2003-2007.*

*I assure you of the confidentiality of all information you shall give and that I seek these information purely for research purpose only. Thank you.*

### *SECTION 1: INFORMATION ON INTERVENTIONISTS*

1. What is the name of your organization?
   .....
2. What is the Registration Status of the Organisation (indicate government agencies the organization is registered with e.g. Corporate Affairs Commission, FACA, SACA, Ministry of Social Development, Local Government Council, etc.
   .....
   .....
3. What are the key objectives of your organisation?
   .....
4. State your organisation's **Mission Statement:**
   .....
5. What is the organisation's major programming area in the last four years, e.g. prevention, treatment and care, testing and counselling?
   .....
6. In what year was the organisation established? (Please note that this may be different from the year it was officially registered).
   .....
7. Please indicate the organisation's Headquarters Office (include addresses elsewhere, it the organization has branches, please):
   .....
8. Telephone contacts:.....
9. Name of Chief Executive Officer.....
10. What is the organisation's staff strength?.....
11. What are the major sources of funding for your HIV/AIDS projects/programmes?
    .....
12. Please indicate the organisation's average Annual Budget (income and expenditure).
    .....
13. List the Designations of your principal Staff and Consultants, with their qualifications please.
    .....

## SECTION II: PROGRAMMING INFORMATION

14. Name and explain the dominant method your organisation employs to carry out HIV/AIDS Interventions:

.....

15. Describe the most effective human communication method your organisation employs in carrying out its programmes? Kindly explain in detail.

.....

16. Please list and explain all HIV/AIDS communication approach(es) that you know:

.....

.....

17. Which particular communication approach(es) have you found most effective in your HIV/AIDS programmes?

.....

.....

18. List the communication materials that you have or use for your HIV/AIDS programmes

.....

.....

19. Do you have a communication specialist in your organization (as employee or consultant)?

Yes..... No.....

20. If your answer to Question 19 above is "Yes", how did he or she obtain most of his/her communication knowledge, e.g. through University/Polytechnic Course, Seminars, Workshops, Conferences, etc.

.....

21. If your response to Question 19 above is "No", why do you not have a communication specialist?

.....

22. How do you most often determine which communication approach(es) to adopt for your programme?

.....

.....

23. Would you say your organization (represented by its principal officers such as Programme Officer, Communication Officer, Mobilisation Officer, Executive Director, etc.) has 'communication skills'?

Yes.....No.....

24. If your answer to Question 23 above is "Yes", what are the best skills (the best skill first)?

.....

.....

25. How do you (did you) often obtain information about the target groups of your programmes mostly?

.....

26. If you have to run a similar programme to the ones you have done before, would change your communication approach?

Yes..... No.....

27. Please explain your response to Question 26.

.....

.....

28. Do you use any Communication Theory as guide whenever you want to adopt a communication approach for your programme?

Yes..... No.....

29. If your response to Question 28 is "Yes", please mention these theories:

.....

30. If your response to Question 28 is "No", Please explain why.

.....

31. In the context of HIV/AIDS programming, how would you define **'communication'?Please note that we want *your* own definition, not necessarily a book definition.**

.....

## SECTION III: PROBLEMS AND CHALLENGES

32. What has been the most crucial communication problem or challenge that have your organisation encountered in its interventions?

.....

33. What is your major programmatic problem generally, in carrying out HIV/AIDS programmes?

.....

.....

34. How do you think the problem or challenge you stated in Question 33 could be solved?

.....

.....

35. What would you say is your **major** communication strength/advantage (e.g. 'I speak the local language of target audience', 'I am a PLWHA', 'I have communication work experience' etc.?

36. What, in your view, is the **major** communication weakness of your organization in implementing its HIV/AIDS programmes?

.....

## SECTION IV: PROGRAMMES EVALUATION

37. How do you (what technique to you use to) measure the performance of your programmes?

.....

38. Which is the most successful HIV/AIDS Programme ever implemented by your organization?

.....

.....

39. Describe in brief, the success attained in the project mentioned in response to Q. 38.

.....

40. What were the important reasons for the success(es) stated in Q.39?

.....

41. What was the least successful HIV/AIDS programme ever implemented by your organization?

.....

42. What do you think was the **most important factor** responsible for the unimpressive results in your response to Q. 41?

.....

43. Has your organization implemented other programmes not related to HIV/AIDS?
Yes.....No.....

44. If your answer to Q.43 is "Yes", list the programmes.

.....

45. If your answer to Q. 43 is "Yes", how would you compare the communication challenges in these non-HIV/AIDS-related programmes and those related to HIV/AIDS?

.....

46. What top priority recommendation would you suggest in the area of communication for HIV/AIDS programmes?

.....

47. What was the most result-oriented action you took in contextualising your programme?.....

.....

48. State Prevalence Rate (%).....

49. State.....

THANK YOU VERY MUCH

BOLU JOHN FOLAYAN (08023089548)

*APPENDIX II*

## INTERVIEW SCHEDULE CONTENT CATEGORIES

### SECTION I: INFORMATION ON INTERVENTIONISTS

1. Name of Organization_____

2. Registration Status
    1. Registered with CAC and State Action Committee on AIDS
    2. Registered with State Action Committee on AIDS only
    3. Registered with Government Ministry/Local Government/International Organization.
    4. Not registered

3. Key Objectives of Organization
    1. Prevention
    2. Awareness
    3. Testing and Treatment
    4. Counselling
    5. Care and Support
    6. Attitude and Behaviour Change
    7. Education and Research
    8. Capacity Building and Empowerment
    9. Other

4. Mission Statement
    1. Mission relates with objectives and projects carried out
    2. Mission does not relate with objectives and projects carried out
    3. Mission not stateexplicitly stated/does not have Mission Statement

5. Organisation's major programming areas in the past four years
    1. Preventision
    2. Awareness
    3. Testing and Treatment; Care andSupport
    4. Counselling
    5. Attitude and Behaviour Change
    6. Education and Research
    7. Capacity Building and Empowerment
    8. Other

6. Age of the organisation.
    1. Organisation is over 15 years old
    2. Organisation is between 5 and 14 years old
    3. Organisation is less than 5 years old

7. Office Location
    1. Well established office

2. Well established office with branches
3. Office not well established/no business offi

8. Telephone_____

9. Name of Chief Executive Officer_____

10. Staff Strength
    1. Less than 5 members of Staff
    2. Between 5 and 10 members of Staff
    3. Above 10 members of Staff

11. Major sources of funding projects and programmes
    1. Self-funding, including own income generating projects
    2. State Action Committee on AIDS
    3. NACA
    4. International agencies/organisations
    5. Other donors/sources

12. Annual Total Expenditure Staff Roll.
    1. Less than N500,000
    2. Between N500,000 and N1.5 million
    3. Above N1.5 million up to N2.9 million
    4. Between N3million and N5million
    5. Above N5million

13. Relevance of Principal Management /Staff roll/Consultants to communication and HIV/AIDS
    - Has at least 5 relevant specialists except communication specialist on management /staff/consultancy
    - Has at least 5 relevant specialists including communication specialist on management /staff/consultancy
    - Has fewer than 5 specialists without a communication specialist on management /staff/consultancy
    - Has fewer than 5 specialists including a communication specialist on management /staff/consultancy

## SECTION II: PROGRAMMING INFORMATION

14. Dominant method organisation employs in carrying out HIV/AIDS interventions.
    1. Advocacy/Social Construction
    2. Social Marketing
    3. Counselling
    4. Formal Education
    5. Information-Education-Communication
    6. Edutainment
    7. Peer Education
    8. Multiple Response Model
    9. Multiple Response Model
    10. Empowerment/Capacity Building
    11. Traditional Communication
    12. Participatory Communication
    13. Faith-based (Christianity)
    14. Faith-based (Islam)
    15. Other

15. Human Communication Method perceived to be most effective by NGOs
    1. Interpersonal communication in local language only
    2. Interpersonal communication in universal language
    3. Interpersonal communication in local and universal language
    4. Empathy
    5. Communication Skills (context, demonstration, proverbs, songs etc.)
    6. Communication aids

16. Knowledge of current popularly used communication approach(es)
    1. Has very good knowledge of HIV/AIDS communication approaches
    2. Has good knowledge of HIV/AIDS communication approaches
    3. Has poor knowledge of HIV/AIDS communication approaches
    4. Has very poor knowledge of HIV/AIDS communication approaches

17. Approaches found from experience to be most effective
    1. Advocacy
    2. Social Marketing
    3. Counselling
    4. Formal Education\
    5. Information-Education-Communication
    6. Edutainment
    7. Multiple Response Model
    8. Empowerment/Capacity Building
    9. Traditional Communication
    10. Participatory Communication
    11. Faith-based Approach
    12. ACADA
    13. Other
    14. None

18. Communication Materials used for HIV/AIDS programmes
    1. Posters and Handbills

2. Pamplets/Books/Journals
3. Billboards and Banners
4. Communication Equipment such as megaphone, video recorder, Power Point Projector, GSM phone, etc.
5. Radio/TV jingles/Print Advertisement
6. Merchandize
7. Other

19. Engagement of Communication Specialist (as employee or consultant)
1. Yes
2. No

20. Where Item 19 is 'Yes', how communication specialist acquired most knowledge.
1. Formal academic training
2. Seminars, conferences and workshops
3. Reading (books, Internet, tapes, video learning etc.)
4. Other

21. Where Item 19 is 'No', why did the Interventionist not have communication specialist.
1. Cannot afford the fees
2. Cannot (easily) find a communication specialist
3. Does not see a need for a communication specialist
4. Other

22. How Interventionists mostly determine which communication approach(es) to adopt for programme.
1. From experience of management staff
2. Through recommendation of a Communication Specialist
3. Through advise of Donor/Fund agency
4. Context/Situation
5. Does not adopt any particular or elaborate communication approach
6. Other

23. Possession of communication skills by management staff
1. Yes
2. No

24. If the response to Q. 22 is 'Yes', which particular communication skills (best skill possessed)
1. Mastery of target audience's languages
2. Empathy
3. Conversational Management Skill
4. Writing Skills
5. Technical (mass) communication skills, e.g. use of multimedia, etc.
6. Knowledge of communication theories
7. Rich communication practice/experience
8. Other

25. Most-used Source of Information about Target Groups
1. Formal investigation/research
2. Oral interviews/informal interaction
3. Intuition/experience

4. Other

26. Probability of Interventionist using its previous communication approach for future similar programme.
    1. High
    2. Low
    3. Not certain

27. Major reason Interventionist would or would not use its current communication approach
    1. Due to the effectiveness or non-effectiveness of the approach
    2. Due to knowledge of better communication approaches
    3. Based on requirements of donors/regulatory agencies
    4. Due to cost
    5. Other reasons

28. Knowledge and application of any communication theory for programme implementation.
    1. Yes
    2. No

29. Recall of specific communication theories applied, response in Q. 28 is 'Yes'.
    1. Successfully recalled two known communication theories
    2. Successfully recalled three to four communication theories
    3. Successfully recalled over four communication theories

30. Reason for non-application of communication theories, if response in Q.28 is 'No'.
    1. Not aware of the theories
    2. The theories are not/rarely helpful
    3. Other

31. Definition of **communication** in the context of HIV/AIDS programming.
    1. Dissemination of information
    2. Sharing of ideas, values, meanings and knowledge
    3. Persuading people to change their habits/behaviour
    4. No meaningful definition offered

32. Most crucial communication problems and challenges encountered during programming
    1. Lack of adequate fund for communication materials
    2. Cultural barriers such as language, values, beliefs, etc.
    3. Lack of access to the mass media by Interventionists as well as target audience
    4. People not offering truthful information due to lack of trust and stigmatization

## SECTION III: PROBLEMS & CHALLENGES

33. Most crucial programmatic problem
    1. Lack of consistent and adequate funding
    2. Lack of technical support
    3. Stigma/culture-related problems

4. Lack of information database
5. Political interference and influence
6. Accessibility to PLWHA is difficult
7. Economic hardship in the country hardens people from changing
8. Other

34. Solutions recommended for problems in Q 33.
    1. More funding
    2. Training
    3. Technical Support
    4. Exchange Programmes
    5. One or more of 1-5 above

35. Major communication strength of the Interventionist
    1. Ability to win the confidence of target audience
    2. Possession/use of communication tools
    3. Regular sourcing of funds for communication tasks
    4. Skilled communication staff/consultant
    5. No major strength
    6. Other

36. Major communication weakness of the Interventionist
    1. Lack of communication Specialist/Knowledge
    2. Inadequate funds
    3. Difficulty in penetrating cultural barriers
    4. Other

## SECTIN IV: PROGRAMMES EVALUATION

37. How programmes performance is measured
    1. Self assessment using SACA/NACA/donor yardstick
    2. Self assessment of project
    3. 1 & 2 above
    4. No serious performance assessment is made

38. Most successful HIV/AIDS programme ever implemented.
    1. Awareness campaigns
    2. Attitude/Behaviour Change Campaign
    3. Care/Treatment/Support/Counselling
    4. Capacity Building
    5. Workplace Policy/Advocacy

39. Brief description of success attained
    1. (Excellent) Over 90% of goals and objectives attained
    2. (Very Successful) Between 70% - 90% of goals attained
    3. (Successful)Between 50 – 69% of goals attained
    4. (Poor) Between 40 – 49 % of goals attained
    5. (Very Poor) Below 40% of goals attained

40. The most important reason for the success attained in Q. 38.
    1. Good funding/availability of funds
    2. Good technical support
    3. Communication approach
    4. Cooperative attitude of the target audience
    5. Determination and hardwork
    6. Reason not clear
    7. Other reason

41. The least successful HIV/AIDS programme even implemented
    1. Awareness Campaign
    2. Attitude/Behaviour Change Campaign
    3. Care
    4. Capacity Building
    5. Empowerment
    6. Can't Say/Don't Know

42. The most important reason for the failure rate in Q.40.
    1. Cultural barriers such as stigma
    2. Inadequate information/communication about the target audience
    3. Inadequate funding
    4. Communication approach
    5. General paucity of programmatic skills
    6. Cannot say
    7. Other

43. Implemented non-HIV/AIDS projects
    1. Yes
    3. No

44. The nature of programmes if answer in Q.43 is 'Yes'
    1. Training (workshop/conferences, etc.)
    2. Gender issues
    3. Research/Publications
    4. Communication tools production
    5. Small scale business ventures
    6. Fundraising
    7. Civic education

45. Comparison of communication challenges in non-HIV-related programmes, if answer in Q.43 is 'Yes'
    1. HIV/AIDS communication more challenging
    2. HIV/AIDS communication less challenging
    3. The challenges were not significantly different
    4. The challenges were not similar
    5. Can't say

46. Topmost priority recommendation in the area of communication for HIV/AIDS programmes.
    1. More and regular funding
    2. More training in communication skills

3. Engagement of communication specialist
4. Donation/acquisition of communication equipment/materials by SACAs for use of Interventionists
5. Monitoring of State Governments to ensure proper administration of funds meant for HIV/AIDS
6. General empowerment of Interventionists

47. Most significant action adopted to contextualize programme
1. Stopped use of none-user-friendly I-E-C materials
2. Consideration for local environment, such as culture and language
3. Use of PLWHA and local staff
4. Programme not contextualized.

48. State Prevalence rate
1. 0-2.9%
2. 3.0-4.9%
3. 5.0-6.9%
4. 7.0-8.9%
5. 9-10%

49. State (Study Location)
1. Ondo
2. Lagos
3. Cross River
4. Nasarawa

*APPENDIX III*

***TRANSCRIPTS OF FOCUS GROUP DISCUSSIONS***

FOCUS GROUP DISCUSSION
ONDO STATE

Venue: Conference Room, Ministry of Information & Orientation, Akure
Date: April 17, 2008
Time: 11:15 am – 12:07pm

RESEARCHER:
**May I thank all of you distinguished participants for accepting to be part of this discussion despite your very busy schedules. We want to know from those who are directly involved in managing the HIV/AIDS problem the communication challenges regarding the scourge. We are primarily interested in examining how people, interventionists, communicate. How do they handle HIV/AIDS communication? Let's begin by introducing ourselves. My name is Bolu John Folayan. I am a PhD Mass Communication candidate of the University of Lagos. I am also proud to say I am an indigene of Ondo State.**

PARTICIPANTS (INTRODUCTION)

1. **Mr. Edmund Akintunde** (Communication Specialist, ODSACA)
2. **Mrs. C.O. Awe** (Medical Laboratory Scientist/Focal Point Officer [HIV/AIDS], Health Management Board, Akure)
3. **Prince Adesina Aladelusi** (Secretary, NEPHWAN, Ondo State)
4. **Pastor John Adedeji**, (Programme Manager, Better Living Foundation).

DISCUSSION.

RESEARCHER
**Do you think we are making progress in this fight? The national median prevalence rate is 4.0 per cent. Are we making progress generally in this state?**

ADEDEJI
I think we are making progress. But the progress is slow. Those of us on the field that the know that the current level of optimism is exaggerated. But I agree we are making progress.

ALADELUSI
We are on the field. For instance my NGO works in the riverine areas. The level of awareness is very high now unlike what it used to be. Now people know the symptoms to watch out for and what they should do – for instance visit the nearest hospital. But we should not deceive ourselves that the present optimism is exaggerated. People are still having sex unprotected and are having multiple sex-partners. Sex workers are still over the place in Akure and other towns. Getting on the radio and TV will not do much unless we use interpersonal communication.

AKINTUNDE
Let me add that the various interventions that are going on in this state have been yielding positive results. There is a high level of awareness. However, there does not seem to be a shift in attitude and behaviour. That is the big challenge. The reasons people continue to

engage in risky behaviours despite the reality we have been communicating is difficult to understand. Certainly, the pervading level of poverty in the land is a factor. People engage in sex as a way of economic survival either as an outright prostitute or in some other forms of commercial sex in camouflage.

MRS. AWE
There is progress. But the challenges keep coming. We asked people to go for voluntary counselling for example and they are coming up. What happens to them after the screening? Suppose they are now positive, are we prepared to take them on and assist them live a normal life? If we fail to do that, then others will not want to come for testing or want to reveal their statuses.

RESEARCHER
**Do the interventionists have communication skills or proficiency?**

MRS. AWE
Generally speaking I wouldn't say all or most interventionists in Ondo State possess communication skills. It depends. For instance in my place of work, the Ministry of Health, we are more into testing, counselling and treatment. Although we are most medical specialists, we are trained in communication skills through various courses and seminars. But we are not communication experts in the real sense of it. We have specialists. As for the NGOs, from my experience and interaction with quite a number of them, I wouldn't say they have communication skills.

AKINTUNDE
There is a national guideline for training and communication proficiency is part of the skills required for counsellors, especially for attitude and behaviour change. This is an area in which capacity is still very low. What we have found out is that a lot of people are not adhering to the training guidelines. Yes, we do have counsellors who have not been taken through the requirements stipulated in the national guidelines for counsellors and such counsellors would most certainly be deficient in communication skills.

RESEARCHER
**Would you recommend that Interventionists should possess communication skills?**

MRS. AWE
If they are involved in attitude and behaviour change for example, I think they would need to possess communication skills. As a medical laboratory scientist, I am more involved in the medical aspects of managing HIV/AIDS. From the little communication skills that I have I am able conduct my test and communicate effectively with the patient. If the patient is found to be HIV positive, at that point, I bring in the communication specialist, someone who is a professional counsellor. This is what I would recommend for other states.

RESEARCHER
**Does any one of us here disagree with Mrs. Awe on this point?**

AKINTUNDE
I think we all agree. Communication is very basic to HIV/AIDS programming and right now that is the most crucial challenge we face in bringing about attitude and behavioural change, that is building capacity in communication. Even NACA and the World Bank are

emphasizing this area. I think we agree with her that programmers need to possess communications skills (or proficiency as Mr. Folayan called it).

RESEACHER
This panel agrees that we now have a high level of awareness. The problem is moving to attitude and behaviour change. What are the challenges in this area? Let me start by asking the NGOs this question: 'what communication method helped the most in attaining awareness,' Pastor Adedeji.

ADEDEJI
Someone came to talk to us (members of our organisation) a few weeks ago. He was giving us papers, data and so on. I have quite a number of such papers and I may not read them. From our experience, visuals communicate better...better than newspaper and even radio. Showing to them the grim realities of the implication of what they are doing and this would create not only awareness but also caution. Instead of putting the label 'you are liable to die young on a cigarette pack, put the picture of someone suffering from cancer of the lungs on the pack.'

ALADELUSI
I like to add that if we can get people that have HIV/AIDS to come out and speak up and talk to people, it is the best form of awareness. When people see them physically, the impact is tremendous. My wife and I are PLWHAs. We got interested because of our conditions and over the years now, we are alive and doing well. So we felt challenged to educate people. But people like us (organisations like ours) do not get the funds. Sometimes, to go to Obafemi Awolowo University Teaching Hospital, Ile Ife to get our drugs is a problem, not to talk of travelling down to the remote villages to enlighten people. The government and ODSACA know the organisations that are doing the work, but they have to follow the conditions set by those who give them money (the World Bank). If you look at the various conditions that the World Bank stipulates to access their funds, you will just conclude that they are not really ready to help in managing HIV in this country. Until our own individual and corporate citizens come into this problem, the advanced countries will just be using developing countries for their international politics.

RESEARCHER
**Do we all agree with Prince Aladelusi's position on this?**

AKINTUNDE
There is this doctrine of GIPA (Greater Involvement of People with AIDS) in implementing HIV/AIDS programmes. It has helped tremendously. I agree, and I believe my colleagues on this panel do agree. For instance, ODSACA is placed under the Secretary to the State Government. He authorizes everything we do. Funding is mainly for utilities such as vehicles and payment of salaries, not for NGOs. It is true that we see NGOs working so hard...for instance I was with the Executive Director of an NGO yesterday as at 9.30 pm and he was still working. This is an NGO that has only gotten funding once from ODSACA. They source money from wherever they can to keep going. These are the people that need help to move the campaign forward. But in reality, you find out that when the big funds come, political considerations come in and the best or most hardworking never gets the funds.

Mrs. AWE
Yes. I agree. Let us use more PABA. Those who have the disease or have relatives who are suffering from it are a lot more genuinely concerned. Even people that are very well educated think of the HIV/AIDS thing as something that is abstract. But when they come in contact with someone who has the disease they'd say '*waoh*, come and hear about what I saw today...' Such a person has left the realm of theory or textbook to what he or she now sees.

RESEARCHER
**Context. Most communication theories are propounded by western scholars. When you apply them here, they do not seem to be working. In Ondo State here, to what extent is HIV/AIDS communication contextualized?**

AKINTUNDE
It is a fundamental problem which we are addressing. Most of the I-E-Cs that we use is not properly contextualized. Some of them have the pictures of white men. What do you expect people in this environment to think...that it is an *oyibo (white man's)* disease. In the early period of the campaign we did not have local pictures. Now, we do have and use them. We now have some of our I-E-Cs in the local languages. There is still much to be done in this regard. For instance, even though Ondo State is predominantly Yoruba-speaking, we have numerous dialects. There is even Ijaw (Izon) which is not even Yoruba. Communication that is in local dialects generally conveys better meaning, from our experience in ODSACA.

MRS AWE
We do train our counsellors to speak the local dialects during counselling sessions. We go beyond that to also find out about culture and tradition in the area where the person being counselled comes from. And we have found this approach very effective.

RESEARCHER
**How do we now use communication to attain behaviour change?**

ADEDEJI
After contextualizing, we need to be consistent. It is not a one-day thing. It must be continuous and sustained before you can expect to attain behaviour change. That's why we continue to say funding is crucial. I am not a trained communicator. I need to be trained or to hire those who have the skills. In this state there are various dialects even within the Yoruba language. The Ijaws speak a completely different language. To work in Ijaw-speaking areas, I have to hire someone who speaks the local language and who is very good at it...someone who understands the local culture, who knows the taboos, dos and don'ts of the Ijaw people. We really have a lot to do beyond all the noise that prevalence rates are going down.

Mrs. AWE
Behaviour change is almost a life time thing for most people. You are talking of people who have been engaging in a life style...you are not talking of ten years, you are not talking of fifteen years, not even 20 years. Look at the age people experience their first sexual intercourse. You find out that many girls had their first experiences about age 10. Little boys in primary schools are already having sex. When these boys and girls are now in their 20s and having tasted so much of it, you now want to change their attitude and behaviour. It has become their whole way of life. I think one good beginning is to remove the veil that society has placed on sexuality. Talk about it openly. Fathers talking about it to their children. Teachers talking about it to their students. It's not all about NGOs alone. Everybody has to

get involved. For instance, many of our home videos are communicating the wrong values. You see have TV adverts of toothpastes for instance, showing ladies not properly dressed. All these things matter. You cannot be doing this here and it is being countered right there.

RESEARCHER
**Your lines of arguments remind one of the distinction being made by scholars now that 'behaviour modification' is different from 'behaviour change'. They are saying you cannot really talk of behaviour change in the short run. What you have at best in the short run is *behaviour modification*...**

AKINTUNDE
Yes. Let me remind you of one of the reasons for the stigmatization that has become a big problem today. It has to do with the wrong tactical communication approach at the on-set of the campaign when skulls and skeletons were used as symbols of HIV/AIDS. So when people saw anyone positive, they put on their shoes and ran away. Yet, from my experience as a communication specialist, I would say the best approach is a combination of both. Why I say this is this: there is complacency now. People may ask you 'how people have died', 'HIV does not kill' so there is complacency. People now suggest that there should be a combination of fear and love.

Mrs. AWE
When you create an atmosphere of fear and you do not back it with the right actions, the change in behaviour would be usually short-lived. In those days, many parents used to warn their little girls that if they sat besides a man, they would get pregnant. This instilled fear in the girls but the very day they sat by a man (may be by mistake or deliberately) and they did not get pregnant, the fear evaporates and you have problem on your hand. That would open the door to many other things. The proper information that should have been passed across to the girl was, 'if you attain a reproductive age and you have sexual intercourse with a man, you would become pregnant, and when you become pregnant, this and this is the implication.' You need to give *information* not *fear*. If we are to attain behavioural change with regard to HIV, we cannot run away from the concept of 'strong will'. The parents for instance can build a strong will to take on a particular life style in their children at the early stage. They can do this by offering the children important, helpful information. They are a thousand and one contending information out there that would tell the child that what daddy said was not right. Let him or her find out as he or she encounters these contending forces that daddy was right. You build this strong will, you don't give it.

Even though people on the field may not give the approach they use a particular name, they use these approaches in isolation or in combination all the same. I read a study in which the faith-based approach is reported to have produced outstanding result in Plateau State for instance. What is the dominant approach in Ondo State?

ADEDEJI
We may not be able to say that this approach is dominant or that is less dominant. But I can assert that the religious approach (which you referred to as the faith-based approach) is working effectively in terms of behavioural change. Interestingly, it has been producing good results in both Christianity and Islam. We work together. Formal education is not dominant here but in the few cases where empowerment has been used, we have seen good results. I-E-C is also helping because whatever approach you use, you need to give out *information* in a professional way.

RESEARCHER
We have talked about fear and its limitations in bringing about lasting change. How about *force*? For instance, if we make testing compulsory, we might be able to capture quite a lot of people out there who are living with HIV/AIDS and are causing much damage unwittingly...

Mrs. AWE
May I tell you that even for those who come voluntarily...it's not all of them that are well taken care of after the test? So, it is not just about you coming up so we cannot know your status. It is about you *not spreading the virus*. The goal is about not letting this virus spread and if you want to let that happen, you need to make people change their behaviours. You cannot change people's behaviours without engaging the will of people. You cannot engage their will by enforcing them. I remember when I was young. Occasionally, my father had reasons to beat me but before he did, he would tell me, this and this are what you had done wrong and for that reason I must beat you. He was simply engaging my will to accept that punishment. I now reasoned that it was not because my father did not love me that he beat me. If he had not done that (engaged my will) I would probably have believed that he was just punishing me...change, change, change. At the end of the day, you have a rebellious child. If you use force and don't engage people's will, they might be deviant: why must it be me alone that would die of AIDS. Let me spread it.

ADEDEJI
It is already happening. People who are positive go to other states where their statuses are not known and they spread the disease.

RESEARCHER
**From my experiences in the course of this research in other states, many of these NGOs that are relied upon to do the interventions are not on ground. They operate from their living rooms. What can be done to support these Interventionists to do the work more effectively?**

AKINTUNDE
The response from the corporate sector in Nigeria to the HIV/AIDS problem has been poor. There is very little you can do without funds. You have banks and other corporate bodies making billions of naira from the community giving back little or nothing to the society. We also need to look at the issue of people who run NGOs. In this state, we have some NGOs that are very committed...they are doing the work. I was in the office of one Executive Director of an NGO as at 9.30 pm yesterday; people were still working in the office. But because of the poverty in the country, we have scores of others whose briefcases are their offices. We derogatorily call them Non Governmental Individuals. The problem is that these serious NGOs do not get the funds. Government is playing its role but this needs to be complemented by the private sector. We need to have foundations. Apart from the World Bank and a few international organisations, you don't get funding for HIV/AIDS programming in this country. To access funds from the World Bank, you have to meet their criteria. In many cases, many of these small, serious NGOs don't meet these stringent criteria. But if we have indigenous foundations with minimal requirements, they can fill the gaps. Government needs to do more. But the NGOs too need to get their acts together. They need to focus on their area of core competence. Some of these NGOs...they are into empowerment, reproductive campaign, rural development, gender, HIV/AIDS, cancer, everything.

Mrs. AWE

The NGOs are trying but you know the poverty level is high. Quite a lot of people are into HIV/AIDS programming because they have found there are lots of funds there; let's put our pipes there and let's drain something. For the ones that are really working, they need further support. Unfortunately, the way we appreciate our rich men in this society is defective...including what we appreciate them for. When people are rich in this environment, we don't ask them what they put back to the society. We should encourage more philanthropists. We have people in this country that say they are third or thirtieth richest man in the world. For God's sake, what are they doing about making the society better? We have corporate organisations netting billions after tax in their annual reports published in the newspapers, what are they putting back to society?

ADEDEJI

The NGOs too have their own problems. The people who are not doing the job are getting the funds. The government and donors must separate the wheat or grain from the shaft. I am a member of the executive committee of NGOs into HIV/AIDS programming in this state. It is when the World Bank is coming that you see these NGOs. Otherwise they are non-existent.

RESEARCHER

**Thank you ladies and gentlemen. Before we round off this discussion, let me summarize what we have said in this wonderful discussion:**

- **We have attained a high level of awareness in Ondo State but attitude change is still a big problem.**
- **There is need for consistent funding**
- **Communication skills and other technical skills must be imparted in NGOs and other programmers**
- **Attitude and behaviour change require more painstaking approaches and we should not get carried away with drops in prevalence nationwide and go to sleep. We are at the most critical stage now: changing attitude and behaviour.**
- **Interventionists need to more serious and prove their worth so that they can get the necessary support. HIV/AIDS programming should not be seen as another way to make easy money.**
- **Political considerations or contacts-in-government is a key factor in getting funds; this should not be the case. Organisations which are doing the work should get the funds.**
- **The criteria set by major donors such as World Banks for NGOs are unrealistic and too pro-government. They should identify those doing the work and deal with them directly rather than work entirely through government.**

**I believe the aforesaid represent the consensus during this discussion. I thank you very sincerely for your informed contributions to this FGD. God bless you all.**

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## FOCUS GROUP DISCUSSION
## LAGOS STATE

**Venue:** Oyo Hall, Lagos Airport Hotel, Ikeja.
**Date:** August 13, 2008
**Time:** 11:15 am – 12:10am

RESEARCHER:
**My name is Bolu John Folayan. I am a PhD Mass Communication candidate of the University of Lagos. As you are aware through the letters of invitation, I am doing a study on *HIV Communication Approaches in Four Nigerian States – Lagos here, Ondo, Nasarawa and Cross River States.* I like to thank you, distinguished lady and gentlemen for accepting to be part of this discussion despite your very busy schedules. We want to know from those who are directly involved in managing the HIV/AIDS problem the communication challenges regarding the scourge in this state. We are primarily interested in examining how people, interventionists, communicate. How do they handle HIV/AIDS communication? Please be assured that you are giving this information in confidence and in your individual capacities, not on behalf of the organisations you represent. Let's begin by introducing ourselves.**

PARTICIPANTS (INTRODUCTION)
1. **Dr. Olusegun Ogboye** (Head of Projects, LSACA)
2. **Dr. Paul Akintelure** (Medical Director, Broad Hospital, Ikotun, Lagos)
3. **Mrs. Nike Alaka** (Executive Secretary, Women Against AIDS International, WAASI)
4. **Mr. Yomi Opakunle (CEO, KEEM Communications Ltd).**

RESEARCHER
**Permit me to start by asking Dr. Ogboye the secret behind the reduction in the prevalence rate in Lagos from 2003 to 2005. The population of Lagos is huge and intimidating. It is a border state and the mouth of trans-border operations in West Africa. What magic produced the drop in prevalence rates?**

OJOYE
Well (*laughs*), there is no magic at all. I will attribute the encouraging results to good funding and good organisation. We started HIV/AIDS programming early. I think after NACA, Lagos was one of the first states to have its State Action Committee on HIV/AIDS in place. Now, we have been upgraded into an agency. We built an organisational system which attached the scourge from multiple angles. We capitalised on the high presence of business corporations to stimulate the formation of Private Sector Organisation involvement and subsequent establishment of various workplace programmes. We enumerated the NGOs in the state into HIV/AIDS programming and we identified those actively on the field and gave them good support. The state government gave us good support in terms of funding. We have operated strictly as professionals. Our CEO reports directly to the governor of the state and we take decisions professionally. I think those are the principal reasons why we have got encouraging results in the past few years.

RESEARCHER
**You would not say the success has been due to various communication approaches employed by NGOs, PSOs, FBOs that have been working with you?**

OGBOYE
Communication approach is certainly a factor. It depends on the particular interventions you are referring to. While I would not consider communication approach a top priority in testing and counselling for instance, I would consider it so for awareness and attitude change. For organisations working with us in awareness and attitude change, the number criteria is ability in terms of communication. For Care and Support, we will look at technical expertise and facilities available. Certainly, communication skills are a factor, but not the critical factor in all situations.

OPAKUNLE
As you know, Lagos in the media hub of the nation. Seventy per cent of the leading mass media institutions in Nigeria are located in Lagos. Then, Lagos is largely cosmopolitan; most people have access to one mass communication medium or the other – be it telephone handset, TV, radio, newspaper, and so on. All of these have helped to create the necessary awareness. This is just to complement what Dr. Ogboye just explained.

RESEARCHER
**In other words, we are saying communication approach has been an important instrument in the reduction of HIV/AIDS incidence in Lagos State.**

OPAKUNLE
Exactly. Communication approach and existence of communication infrastructure.

RESEARCHER
**How would you describe the communication competence of organisations handling HIV/AIDS programmes in the State?**

OGBOYE
Good. There was a baseline study in 2001 with funding from Family Health International. It convered almost all the LGAs in the state. One of the principal findings of that study was that most of the NGOs running HIV/AIDS programmes in the state did not have the necessary communication skills. So we made it a pre-requisite for prospective partners with LSACA, that is, they must have communication competence. Since that time, we have made it compulsory that if you want to do programmes with us, especially if it has to do with prevention, education and awareness, even attitude change, you have to show us that you possess necessary communcation competence. It has helped tremendously. When you use the right approach, you spend less. For instance, if you are skilled in communication, instead of running full page advertisements in two national dailies at the cost of almost a million naira, you can use half of that money to do a Focus Group Discussion, just like you are doing. It depends on what you want to achieve.

RESEARCHER
**Would you say that communication played a significant role in helping to reduce prevalence rates in Lagos State.**

Mrs. ALAKA

Yes, of course from what distinguished panelists have stated so far and from what I know. But when we talk of role of communication in terms of contributions to success, I hope we know that we are talking from the holistic view point. What I mean is that we are not

attributing the reduction in prevalence rates to the efforts of NGOs alone. There are several other health institutions in Lagos State – health centres, general hospitals, specialist hospitals, even private sector organisations. Even LSACA carries out direct interventions on its own But we agree that all of these organisations or institutions could not have succeeded this much without having good knowledge of communication approaches or techniques. Coming to NGOs, I am aware that there are over 150 NGOs registered with the LSACA in the area of HIV/AIDS programming. I do not think all of them have communication competence or that they have knowledge of the right approaches. Those who work with LSACA however possess this communication skill because (and as Dr. Ogboye has said) this is a condition you have to meet to get technical and financial assistance of LSACA. The organisation to which I belong, an NGO has benefitted from several communication capacity building trainings by LSACA and other training institutions and I want to say it has made a big difference in the way we design and implement our programmes. Overall, I want to say that communication has played a significant role in helping to reduce prevalence rates in Lagos State.

AKINTELURE

When Mrs. Alaka was mentioning the role of institutions and organisations, she did not mention private hospitals. This is one area that I know has helped the fight against HIV/AIDS in Lagos State. Well over half of Lagosians who attend hospitals, go to private hospitals. So, there is no way you can talk of meaningful interventions in the sphere of clinical services without factoring in private hospitals. Private hospitals do quite much more than diagnosing, treatment and counselling. They do a lot of prevention and awareness programmes. In core communication areas such as persuasion and attitude change, doctors in private hospitals have a big role to play. For instance, a medical doctor spends quality time talking with his or her patient – advising him or her, warning him or her and so on. If the doctor knows the relevant communication techniques, he would be more effective in counselling people or making people to change habits or behaviours. Let me share an experience that I had. There is a lady that I knew to be very promiscuous (she is one of my patients). This lady told me confidently that she did not like the use of condoms and that he trusted the people that she went out with. I tried to explain that it was wrong of her to trust people just like that and that she loses nothing by insisting on the use of condom. She would never agree with me. Recently, I attended a communication workshop on techniques for attitude change (for doctors and nurses). I got to know various techniques such as peer group, I-E-C, participatory communication, fear appeals, and so on. I decided to use the fear appeals theory for her. I gave her a DVD on how an 18-year-old ruined here own life through unprotected sex. This was no drama. She was scared stiff. She repented immediately and I have been following here up since. So, you see, even doctors have a lot to learn in terms of communication competence. Let me say that I see potentials in this state in the area of networking between NGOs and private sector hospitals. LSACA needs to sort out the comparative strength of the various NGOs. You can have those who specialize in peer group, others may specialise in counselling. We the medical people will now access these specialists through the LSACA. I do not need to be an expert in communication. In medical practice, even in HIV/AIDS, we have specializations. So, where will I get the time to begin another course in communication? But if these experts are there, we can use them. They can also train us to handle little things...simple communication techniques. In the Lagos University Teaching Hospital, Idi Araba, trainee doctors and resident doctors take courses in health communication for example. But that does not make them the experts. In summary, as it is today in Lagos State, you still have NGOs who are jacks of all trades. They do all manners of programming once there is fund to access. It is not right. Even NGOs made up of communication professionals need to specialize. Experience counts when you are talking of attitude change. I am a medical doctor for instance. I treat eye problems and take deliveries

of babies. But I know there is a point when I have to refer a case to an ophthalmologist (eye specialist) or a gyneacologist (reproductive expert). If you have that in the communication field, then I have not seen it being applied in Lagos State.

RESEARCHER

**Dr. Ogboye, to what extent would you say interventionists in the state contextualize their programmes**

OGBOYE

To a reasonable extent, I would say yes. There are limitations. You have to reach a large number of people who are heterogeneous. Almost all of the over 300 ethnic groups that make up Nigeria are resident in large numbers in Lagos State. Lagos State itself has a large number of people who reside in rural areas. So, there is a limit to how you can vary, for instance, your advertisements or handbills to address small groups. It is more costly to do that. Nonetheless, most of the interventionists know that they must address local contingencies to be effective. Perhaps because awareness does not require so much of context (at least when compared to attitude change campaigns), we have not really played up context. But now that we are looking at behaviour change, context must be taken into consideration.

Mrs. ALAKA

I think that for smaller interventions, context is not a big problem. If you are doing an intervention amongst secondary school students in a Somolu local government for example, you will automatically contextualize the programme because of that small size. You know the language, the culture, the locations of the schools, the kinds of homes they mostly come from and you can design your programmes. But consider a situation when that programme covers the entire state, how do you address the local conditions or local variations...because you cannot treat all secondary school students in Lagos State as one homogenous audience. Students in Victoria Island and Ajah cannot be compared to those in Idimu or Bariga. On this issue of context, my advice is that we should learn from the successes of organisations such as Family Health International, FHI which has recorded quite a good number of success stories across various countries. When you look at the success stories, you will find out they are small, specific interventions. But here, we attempt to do very big projects. Donors want you to cover very large areas...

RESEARCHER

**But there is the problem of 'scaling up'. How do you reproduce the success on a larger scale?**

OPAKUNLE

Once we know what works and the conditions in which they work, we will be able to know how to replicate successes. I think we need studies in that area – one of such studies being done by Mr. Folayan. It we know what works in small interventions; we can carefully adopt or adapt it for larger segments or problems.

RESEARCHER

**What have been the major challenges being faced by interventionists in Lagos State in the past few years?**

Mrs. ALAKA

I think it is in the area of capacity building or empowerment. Funding is still a problem but I believe with empowerment programmes, funding will not be a problem. NGOs should not look up to international organisations and the LSACA for funding – at least not for the bulk of their fund needs. My own view of empowerment is not going around begging for funds.

My understanding of empowerment is to teach the NGOs how to fish rather than give them fish and they would be able to generate their funds. LSACA should spend what it gets from the government and World Bank on this area such that we can have over 1,000 organisations empowered. When these 1,000 organisations can fend for themselves, they go to the nooks and crannies of the state doing one intervention or the other, the entire state is covered. LSACA has no business doing direct interventions.

RESEARCHER

**How can an organisation working with prostitutes be empowered to generate funds...I think it may not be as easy as Mrs. Alaka is suggesting.**

OGBOYE

I think it can be done. What she is saying (which I totally agree with) is that we can teach these organisations to have programmatic skills, including the capacity to generate funds. To answer your question, an organisation working with prostitutes can be taught how to source funds from private companies and philanthropists. How you convince such potential donors? How do you make your presentation persuasive? How do you link up with the organisations? I can recall such an organisation that we had given funds of up to N2 million and that was the only programme it ever did. Many of such organisations remain dormant for years. But if they are taught to take care of funds and other programmatic skills and we still follow them up, I mean backing them up from time to time, they will be on their own.

OPAKUNLE

For instance, that NGO can organise the prostitutes into cooperative society or union, get probably a corporate body to buy sewing machines and train them to make clothes. By the time they graduate, they have already gotten a volunteer to set them up from within the local community. LSACA can help members of the association source patronage. For instance, they can make school uniforms for Lagos State pupils and make good money. I think this is how it should be, not NGOs applying all the time to LSACA to get World Bank funds.

AKINTELURE

I keep saying this: until Nigerians get into NGO business with sincere heart and out of sincere compassion, they will continue to talk about funds. The problem is in building capacity not in funds to do programmes. Funds made available by government should be for building capacity in this area. As Mrs. Alaka said, let us teach people to fish rather than give them fish to eat.

RESEARCHER

**Dr. Ogboye, any conclusive remarks from you?**

OGBOYE

Well, my colleagues on the panel have said it all. I may only add that the response from the private sector in Nigeria regarding HIV and other health problems is poor. May be response to malaria has been encouraging but HIV and cancer have not gotten the expected backing. It is too bad. These things should be part of Corporate Social Responsibility of companies. I am not talking of huge sums of money...as we have said; even little funds go a long way to help these NGOs. What stops a local bank operating in an area to pay the monthly salary of two members of staff of an NGO doing HIV awareness in that locality? Probably that will not be more than N50,000 every month. The organisation benefits. The society benefits. Everyone benefits from that N50,000. But the NGOs too need to get their acts together. If they are doing the task very well, getting funds will be a lot easier.

OPAKUNLE

With apology to Mrs. Alaka here, I want to say that the average HIV NGO in Nigeria is into it because there is money. You find people say 'why don't you float an NGO on AIDS, that's where the money is now'. When I wanted to set up an NGO with some friends on street football a few years back, many of my friends suggested that I go into HIV and democratic governance...that money is in it. That's the point at which we missed it. My passion is for saving young lads who have football talents from the streets, why must I go into HIV/AIDS because of money. LSACA has to do some sanity work. But I agree that it needs NGOs, FBOs, churches and other organisations to do the work.

RESEARCHER

**Dr. Akintelure...any final remarks by way of conclusion?**

AKINTELURE

None really. Everything is well-said. But let me explain that some areas of programming may not readily attract funding. For instance, getting drugs for PLWHAs, and...

RESEARCHER

**I think it all depends on creative capacity building. If we localize and contextualize our programmes, that (getting funds for drugs) can be done. I can get a local Chief or owner of the local Nursery and Primary School to adopt a PLWHA and sponsor their drugs for a month. That probably will cost just N5,000:00k. It is when we are looking for millions of naira that we run into problems. (*Panelists agree with the researcher on this point).* I will then, go ahead to summarize the key points of this discussion:**

- **In Lagos State, funding is still a critical success factor but not as much as technical skills and programmatic competence of NGOs.**
- **The right communication approach will produce better results in terms of set goals and it will also save funds.**
- **Good, deliberate efforts were made by LSACA and interventionists working with them to contextualize their programmes.**
- **Prevalence rates in Lagos are dropping in Lagos State due to largely multiple response (medical, social, economic, communication) and it is certain that communication is not solely responsible for the drops.**
- **The use of multiple approaches (involvement of all sectors and stakeholders) is largely responsible for the encouraging results from Lagos.**
- **Small-scale interventions that could be replicated on larger scales should be encouraged.**
- **Interventionists should be sincerely and genuinely interested in the HIV problem to create the tonic to drive programmes.**

MRS. ALAKA

And that LSACA should encourage specialization among NGOs and other interventionists to bring about expertise. Interventionists should be properly focused and over a period of time, they will become well-known in that area of strength. Jacks of all trades become masters of no trade.

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## FOCUS GROUP DISCUSSION
## CROSS RIVER STATE

**Venue:** Conference Room, CRSACA, Calabar.
**Date:** August 16, 2008
**Time:** 1:30 am – 2.10pm

RESEARCHER:
**My name is Bolu John Folayan. I am a PhD Mass Communication candidate of the University of Lagos. With me is Mr. Ayo Adedokun, my research assistant. I like to thank you, distinguished lady and gentlemen for accepting to be part of this discussion despite your very busy schedules. We are primarily interested in examining how people, interventionists, communicate in the management of HIV/AIDS. How do they handle HIV/AIDS communication? You are featuring in this discussion purely in individual capacity, not on behalf of the organisations you work for. Let's begin by introducing ourselves.**

INTRODUCTION
Martins Akpan *(Monitoring and Evaluation Officer, CRSACA)*
Dr. Ufot E. Bassey *(Medical Officer, Ministry of Health, Calabar)*
Miss Kate Amaechi *(Mobilisation Officer, Cross River State NYSC HIV/AIDS Team 2008)*
Mrs. Victoria Udoh *(Executive Director, Civil Society Coalition Against AIDS)*

RESEARCHER
**May we begin by taking an overview of the situation in Cross River State, regarding the HIV/AIDS? Are we succeeding in taming the scourge...Dr. Bassey?**

BASSEY
\Generally, I will say 'yes'. But that 'yes' will have more meaning when we break it down into various areas. In terms of awareness, there is no doubt that things have improved tremendously. People now know what causes HIV/AIDS and how it may be contacted. In the sphere of epidemiology, success has not been outstanding. The prevalence in this state in 1999 was 5.8% This increased to 8.0% in 2001 and by 2003, it had hit 12.0%. But by 2005, the figure dropped to 6.1%. That was very significant. Now, when you look at regional variations within the state, some areas have higher prevalence than the state average. Interestingly (may be unlike in other states) rural areas have higher prevalence here. Akampka for instance, has 8.0% prevalence rate which is higher than the state average. Last year (2007), more people were pre-counseled but less number of people eventually went for HIV test. Last year also, there was an increase in the rate of infection, compared to 2006. But overall, there was improvement. In terms of attitude and behaviour change, I don't have the facts. But when we look at individual reports of NGOs, World Bank/NACA evaluation exercises and reports of key partners, we can say there has also been some progress.

RESEARCHER
**Thank you for that detailed and factual assessment. Mr. Akpan, to what extent would you attribute the results to the efforts of interventionists such as CBOs, FBOs, NGOs, CSOs in the state?**

AKPAN
Basically, HIV/AIDS field activities in Cross River are driven by private local and international non-governmental organisations (whether they are faith-based organisations or community based organisations, and so on.) CRSACA does essentially a coordinating job. We have a Technical Working Group that coordinates funding and strengthening of activities in the various ministries, LACA and support groups. We have a State Coordination Structure consisting of the CRSACA, LACAs, Networks of CSOs and NEPWHAN. So, there is team work. In that sense, I will say interventionists have contributed tremendously to the achievements we have had so far. CRSACA does not engage in direct interventions so it was the NGOS that did the field work in most cases.

RESEARCHER
**Between 2003 and 2007, what was the relationship between communication approaches deployed by these organisations Cross River and the outcome of their interventions?**

UDOH
I think Cross River's high prevalence in 2003 has turned out to be a blessing in disguise. This was what gave the state a national attention such that NACA and the World Bank were forced to look this side. This led to increased funding and numerous NGOs got a lease of life in their activities. Having said that, let me point out that in Cross River State, the interventionists are organised – from the local government level to the state level. We have the HIV/AIDS Network comprising of CRS Civil Society Coalition, CRS NEPWHAN, Interfaith Coalition, CRINET and so on. All of these organisations have key partners. One of the first things the partners did to help us (NGOs) was to build capacity. We have had various kinds of training in various areas of HIV/AIDS programming – from communication (which the researcher is interested in) to accounting, monitoring and evaluation. This helped us to know which communications approaches were suitable for various situations. Is it awareness you want to build? It is not a matter of buying space on the local TV. You have to find out if the people you want to reach do watch TV, have TV and whether TV as a medium could actually help to persuade them to adopt your recommended behaviour. You then have to consider other communication options, probably based on how much you have to spend. We were taught these things several years ago. So, I will say communication approaches are vital in terms of what comes out of the efforts we are making. In fact, communication is the heart of HIV/AIDS intervention; money is the soul.

AMAECHI
We cannot talk to or talk with an elderly person the way we talk to a young person or a kid. We continue to say youths are the most vulnerable, but why are we not reaching the youths? Part of the reason [why HIV/AIDS interventions fail] is that we are not negotiating with the youths. We are not engaging their will by working in partnership with them. That's where the mistake lies. We want to see things from our view point but we don't want to see things from their view points. That's why partnership is being recommended. The importance of diagnosis is important before you treat an ailment. If a medical doctor makes the right diagnosis and applies the wrong drugs, the patient cannot get healed. And sometimes when a doctor prescribes drugs, he or she talks with the patient on how to ensure that he or she takes the drugs. That is the right approach. It really matters.

RESEARCHER

**From our various experiences and facts available, can we say Interventionists in this state have communication proficiency? I mean, can we say they possess communication skills that are vital or necessary to make their interventions succeed?**

AKPAN

I can say without mincing word that a majority of the NGOs in Cross River working with CRSACA have communication proficiency. Like Mrs. Udoh said, a top priority of CRSACA has been capacity building. We are not yet there but we have achieved a lot through capacity building. You see, people who get into HIV/AIDS programming have very wide and varied backgrounds. Some of them are medical doctors. Some are journalists. Some are activists. Many were pastors who got into the whole thing on the leading of the Holy Spirit. There is therefore a need to impart knowledge, relevant knowledge that could enhance their performance. It is not only in the area of communication that capacity building is important. We have found that it is also important in project monitoring and evaluation. Even in financial management, and so on.

BASSEY

HIV/AIDS is one monster of a problem that you cannot succeed at unless you are kept abreast of latest developments in the field. Even those of us in the medical line, we have to continue to update our knowledge. Now, we have ARVs (anti-retroviral drugs). We didn't have it several years back. That development, for instance, has implication on what we communicate or on how we counsel patients. That has helped to allay their fears that once you contact the virus, you will die. But then, if you give people the impression that with condom and retroviral drugs they are safe, then they will increase their careless lifestyle. This is why communication skills are important. I recall clearly one of the first campaigns we did many years ago. I think the headline was something like *AIDS is real, use a condom.* We found out that people got the wrong message from that theme. Instead of reducing promiscuity, they increased it because condom is there. In the next campaign, our communication people had to adjust it to *AIDS is real, be faithful to your partner...but if you can't be faithful, please use a condom*...I am not sure of the exact wordings but it was something like that. And this really helped.

RESEARCHER

**How is the funding situation in Cross River? In other states where I did this kind of discussion, lack of consistent funding was seen as a major handicap. What is the situation here?**

BASSEY

Every intervention requires funds. I have not found anything in life that does not require fund. In that sense, I would say funding is necessary in HIV/AIDS programming. You are talking of monitoring and evaluation, VCT,OVC, PPTCT, training, etc., in all eighteen local government areas across difficult terrain. My brother, it costs money. But let me say that the issue of funding is not so acute in Cross River. Through capacity building, more NGOs have learnt to initiate ways to creatively get funds and sustain their programmes. And we were lucky for being one of the states under the focus of NACA and the World Bank in the past few years. That attracted good funding. At the moment, donor organisations such as Family Health International, GHAIN, ICAP Columbia University, MTN Foundation, UNAIDS, Hope World Wide Nigeria, Society for Family Health, UNDP, UNICEP and many private sector organisations are sponsoring various interventions across the state. The State

Government too has been forthcoming. So, I will say there is room for improvement but the situation is not very critical.

RESEARCHER
**I don't think Mrs. Udoh and Kate will agree with that...**

UDOH
I agree with what Dr. Bassey has said. Like Oliver Twist, we ask for more [funds] but a serious NGO, which has done its diligence and shows serious commitment will certainly get reasonable funding. I am not speaking for NGOs in other states and those not serious-minded.

AMAECHI
Even we who are youth corps members were able to get some funding for our activities. It is a matter of knowing what you want to do and convincing people who share you dream to support you. NGOs should not just sit down and expect funds to come to them.

RESEARCHER
**I know that in Cross River, you have moved further from awareness to attitude and behaviour change communication. This is where the big challenge lies, according to experts. How has it been?**

AKPAN
Rather than say funding is the biggest problem that we face or which Interventionists face, I would say the greatest challenge is in attaining attitude and behaviour change. In Cross River, we have so many ethnic groups, so many languages and they occur in isolated communities separated by distance. There is trans-border influence. There is poverty. You are in a community where someone entertains a guest with her daughter, i.e. offers her to satisfy the sexual pleasure of an important guest. Consider another community in which keeping virginity is considered a taboo for a young girl. You need more than putting advertisements on radio or TV to bring about change in that kind of society. And this is the situation we face in Cross River. Without engaging the will of the entire society, I am afraid; we will not be able to do much. That's why we are strongly recommending participatory communication approaches to NGOs working with us. They way forward is to teach the Interventionists the best practices world wide in attaining attitude and behaviour change.

RESEARCHER
**But the best practices worldwide may not work in Cross River...**

AKPAN
Yes, I was going to add that these best practices must be re-designed to fit the local context. We have found that the more you put an intervention in context (make it have relevance to the people's particular circumstances and situations), the better results we will get.

UDOH
People say the theories are not working. I disagree.

RESEARCHER
**What are the general programmatic problems being faced by programmers in the state?**

AKPAN
We have mentioned them in the course of the discussion – basically culture or the problem of contextualization of programmes, funding and sustainability of present achievements.

RESEARCHER
Thank you very much. May I now summarize our key points in this FGD?

- We said we have made good progress in curtailing HIV/AIDS and caring to PLWHA in the state.
- That this success could be attributed partly to the efforts of NGOs and other organisations and partly to other interventions not carried out by NGOs such as Ministry of Health, Women Affairs, etc.
- That knowledge of communication approaches or access to them is very vital for HIV/AIDS programming.
- Engaging the will of the audience and empathizing with them will enhance the success of interventions.
- That self-efficacy should be emphasized in building capacity for Interventionists.

Thank you and God bless.

## FOCUS GROUP DISCUSSION
## NASARAWA STATE

**Venue:** Conference Room, Mosmera Hotel, Lafia.
**Date:** May 23, 2008
**Time:** 3:15 am – 4:30pm

RESEARCHER:
**I like to thank you, distinguished lady and gentlemen for accepting to be part of this discussion despite your very busy schedules. We want to know from those who are directly involved in managing the HIV/AIDS problem the communication challenges regarding the scourge in this state. We are primarily interested in examining how people, interventionists, communicate. How do they handle HIV/AIDS communication? Let's begin by introducing ourselves. My name is Bolu John Folayan. I am a PhD Mass Communication candidate of the University of Lagos.**

PARTICIPANTS (INTRODUCTION)

1. **Mr. Daniel Sagbeda** (Head of Monitoring and Evaluation, NASACA)
2. **Dr. Mohammed Ibrahim** (Medical Doctor, Health Management Board, Lafia)
3. **Alhaji Hassan Lawal** (Secretary, NASFAT, Lafia Zone)
4. **Mr. Labaran Solomon-Apeh,** (Secretary, Nigeria Union of Journalists, Nasarawa State).

DISCUSSION

RESEARCHER
**Let us begin this discussion by taking an overview of the HIV/AIDS campaign generally. Nasarawa in particular has been a focal point because of the very high incidence according to the 2003 sero-prevalence survey. Where are we now? Are we progressing in the combat against this scourge?**

IBRAHIM
I will answer that question affirmatively, yes. When you consider the fact that Nasarawa is a trans-boundary region...especially Lafia here, Akwanga and Mararaba near the FCT...you will appreciate the fact that we have made tremendously progress. In terms of awareness, quite a lot more people are aware of the disease, how one can contact it and so on. That to me, is progress. Then, people are more receptive in terms of the social marketing efforts. Quite a lot more people now use condoms unlike before. Commercial sex workers have found their ways out of the state, although not completely. I think, generally, we have made good progress given the extent of the situation and the acute problem of funding.

RESEARCHER
**What of in the area of attitude change and behaviour change?**

SAGBEDA
As you know, attitude change and behaviour change is an entirely different thing. With the mass media and good interpersonal communication, one can easily attain a satisfactory level of awareness but people do not change their attitudes that easily. There are a lot of pre-conditions you have to meet. The problem is religion is there. I met a young man few days ago who told me point blank that using condom was against his religion. And he was very

serious about this. The average Nigerian is very religious or we pretend to be so. If you we do not look at people's deep-seated attitudes and work through that, we might not be able to do much in behaviour change. In terms of progress, I will just say we have made steady progress in bringing about attitude and behaviour change in Nasarawa State. If less people now line the streets as call girls and more and more young adults use condoms, for instance, like Dr. Ibrahim said, then attitude is changing. Behaviour is a continuum and if I look back three years, looking at the point where we started – a crisis situation if you recall – then we have made good progress.

LAWAL
In this part of the world, culture and religion are very important in making the people do or don't do certain things. Nasarawa State has over 15 different ethnic groups with different languages, ways of life, and so on. Christianity and Islam are the most common religions and we cannot pretend that the traditionalists are not there. What we do at NASFAT is to use Quoranic precepts and injunctions to communicate with people. This has been very effective in persuading the people on this HIV/AIDS issue. Islam is completely against promiscuity and infidelity and if these two behaviours are curtailed, we automatically curtain the chances of infection through multiple partners. Rather than be promiscuous, you are allowed under Islam to take at most four wives once you meet the conditions for it. The approach of religious faith enables us to use 'fear appeal' without necessarily scaring people. If you tell you AIDS kills or that if they are promiscuous, they could die young, it hardly discourages them. But if you bring out the religious implications, they readily tune in to you.

RESEARCHER
**Do the interventionists have communication skills or proficiency?**

IBRAHIM
It depends on the particular interventionist. For instance, I am a medical doctor who has been working with PLWHA and PABA for several years now. I do quite a lot of counselling. Sometimes, my job is entirely counselling. You can imagine the burden of having to tell a couple that they HIV-positive. It is as if their world has ended! Your communication skills can help in this situation. So I subscribe to the view that interventionists must have good communication skills. What I was trying to say is that the kind of programming you are into will determine your kind of communication orientation. If you want to do massive awareness, you will require working with professional mass communication specialists, if you are not one.

RESEARCHER
**What would you say is the most important success factor regarding HIV/AIDS programming in this state?**

LAWAL
Funding. Money solves a multitude of problems, so says the Holy Quoran. And I know it is in the Holy Bible. My organisation, NASFAT has a network that covers all the nooks and crannies of this state and even nationwide. We are in contact with the people at individual, family and small group levels (who are Muslims), which is why you get the best results. But where is the money to work? The World Bank gives all the money to the State Government to distribute to NGOs. At that level, politics enter into it. Governor's wives, commissioners' wives and local government wives hurriedly set up NGOs and they get the funds. So, we have organisations ready to work but are handicapped by funds inadequacy. This, in my view, is the biggest problem in managing HIV/AIDS in Nasarawa State.

RESEARCHER

**But why must we rely on the World Bank and other developed contries to solve our problems...**

LAWAL

That's Nigeria for you

SOLOMON-APEH

Let me come in here. Political interference is a problem as Alhaji Lawal said. As a journalist I know these things. The NUJ probably would not have been funded if not for the fact that it is constituted by journalists. When you talk of deep-seated problems such as attitude, you cannot but address the religious belief. Nigerians have been described as one of the most religious people in the world. But do we utilize it? When you are recommending an action to someone and that action contradicts his or her religion, he or she will opt to take after his or her religion. When you approach such a person from the religious angle you stand a chance of succeeding. An organisation like NASFAT and many Christian network groups can actually do a lot. But they do not get the necessary technical and financial support.

SAGBEDA

I think my colleagues are misrepresenting the facts. The government gets funds and the disbursement is based on certain conditions which we must follow. I think an NGO worth its calling should be able to generate funds on their own (*sic*) if they are really committed to their volitional calling...

SOLOMON-APEH

We do generate income of our own to do this work but what we are saying is that where international funding is available, disbursement should be on merit.

RESEARCHER

**Let's not politicize the discussion. The points made on all sides are well-taken. I don't think Alhaji Lawal is blaming NASACA. It's the other way round: he is saying NASACA should be allowed by the politicians to do a professional job based on merit so that the results would be more encouraging.**

LAWAL

Mr. Sagbeda is well-known to us. He knows those who are working and those who do not have visible addresses...who are not on ground. He knows what we go through. Ask him, after the funds provided in 2003 when the State had the highest prevalence rate in the country and international funding was provided, has there been any other funding since that time?

RESEARCHER

**Let's move to context. How important is it to contextualize programmes and are programmes in this state contextualized in the past three or four years?**

SAGBEDA

Usually the easiest phase to cross in a communication campaign is the awareness stage. In this era of mass communication technology, we can spread information very fast. We can use the TV, radio, GSM, newspapers and word-of-mouth takes over and it goes on. When it comes to attitude change, it is a different ball game. Research has shown that programmes that are contextualized produce better results in terms of attitude and behaviour change and we have been building capacity in this area at NASACA. In fact, for our I-E-C programmes, we do it directly through the state media and other mass communication media. It is in interpersonal communication and group communication that we require a lot of support from

the NGOs. This is so that they can go on to the field and execute small-scale projects that are contextualized. You cannot use the same approach or strategy that helped you in Keffi in Lafia although both are key cities in the state. It may work and it may not work. You have to adapt your programme to suit local situations. We are at the moment trying to do this.

SOLOMON-APEH
In addition to that, I want to say that we have to use structures in the society (formal and informal) to be able to contextualize our programmes. In many cases we have to build these structures – like organizing people into groups. Existing structures such as the Emir's Palace can be effectively used to reach people in the rural areas. This costs very little money when compared to the cost of running adverts on radio, TV and newspapers.

IBRAHIM
How many people in Nasarawa State read newspapers for instance? In this state, there are numerous local languages although Hausa is also well-spoken by a good majority. The more our target audiences see the communications tools in their own context, the better. For instance, most of the time, I speak with my patients in local dialects or Hausa. From experience, I have found that this enables them to have more confidence in me, unlike when I speak English. They readily open up to me during counselling when they see me as their 'brother'. These things really help.

RESEARCHER
**So, we can say in Nasarawa State, most NGOs contextualize their programmes.**

SAGBEDA
Yes they do. It is one of the pre-conditions for funding now.

RESEARCHER
**Nasarawa State prevalence rate dropped between 2003 and 2005 according to the national SSP although when you compare the rate to national average, it is still high. Could effective and appropriate use of communication approaches have brought a better result?**

IBRAHIM
I think we have to be careful in drawing conclusions. Personally, I look at the national SSP with caution. This rate was produced using figures collated from tests on pregnant women who visited hospitals and health centres. We all know that in our society quite a lot of these women do not go to conventional hospitals. So, even if we say it is okay to use pregnant women, we have a problem there. Second, we have quite a lot of people who are vulnerable outside that bracket. So, to me, quite a lot of figures are not tracked into the SSP. It does not truly represent what is on ground when you talk of patterns of prevalence. But for our purpose here, let me use the data you have described. Let me accept it as okay. Now, comparatively to how serious the problem was, although we have a high rate, I think it is satisfactory. We should not expect magical results when it comes to a social problem such as AIDS. The good thing is that things are getting better. Where I have problems is saying this and this is responsible for it. May be Mr. Sagbeda or Mr. Solomon-Apeh can say something on that.

SAGBEDA
Well, we may not be able to say this is the quantum of contribution by communication approach but we can certainly assert that the encouraging results have been partly due to

good communication approaches. What we did at NASACA was to use a combination of modern mass media techniques with informal communication methods such as societies, schools, churches, mosques, and so on. I am an indigene of this state and I know that if you want to spread information very fast, these institutions are the best. For those you cannot readily reach, you can then use the mass media.

RESEARCHER
**What you are saying is that these mass media channels are secondary vehicles and that the institutional networks are the primary vehicles you use for communicating with the target audience.**

SAGBEDA
Until 2007, it was the other way round. Since 2007 when we shifted strategy to attitude and behaviour change campaign, that is what we have been doing. The mass media is less effective than human communication networks when it comes to attitude and behaviour change.

LAWAL
But the problem remains that these other institutions are under-reached. How many of them are regularly supported by NASACA and how many people do these associations reach. These are some of the things we must consider if the attitude change or behaviour change campaign is to succeed. Old habits die hard and talking to people on TV would not help much in this regard.

RESEARCHER
**But you cannot talk to people one-on-one across the entire...**

SOLOMON-APEH
By no means! What will do the magic is group communication. The African society thrives on excellent social networks. In my home-town, Eggon, up till now, if you pass information through the traditional ruler, everyone in the town will hear it within 24 hours. Half of those people may not have TV sets or read newspapers. One other thing is that the information from the traditional ruler comes with some authority and credibility. I am not suggesting that mass media should not be used. I am saying that group networks should be used more than it is presently. Every family in this state can be reached in this way and communication contextualized for him or her. For instance, the little boy can be reached through his or her teacher at school; the father can be reached through his Pastor or Imam; the mother can be reached through the women society or market women association or other similar groups. I think in the situation we are now, we have to firm up these structures, build NGO capacity and then go all out to begin to reach out.

RESEARCHER
**Thank you. Let us look at the general major programmatic challenges that interventionists in Nasarawa State face in HIV/AIDS campaigns. What are these challenges?**

LAWAL
We have talked exhaustively about funds and let us leave that for now. I would say political interference should be eliminated from HIV/AIDS programming in this state. I am not a politician. We are interested in saving lives, that's why we are into this thing. Let the government put professionals in NASACA and allow them to do their work. Mr. Sagbeda threw a challenge that we the FBOs should be doing something to raise funds...I want to

state categorically that over 80 per cent of what we spend annually are raised from within our organisation and people who believe in what we are doing. We only got funding from NASACA once. We will continue to do this. What we are saying is that if there is international funding, it should be properly channeled. I am confident that much can be achieved if serious interventionists are supported with funds.

IBRAHIM
In the area of counselling, the greatest problem we face is stigma. People are very reluctant to come out and reveal their HIV status. Even to do a test is a problem. People are afraid of coming out to do the test. Medical personnel should be trained to know how to communicate with HIV/AIDS patients and other patients who are potential carriers of the virus. So, by extension, we have the challenge of building communication capacity, not just for NGOs but everyone that may be involved in HIV/AIDS. Communication is a key factor whichever way you look at it.

RESEARCHER
**Let me ask Alhaji Ibrahim this personal question, from your experience sir, how effective do you think the Faith-based approach is?**

IBRAHIM
Very effective. In Islam, *Ulamas* and *Imams* are highly respected. Their voices represent the voice of the Holy Prophet (SWA). Whatever these people say are seen as the truth. Well, there will always be few exceptions where some people would pretend to be religious and they would be doing the other thing underground. The percentage of people in this category is smaller. Even then, the fact that they listen to these messages is hope that one day they could succumb to such messages. But we do not just dish out information. Many people who go into commercial sex, for instance, know that it is a sin to do so. They do so because of poverty and other reasons. So what we do is to offer some form of empowerment for them, which the Almighty Allah also commands. That way, the message would be effective.

SOLOMON-APEH
It is the same in the Christian faith. Virtually all the major denominations such as Catholic Church, Anglican, Evangelical Church of West Africa, ECWA, have vibrant FBOs run with internally-generated funds. They see it as their responsibility, especially Care and Support for PLWHA. But I can tell you it costs a lot of money to do this. They need to be supported by government.

RESEARCHER
**On that note, we shall bring this FGD to a close. I sincerely thank you (*mentions names of panelists*) for coming and making very candid contributions to the discussion. Before we go, let me quickly remind us of the main points of our discussion:**

- **Consistent funding remains a very important factor for success of interventionists in their programmes.**
- **Communication is also key to successful programming especially when it comes to attitude and behaviour change. Human communication methods have potentially greater advantages than mass communication media.**
- **Communication competence of interventionists is fair. There is need to build capacity in human communication methods since these methods are more cost effective than modern mass media.**
- **When viewed against pre-2003 scenario, level of prevalence in Nasarawa State is satisfactory, although there is room for improvement.**

- NGOs have more significant roles to play in managing the HIV/AIDS problem if given the necessary support by government. Government should not politicize administration of HIV/AIDS funds.
- The little progress achieved in the state could be because serious attempts were made by NASACA and interventionists to contextualize their programmes.

I thank you all once again.

* * *

## *APPENDIX IV*

## *LIST OF ACRONYMS/ABBREVIATIONS*

| | |
|---|---|
| HIV/AIDS | Human Immunodeficiency Virus/Acquired Immunes Deficiency Syndrome |
| NACA | National Action Committee on HIV/AIDS (now National Agency for he Control of AIDS). |
| FMoH | Federal Ministry of Health |
| CSO | Civil Society Organisation |
| PLWHA | People Living With HIV/AIDS |
| SSP | Sero-Sentinel Prevalence |
| UNAIDS | United Nations AIDS Programme |
| SACA | State Action Committee on AIDS |
| NEACA | National Executive Advisory Committee on AIDS |
| HEAP | HIV and AIDS Emergency Action Plan |
| NGOs | Non-Governmental Organisations |
| UNFPA | United Nations Fund for Population Activities |
| MSM | Men Having Sex with Men |
| MTCT | Mother-to-Child Transmission |
| FBO | Faith Based Organisation |
| CBO | Community Based Organisation |
| ECR | Expanded and Comprehensive HIV/AIDS Response |
| LGA | Local Government Area |
| EPPM | Expanded Parallel Process Model |
| HBM | Health Belief Model |
| ELM | Elaboration of Likelihood Model |
| CFSC | Communication for Social Change |
| BCC | Behaviour Change Communication |

| | |
|---|---|
| IMB | Information Motivation Behaviour Skills Model |
| UNICEF | United Nations Children's Fund |
| I-E-C | Information-Education-Communication |
| PDC | Participatory Development Communication |
| AC | Advocacy Communication |
| NEEDS | National Economic Empowerment and Development Strategy |
| UNESCO | United Nations Agency for Education and Scientific Cooperation |
| SAP | Self-management, Access and Participation |
| PAR | Participatory Action Research |
| ARV | Anti Retroviral |
| NASFAT | Nasrullahifatihi, Society of Nigeria |
| MICA | Movement for Islamic Culture & Awareness |
| ACADA | Assessment, Communication Analysis, Design and Action |
| FCT | Federal Capital Territory |
| NPC | National Population Commission |
| SFH | Society for Family Health |
| FHI | Family Health International |
| ALIVI | Alliance for Life Association |
| USAID | United States Agency for International DEvelopoment |
| OVR | Orphans and Vulnerable Children |
| E-E | Entertainment-Education |
| IMAN | Islamic Medical Association of Nigeria |
| FOMWAN | Federation of Muslim Women's Associations in Nigeria |
| OPP | Organisation for Positive Productivity |
| PLACA | Plateau State AIDS Control Agency |
| WHOQoL | WHO Quality of Life |

| | |
|---|---|
| FACA | FCT Action Committee on AIDS |
| LACA | Local Government Action Committee on AIDS |
| DFID | Department for International Development |
| CIDA | Canadian International Development Agency |
| JICA | Japanese International Development Agency |
| NEPLWHAN | Network of People Living with HIV/AIDS |
| FGD | Focus Group Discussion |
| VCCT | Voluntary Counselling & Confidential Testing |
| PABA | People Affected by AIDS |
| NASEEDS | Nasarawa Economic Empowerment & Development Strategy |
| CRAN | Cross River AIDS Network |
| CiSHAN | Civil Society Network for HIV and AIDS in Nigeria |
| CRSACA | Cross River Agency for the Control of AIDS |
| LSACA | Lagos State Agency for the Control of AIDS |
| ODSACA | Ondo State Action Committee on AIDS |
| SWAAN | Society for Women Against AIDS in Nigeria |
| WAAI | Women Against AIDS International |
| WHO | World Health Organisation |
| PFFN | Planned Parenthood Federation of Nigeria |
| SAW | Sollala Alaehi Wasalam (May the peace and blessing of God be upon him) |

## *APPENDIX V*

## *PROFILE OF INTERVENTIONISTS STUDIED*

| No | Name of Organisation | State | Major Programme Area | Name of Chief Executive Officer | Telephone | Age of Organisation |
|---|---|---|---|---|---|---|
| 1. | Network of People Living with HIV/AIDS | Ondo | Capacity Building/Empowerment | Mr. Fatai Balogun | 08038620058 | Below 5 years |
| 2. | Vital Voices of Women and Teenage Boys & Girls | Ondo | Prevention | Chief (Mrs.) C.A. Boboye | 08033726529 | Below 5 years |
| 3. | Nigeria Youth for Christ | Ondo | Prevention | Rev. Fr. Freme Obong | 08028822502 | 5-14 years |
| 4. | Good Samaritan International | Ondo | Capacity Building/Empowerment | Mr. Clement Uta | 08029198371 | 5-14 years |
| 5.. | Community Health Action Initiative | Ondo | Testing/Treatment/Care and Support | Dr. Stanley Orji | 0806765225, 0342161301 | Below 5 years |
| 6. | Medical Women Association of Ondo State | Ondo | Testing/Treatment/Care and Support | Dr. Daphe Desouza-Akeju | 08033613496 | Over 14 years |
| 7. | Justice Development and Peace Commission | Ondo | Prevention | Rev. Fr. Patrick Adebayo | 034207101 | 5-14 years |
| 8. | St. Joavic's Foundation | Ondo | Testing/Treatment/Care and Support | Mrs. Folake Esan | 08035922132 | 5-14 years |
| 9. | National Women Coalition on HIV/AIDS (NAWOCA) | Ondo | Prevention | Mrs. Bunmi Nyere | 08038129884, 08053052457 | Less than 5 years |
| 10. | Zoe Foundation | Ondo | Prevention | Rev. Joe Abaka | 08035629852 | Less than 5 years |
| 11. | Fight AIDS Africa Youth Organisation | Ondo | Prevention | Mr. Junaid M.B. Adeyemi | 08034543458, 08027483332 | Over 14 years |

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| 12. | Sunshine Support Group | Ondo | Awareness | Mrs. Oladimeji | 0806440889 | Less than 5 years |
| 13. | Mercy Care Support | Ondo | Attitude and Behaviour Change | Prince Aladelusi Adesina | 07033109214 | Less than 5 years |
| 14. | Youth Action Rangers of Nigeria (YARN) | Lagos | Capacity Building and Empowerment | Mr. Moses Iyayi | 018953098 | Less than 5 years |
| 15. | Nashkur Holdings | Lagos | Attitude and Behaviour Change | Mrs. Maryam Dada Ibrahim | 08036363506 | Less than 5 years |
| 16. | Women Organisation Management Empowerment Network (WOMEN) | Lagos | Prevention | Prof. Nike Grange | 08037130369 | Less than 5 years |
| 17. | Civil Society on HIV/AIDS in Nigeria (CiSHAN) | Lagos | Awareness | Chibuike Amaechi | 08023336279 | 5-14 years |
| 18. | Foundation for Environmental Development & Education in Nigeria (FEDEN) | Lagos | Capacity Building and Empowerment | Prof. A. Osuntogun | 01-7442076 | 5-14 years |
| 19. | AIDS Alliance in Nigeria | Lagos | Capacity Building and Empowerment | Mr. Mohammed Farouk Anwalu | 01-4968359, 08033046972 | 5-14 years |
| 20. | Community Partners for Health | Lagos | Prevention | Deacon Sunday Solanke | 08035607035 | 5-14 years |
| 21. | Rural Dwellers Healthcare Foundation | Lagos | Awareness | Evang. Ajiboye Adepoju | 08023004821, 08038372722 | 5-14 years |
| 22. | Good Neighbours Incorporated | Lagos | Prevention | Pastor Amaechi Chibuike | 08023336279 | 5-14 years |
| 23. | Global Association for War | Lagos | Awareness | Mr. Eddy Sunday | 08038736477 | 5-14 years |

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| | Against AIDS (GAWAA) | | | | | |
| 24. | Action Health International | Lagos | Capacity Building and Empowerment | Mrs. Adenike Esiet | 01-7743745 | 5-14 years |
| 25. | Jazz 38 Centre for Arts | Lagos | Prevention | Tunde Kuboye | 080332448447, 01-28302266 | 5-14 years |
| 26. | HIV/AIDS Concern Group | Lagos | Testing, Treatment, Care and Support | Mrs. Ebun Onabanjo | 08037204133 | 5-14 years |
| 27. | Conscientising Against Injustices and Viiolence (CAIV) | Cross River | Capacity Building and Empowerment | Mrs. Stella Okon | 08057109643 | 5-14 years |
| 28. | We-Women Network (WWN) | Cross River | Prevention | Mrs. Mary Ukpong | 08033491965, 08036665032 | 5-14 years |
| 29. | Drum Beat Theatre for Development Foundation | Cross River | Prevention | Edisua Oko-Ohoboche | 08037241126, 08037183909 | 5-14 years |
| 30. | Nigeria Youth AIDS Programme (NYAP) | Cross River | Awareness | Mrs. Antigha George | 08037257894 | 5-14 years |
| 31. | The AIDS Care Organisation | Cross River | Testing and Treatment; Care and Support | Dr. Ntete Bassey Duke | 08025849878, 08023560099, 08037739398 | 5-14 years |
| 32. | Waman Fred Foundation | Cross River | Capacity Building and Empowerment | Barrister Ngozi Fred | N/A | 5-14 years |
| 33. | Centre for Healthworks Development & Research (CHEDRES) | Cross River | Education and research | Felix Ukam Ugwu | 08053176655, 08034800360 | 5-14 years |
| 34. | Future Initiative | Cross River | Testing and Treatment, Care and Support | Enem John Ekpakpam | 08053176655, 08072197476 | Less than 5 years |
| 35. | Life Empowerment Foundation | Cross River | Awareness | Edim Edim Itakpor | 08025388499 | 5-14 years |

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| 36. | Cross River State Network for People with HIV/AIDS | Cross River | Counselling | Esse Nsed | 08030995169 | Less than 5 years |
| 37. | Rescue the Perishing Mission Services | Cross River | Counselling | Rev. (Mrs.) Serah Abam | 08025751242 | 5-114 years |
| 38. | Positive Development Foundation | Cross River | Capacity Building and Empowerment | Mrs. E. Nwakama | 08036744202 | 5-14 years |
| 39. | Society Against the Spread of AIDS (SASA) | Cross River | Prevention | Mrs. Helen J. Ikpeme | 08053691841, 08058585677 | 5-14 years |
| 40. | Action for Rural Development | Cross River | Prevention | Deacon Gregory | 08055152621 | Less than 5 years |
| 41. | Cares Initiative | Cross River | Testing and Treatment, Care and Support | Dr. (Mrs.) Mfon Akpaso | 0807772138 | 5-14 years |
| 42. | Society for Women and AIDS in Africa, Nigeria (SWAAN) | Cross River | Attitude and Behaviour change | Grace N. /Takon | 08036686039 | Over 14 years |
| 43. | Voice of Widow and Orphans | Nasarawa | Capacity Building and Enpowerment | Mrs. Elizabeth Obande | 08054436726 | Less than 5 years |
| 44. | Centre for Peace and Rural Development (CENPARD) | Nasarawa | Testing, Treatment, Care and Support | Mr. Audu Blackgold Sanni | 08036146117, 08056474376, 08080900641 | 5-14 years |
| 45. | Justice & Human Empowerment Centre | Nasarawa | Awareness | Barrister Olusoji Akinbayo | N/A | 5-14 years |
| 46. | Centre for Youth and Community Action | Nasarawa | Capacity Building and Empowerment | Aboki Nawani | 08034521680 | 5-14 years |
| 47. | Nigeria AIDS Group of Islam | Nasarawa | Care and Support | Alh. Hayatudeen Ahmed Keana | 07031276009 | 5-14 years |

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| 48. | Young Men Christian Association Mada Hills | Nasarawa | Prevention | Edward Andaku, Solomon Yakubu | 08036567234, 047-221440 | Over 14 years |
| 49. | Accelerated Family Improvement | Nasarawa | Attitude and Behaviour Change | Dr. Thomas A. Affe | 08035981257 | 5-14 years |
| 50. | Family Healthcare Foundation | Nasarawa | Prevention | Mrs. Mary Ashenanye | 08035891145 | 5-14 years |
| 51. | Faith and Action Gospel Services (FACS) | Nasarawa | Counselling | Emmanuel Peter Dadean | 08037513778 | 5-14 years |
| 52. | Foundation for Voice of Islam | Nasarawa | Attitude and Behaviour change | Alh. Dr. Abubakar Akirga | 08033617772, 08036360486, 08036853556 | 5-14 years |
| 53. | Journalists for Peace and Development | Nasarawa | Capacity Building and Empowerment | Musa Abdullahi | 08065560370, 08028576286 | 5-14 years |