PROCESS EVALUATION OF BEHAVIOUR CHANGE COMMUNICATION MATERIALS DEVELOPED AND UTILIZED FOR HIV PREVENTION BY NON-GOVERNMENTAL ORGANIZATIONS IN OYO STATE, NIGERIA

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CERTIFICATION

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DEDICATION

This work is dedicated to God Almighty, the source of all good and great achievements who inspite of all obstacles has made His Grace sufficient for the completion of this work.

To my father; Pa M.S.O. Bolarinwa, my loving mother; Mrs. W. Bolarinwa, my sweetheart; Mrs Oluwatosin Bolarinwa and the wonderful gifts of God in my Life; Faith and Love.

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BOLARINWA, Kolawole Kazeem

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ABSTRACT

Public health education is a major strategy for controlling the spread of HIV. An important component of this strategy is the effective utilization of well-designed Behaviour Change Communication (BCC) materials. The Oyo State World Bank-assisted HIV and AIDS programme funded 40 Non-Governmental Organizations (NGOs) from 2006 to 2008, to produce BCC materials to reach target audiences. However, the process evaluation of the development of the materials in line with the WHO model has not been systematically conducted. This study was therefore designed to assess the level of adherence by these NGOs to basic standards in the process of development of the BCC materials.

The study was a descriptive cross-sectional survey. Balloting was used to select 20 out of the 40 funded NGOs. The NGOs were categorized into five equal groups based on target audience that is; Female Sex Workers, Mission Birth Attendants, In-school Youth, Women and People Living with HIV. A checklist was used to assess compliance with each of the following seven stages of educational materials development in line with the WHO model: Needs Assessment (NA); message conceptualization; design; pre-testing; production procedure; implementation and outcome evaluation. In-depth Interviews (IDIs) were conducted for the twenty NGO project coordinators while one Focus Group Discussion (FGD) was conducted among each of the five target groups. Descrptive statistics was used to analyze quantitative data while the FGD and IDI data were transcribed and analyzed using thematic approach.

Only two out of twenty NGOs complied with all the seven stages of WHO model of BCC material development. All the NGOs conducted NA and material design, 95.0% carried out implementation involving target audience and 85.0% conducted outcome evaluation of the materials. Eighty percent pre-tested their materials, 65.0% conceptualized communication messages while 25.0% of the NGOs involved target audience in the production procedure. Some (40.0%) project coordinators had one form of training or the other on BCC material development while 60.0% had no training. Only 35.0% conducted training for their target audiences before distributing the materials. Weak technical

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capacity in BCC material development was a major challenge as reported by the project coordinators. The FGD findings corroborated responses from the IDIs that target audiences were involved in NA, pre-testing and material distribution but not in message conceptualisation, production procedure and outcome evaluation.

Adherence to basic standard process of developing Behaviour Change Communication material is low among the Non-Governmental Organizations assessed. An intervention comprising training and supportive supervision is needed to enhance the skills of project coordinators in the development of behavioural change communication materials.

Keywords: Behaviour change communication, HIV/AIDS, Non-Governmental Organizations, Process evaluation.

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LIST OF ACRONYMS

AIDS	Acquired Immune deficiency Syndrome
ARV	Antiretroviral
ANC	Ante- natal Clinic
BCC	Behaviour Change Communication
CDC	Center for Disease Control
CSW	Commercial Sex Worker
CSO	Civil Society Organization
DFID	Department for International Development
FMOH	Federal Ministry of Health
FSW	Female Sex Worker
FGD	Focus Group Discussion
FOSY	Female Out-of School Youth
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HEAP	HIV/AIDS Emergency Action Plan
HAF	HIV/AIDS Fund
HBC	Home Based Care
HCT	HIV Counseling and Testing
HIV	Human Immuno-deficiency Virus
IDU	Intravenous Drug User
IDI	In-depth Interview
IEC	Information Education and Communication
LACA	Local Action Committee on AIDS
LDD	Long Distant Drivers
MAP-1	First Multi-Country HIV/AIDS Programme
MOSY	Male Out-of School Youth
MSM	Men having Sex with Men
NACA	National Agency for the Control of AIDS
NAC	National AIDS Council
NGO	Non Governmental Organization
NSF	National Strategic Framework

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NNRIMS	Nigeria National HIV Response Information Management System
OYSPOA	Oyo State Plan of Action on HIV/AIDS
OYSMOH	Oyo State Ministry of Health
OYSACA	Oyo State Agency for the Control of AIDS
OYSSP	Oyo State Strategic Plan
PAD	Project Appraisal Document
PATCH	Planned Approach To Community Health
PCA	Presidential Committee on AIDS
PMTCT	Prevention of Mother to Child Transmission
RA	Rapid Appraisal
SACA	State Agency for the Control of AIDS
STI	Sexually Transmitted Infection
UNAIDS	United Nation working on HIV/AIDS
UNDP	United Nation Development Programme
UNGASS	United Nation General Assembly Special Session on HIV/AIDS
USAID	United State Agency for International Development
WB	World Bank
WHO	World Health Organization

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CHAPTER ONE

INTRODUCTION

1.1 Background Information

HIV and AIDS is a major public health problem affecting people in their prime and most productive years of life. It is the worst the world has ever faced and it still remains the greatest threat to human health and development (UNAIDS 2004). Since the first two cases of HIV and AIDS were first identified in Nigeria in 1985 and were reported at an International AIDS conference in 1986, the epidemic has grown rapidly extending beyond the high risk groups (sex workers, migrant labourers etc) to the general population. The sero prevalence studies conducted by the Federal Ministry of Health of Nigeria showed a steady increase in the adult HIV prevalence from 1.8% in 1991 to 4.5% in 1996 to 5.8% in 2001 to 5% in 2003 to 4.4% in 2005, 4.6% in 2008 and recently to 4.1% in 2010. Some parts of the country are worse affected than others, but no state or community is unaffected (Global AIDS Response, Country Progress Report, Nigeria GARPR 2012).

In Nigeria, an estimated 4.1 percent of the population are living with HIV and AIDS (UNGASS Report 2010). Although HIV prevalence is much lower in Nigeria than in other African countries such as South Africa and Zambia, the size of Nigeria's population (around 160 million) means that by the end of 2011, there were 3.3 million people living with HIV (UNAIDS, 2010). The major route of HIV transmission in Nigeria is heterosexual relationship. Approximately 80-95 percent of HIV infections in Nigeria are a result of heterosexual sex and the contributory factors include a lack of information about sexual health and HIV prevention, low levels of condom use, and high levels of sexually transmitted infections (UNGASS Report, 2010). Poverty, low literacy levels, high rates of casual and transactional unprotected sex in the general population, particularly among youth between the ages of 15 and 24, low levels of male and female condom use, cultural and religious factors, as well as stigma and discrimination are major factors in the transmission of HIV in Nigeria (NACA, 2007).

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Behaviour Change Communication is a process for promoting and sustaining healthy changes in behaviour in individuals and communities through participatory development of appropriately tailored health messages and approaches that are conveyed through a variety of communication channels (PATH, 2003). It is an essential component of a comprehensive programme that includes prevention, services and commodities. Over the last half decade, behaviour change has become a central objective of public health education intervention, as the influence of prevention within the health services has increased. Many health conditions are caused by risk behaviors, such as problem drinking, substance use, smoking, reckless driving, overeating, or unprotected sexual intercourse. The key question in health behaviour research is how to predict and modify the adoption and maintenance of health behaviours. Fortunately, man has in principle, control over his or her conduct. Health behaviour change therefore refers to the motivational, volitional, and actional processes of abandoning such health-compromising behaviours in favor of adopting and maintaining health-enhancing behaviours (PATH, 2003).

The increased influence of prevention has coincided with increased multi-lateral and bi-lateral aid in the area of human development, and the increased need for the international development community to show cost-effectiveness for allocated dollars spent. Behaviour change programs, which have evolved over time, encompass a broad range of activities and approaches, which focus on the individual, community, and environmental influences on behaviour. The term Behaviour Change Communication (BCC) specifically refers to community health seeking behaviour, and was first employed in HIV and TB prevention projects. More recently, its ambit has grown to encompass any communication activity whose goal is to help individuals and communities select and practice behaviour that will positively impact their health and prevent transmission of preventable communicable infection like HIV (PATH, 2003).

This study therefore, was intended to examine and assess the process of design, production and utilization of the various behaviour change communication materials employed by the project implementers of the non-governmental organizations and document the extent of compliance to basic standards of BCC material development by

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the NGOs. It was also intended to evaluate the participatory nature of the process, the relevance of the BCC materials to the needs of the people, comprehension by the target audience and effectiveness for the project intervention carried out.

According to the Center for Disease Control and Prevention (CDC, 2006), educational materials are learning or teaching aids which can be used to reach masses of people, to reinforce or illustrate information given in a one-on-one setting, or serve as references to remind people of information they received earlier. Educational materials also teach skills by providing hands-on experience or by illustrating a step-by-step approach. Effective materials can also influence attitudes and perceptions of target population. Printed health educational materials also allows the reader or viewer to assimilate information slowly, to consider it at greater length, to place it more clearly within his/her own personal psycho-social environment and to refer to it over time (Rasmuson, Scidel, Smith and Booth, 1988).

According to PATH, 2003, using print materials to promote behaviour change has many advantages: they are easy to store and can be used without any special equipment, they are an excellent tool to reinforce messages presented orally during interpersonal contacts, they can be used to remind the health provider or outreach worker not to forget any important messages, they can reach target populations beyond the initial recipient, since people often share their print materials with friends, relatives, or neighbors. They can usually be produced locally and thus can be tailored to the needs of specific target population, they can counteract rumors, reduce fears of possible side effects, and reassure people that the technologies and behaviors needed to reduce and/or prevent transmission of STIs are effective and safe. Carefully designed print materials can support the verbal interaction between health workers and clients, or between peer educators and those whom they advise; hence these materials are often called “support materials.

The role of health education in promoting the involvement of people in their own health care is of very significant. To carry out these roles, it requires a reorientation in the techniques of social analysis and new educational methods which enable people to identify, assess problems and have confidence in solving those problems. Acquiring right

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information and stimulating people towards positive desired health promoting and disease prevention action is no doubt the essence of any health programme (WHO, 1987).

1.2 The Parent Project and background of the research effort

The Government of Nigeria in January 2000 in her bid to stem the tide of the epidemic of HIV, curtail the spread of HIV infection and mitigate its impact, established a multisectoral body- a Presidential Committee on AIDS (PCA) and the National Action Committee on AIDS (NACA) with a 3-year HIV/AIDS Emergency Action Plan (HEAP). The plan was to be implemented by governmental institutions, non-governmental organizations, community based organizations, faith based organizations, development partners and persons living with or affected by HIV/AIDS (National Policy on HIV/AIDS, 2003).

In furtherance of the multi-sectoral response of the Federal Government to the epidemic of HIV/AIDS in Nigeria, the World Bank in July 16, 2001, approved a US$90.3million IDA credit to support a HIV/AIDS Programme Development Project to assist Nigeria in reducing the spread as well as mitigating the impact of the HIV/AIDS epidemic under the first multi-country HIV/AIDS programme (MAP-1) for the Africa Region (World Bank HIV/AIDS Report, 2004). Oyo State was one of the first eighteen participating states selected on the basis of population density, commercial activity and the rate of HIV prevalence which was put at 3.9% in 2003. With high level commitment and intensifying efforts by different stakeholders, the Oyo State government was stimulated to step up HIV/AIDS response by demonstrating some measure of commitment to participation in the World Bank Assisted HIV/AIDS project. Thus, in February, 2004; the World Bank in partnership with the National Action Committee on AIDS (NACA) approved the participation of Oyo State in the world Bank Assisted HIV/AIDS Programme Development Project with a total credit allocation of US$2,379,632.00 million IDA credit under the first Multi-Country HIV/AIDS Programme (MAP-1).

The overall objective of the project was to assist and support the Oyo State Government to reduce the spread and mitigate the impact of the HIV/AIDS epidemic by strengthening her multi-sectoral response to the epidemic through the implementation of a

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comprehensive programme that includes the creation of an enabling environment for a large scale response, and laying the foundation for scaling up HIV/AIDS prevention, care and treatment services at the state and local levels (Project Appraisal Document, 2001).

The three main components of the project as highlighted in the Project Appraisal Document are; Capacity Development, Expanding public sector response and Support to civil society organizations through the HIV/AIDS Action Fund. Even though the scope of this study is limited to the third component of the project, it is however useful to highlight some salient issues identified in the Project Appraisal Document, Oyo SACA, 2001 under the other two components as they all bear impact on the status of the epidemic in the state.

Component One- Capacity Development:

Under this component, the project provided support and enabling environment to the state HIV/AIDS coordinating body, State Action Committee on AIDS (SACA) to undertake responsibilities such as; evaluation of specific action plans proposed by the line ministries and non-governmental organizations, monitoring and evaluation of HIV/AIDS activities in the state, acting as the knowledge manager and clearing house of information on HIV/AIDS in the state to all parties and overall management of the project at the state level (PAD, 2001).

Component Two- Expanding the Public Sector Response:

The project through this component provided support to the State line ministries and Local Action Committee on AIDS (LACAs) to implement those HIV/AIDS activities approved by SACA as contained in their respective action plans. A total of thirteen (13) Line ministries and Thirty three (33) LACAs were supported under the project (Oyo SACA report, 2008).

Component Three-HIV/AIDS Action Fund:

This component provided support for technical assistance, training and implementation to non-governmental organizations to develop and implement programmes that they proposed to bear postive impact on the overall objective of the project in the State. The

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non-governmental organizations were encouraged to focus on programmes targeting high risk groups such as; truck drivers, commercial sex workers, and youths as well as strengthen care for the sick and orphans, which public sector service providers cannot easily reach or organize. Part of the activities is the use of IEC materials. Thus, the HIV/AIDS Fund was established to expand the response of non public sector actors against HIV/AIDS in the country and in the state in particular in the area of implementing interventions that would prevent the further spread of HIV and mitigate its impact among the populace (PAD, 2001).

Support to civil society organizations was premised on the fact that effective response against the HIV/AIDS epidemic requires a partnership with non governmental organizations as evidenced by UNAIDS 1999. There is a growing recognition that non governmental organizations with their unrivalled understanding of the epidemic and people's needs, are essential components of national response, if countries are to progress towards meeting the commitments made by their governments at the UN General Assembly Special Session on HIV/AIDS (UNGASS) in 2001, and that every effort must be made to support and strengthen civil society and give it a voice that is heard. (Report on global AIDS Epidemic, 2006). Premised on this fact, a significant portion of the World Bank credit allocation was made to the non governmental in form of grants to enhance the response to the epidemic of HIV/AIDS in the state. Between February, 2005; when the state was granted no objection to participate in the project and December, 2006 a total sum of ₦158,408,776.00 million was disbursed as grants to Forty (40) civil society organizations in the State, with each of the non-governmental organizations receiving an average of ₦4million. Part of this money is to utilize educational approaches that would increase the opportunity for HIV risk reduction practices of which the use of IEC materials is vital.

1.3 Statement of the problem

The first case of HIV/AIDS in Oyo State was reported in 1987 from Oke-Ogun area (Saki) of the State, and since then there has been a gradual but steady increase in the number of people testing positive with the virus (OYSPOA, 2004). Cases of AIDS have

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been reported in almost every town and villages in Oyo state and currently about three people out of a hundred people in Oyo state have the virus. As in other places in Nigeria, unprotected heterosexual intercourse accounts for about 85% of HIV transmission in Oyo State, whilst the rest is through mother-to-child-transmission and blood transfusion. The most vulnerable groups include, Commercial Sex Workers, Youths (in-and-out of school, especially between the ages of 15 and 24years), uniformed personnel and un-informed individuals (Oyo SSP 2010-2015).

The epidemiologic pattern of HIV infection, with sexual behaviour, use of contaminated skin piercing instrument, transfussion of unscreened blood and mother to child transmission as the principal modes of transmission clearly indicated that behaviour modification is central to HIV prevention. It is widely believed that health intervention integrated with health education component has a great role to play in providing people with appropriate information for the necessary desired behaviour change (Kanki, 2006).

1.5 Justification and Rationale of the study

HIV/AIDS is a major public health problem in Nigeria and especially in Oyo State where the prevalence has been on the increase over the years, affecting people in their prime and most productive years of life. The need for evaluating programmes and activities has been described as indispensable for the purpose of determining the value of specific interventions, understanding the magnitude of the response, identifying the gaps and documenting the best practice for future decision making and better returns on investment (NNRIMS, 2004). In addition to the above and central to effective behaviour change communication which is required for risk reduction in HIV prevention is production and utilization of health education materials as vehicle for disseminating and communicating relevant and appropriate information on prevention and control to the members of target audience and thereby achieve the intended purpose.

All the Forty (40) Non Governmental Organization (NGOs) supported by the Oyo State World Bank Assisted HIV/AIDS Project under the HIV/AIDS Fund (HAF) 1, implemented Behaviour change communication programmes involving production and distribution of certain health education materials, targeting various groups of people such

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as; the in-school youths, out of school youths, women groups, female sex workers and people living with HIV/AIDS for intervention at the community level. The interventions were carried out by some of the NGOs within 12 months while some lasted 18 months (January 2005 to June 2007). The project implementation involved non governmental organizations; many of which developed and used IEC materials for the Behaviour Change Communication (BCC) component of their project. However, despite the massive production of behaviour change communication materials by the project implementers and the huge amount of cost involved, there has not been a substantial behavioural change in the attitude and behaviour of people as regards the transmission of HIV and impact mitigation of AIDS in the society. The questions then arose: are the behaviour change communication materials produced appropriate? Are the intended messages comprehended by the target audience? Are they effective in any way in behavioural change process? Are the materials actually relevant to the needs of the target audience particularly among the high risk group? This concern was equally expressed by (Parker, Ratzan and Lurie, 2003) that most of the materials produced by the civil society organizations, aimed at informing, educating and motivating members of the public towards adopting positive behavioural practices are sometimes incomprehensible, ambiguous, irrelevant and with no concrete meaningful outcome or impact on the target population.

Since the completion of the project activities by the Non Governmental Organizations in June, 2007; there has not been a systematic assessment of the process of development and implementation of the Behaviour change communication materials produced and no evaluation has been done or documented on any of the supported SACA project activities in the State. It therefore, becomes imperative to asses and evaluate the various reproductive health education materials produced by the civil society organizations under the project with a view to determining the process, relevance, appropriateness, adequacy and impact of such materials and their contents on the target population and on the basis of the findings make appropriate recommendations for future development and production of behaviour change communication materials for project interventions.

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In view of the above, the research study therefore focused on the assessment of the process of development of the behaviour change communication materials utilized for HIV prevention by non-governmental organizations in Oyo State, Nigeria.

1.6 Research questions

Specifically, the research provided answers to the following research questions:

Planning

1. Was there any need assessment carried out before material development?
2. Were the target group identified and involved in the conceptualization, design and planning stage?

Production

3. Were the target groups involved in the production of the materials and to what extent?
4. Were the materials pre-tested before final production and with whom were they pre-tested?
5. What languages were used? Were appropriate pictures, words and terms used to aid comprehension by the target audience?
6. Were the message/contents of the materials making a specific call to a change in behaviour?
7. Were the messages and materials used perceived clear, simple, attractive, culturally and socially acceptable to the target group?
8. What was the level of involvement of the target group in the entire process?

Distribution and Utilization

9. How were the materials distributed?
10. Were the target groups involved in the distribution of materials?
11. For how long were the materials distributed?
12. Were the volunteers who distributed the materials trained?

Evaluation

14. Was there any evaluation carried out to assess the impact of the materials?

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15. Were the target groups involved in the evaluation?
16. Were there feedback or dissemination forum on findings and best practices?

1.7 Broad objective

The broad objective of the study was to evaluate considerations in the process of development and implementation of behaviour change communication materials used by the Non-Governmental Organizations assisted by the World Bank under the Oyo State HIV/AIDS project implementation between 2005 and 2007 and document the level of compliance to basic standards of BCC material development.

1.7.1 Specific objectives

1. To assess the process involved in the conceptualization, planning, design and implementation of HIV/AIDS health education materials by the Non Governmental Organizations.
2. To evaluate the extent of involvement of target audience or beneficiaries in the processes of planning, design, and implementation of the behavioural change communication materials developed and utilized.
3. To identify gaps in terms of weakness and strength in the design, production and distribution of the IEC/BCC materials for HIV/AIDS health education programmes implemented under the project.
4. To document the findings and make recommendations for future HIV/AIDS behaviour change educational programming.

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CHAPTER TWO

LITERATURE REVIEW

2.1. Non Governmental Organizations and HIV/AIDS Pandemic

The World Bank defines Non Governmental Organizations (NGOs) as groups and institutions that are entirely or largely independent of government and that have primarily humanitarian or cooperative rather than commercial objectives. They are private agencies in industrial countries that support international development; indigenous groups organized regionally or nationally; and member-groups in villages. NGOs also include charitable and religious associations that mobilize private funds for development, distribute food and family planning services and promote community organization. They also include independent cooperatives, community associations, water-user societies, women groups and pastoral associations. Citizen Groups that raise awareness and influence policy are also NGOs (The World Bank, 1990).

Throughout the world, Non-Governmental Organizations (NGOs) play a critical role in the delivery of HIV-prevention services. Governments usually carry out AIDS surveillance functions and may initiate broad AIDS education campaigns as well as develop national strategic plans for HIV prevention. However, governmental agencies often lack the experience, knowledge, or the will to successfully work with marginalized vulnerable groups. For these reasons, NGOs serve as bridge to at-risk communities and are frequently the major providers of direct HIV-prevention services to vulnerable groups which include injection drug users (IDUs), men who have sex with men (MSM), commercial sex workers, youth in high-risk situations, prisoners, migrants, and other disadvantaged segments of the community (Kelly, Somlai, Benotsch, Amirkhanian, Fernandez, Stevenson, Sitzler, Mcauliffe, Brown and Opgenorth, 2006; Crane & Carswell, 1992).

NGOs have long represented and provided services to impoverished and marginalized groups across diverse areas of health and social development (Kelly, Somlai, Benotsch, Amirkhanian, Fernandez, Stevenson, Sitzler, Mcauliffe, Brown and Opgenorth, 2006; Akukwe, 1998; Craplet, 1997; Motin & Taher, 2001; Mburu, 1989; Smith, 1989). Because they typically originate from or are specifically organized to serve - community

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constituencies, NGOs can respond with culturally sensitive programmes. NGOs are often characterized by relative absence of bureaucracy and flexibility to quickly develop innovative programmes, low cost of operation, autonomy from restrictive and conservative governmental policies, the potential for high levels of community participation in programme development, and the ability to reach and advocate on behalf of population segments in greatest need of services (Akukwe, 1998; Craplet, 1997; Gellert, 1996). These characteristics are especially relevant to the field of HIV prevention, where one must quickly curtail a rapidly advancing infectious disease epidemic, where governments may be reluctant to undertake focused and explicit programmes on sensitive sexual behaviour and drug use safety topics, and where direct prevention services may be more successfully targeted by organizations that are already trusted and knowledgeable of the culture and values of communities they serve (National Centre for Biotechnology Information (NBI) 2006, Accessed Oct 2010; Crane & Carswell, 1992; Kalibala et al., 1997; Wiesman, 1991).

However, many social development NGOs in developing countries face significant operational challenges. These include limited organizational infrastructure, few sources of stable and long-term funding, reliance primarily on volunteer efforts, high personnel turnover, and a paucity of networking and programme coordination opportunities (Akukwe, 1998; Smith, 1989; McKee et al., 2000).

This study evaluated activities (development of HIV and AIDS-related IEC/BCC materials) of civil organisations involved in multi-sectoral responses to the epidemic of HIV/AIDS in Oyo State with the support of the World Bank aimed at reducing the spread and mitigating the impact of the HIV/AIDS epidemic under the first multi-country HIV/AIDS programme (MAP-1) for the Africa Region (World Bank HIV/AIDS Report, 2004). A lot of resources have been provided to the local NGOs to implement HIV/AIDS related projects while the donors and other stakeholders expect transparency, proper accountability and good project performance from them. There is also need to determine whether the set objectives were achieved and extent of achievement of the same as well as capture any lessons learned from the implementation of the projects to aid future projects. This is a function of project evaluation. In addition to evaluating the activities of

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the NGOs, target population involved in the study were assessed of their level of involvement in the development of the IEC/BCC materials and the relevance of such material to them.

2.2 Magnitude of HIV and AIDS Epidemic-Global, National and State Levels

2.2.1 Global epidemic of HIV and AIDS

Acquired Immunodeficiency Syndrome (AIDS) continues to be a major global health priority, although important progress has been achieved in preventing new HIV infections and in lowering the annual number of AIDS related deaths. The number of people living with HIV continued to be on the increase. AIDS-related illnesses remain one of the leading causes of death globally and are projected to continue as a significant global cause of premature mortality in the coming decades (World Health Organization, 2008).

AIDS has caused the death of more than 25 million people since it was first discovered in 1981, making it one of the most destructive epidemic in human history (UNAIDS, 2005). As at December, 2011; the total number of people with Human Immuno-deficiency Virus (HIV) was estimated at 34 million as against the 40.3 million people living with HIV in 2005 (UNAIDS, 2011). Sub-Saharan Africa still bears an inordinate share of the global HIV burden. Although the rate of new HIV infections has decreased, the total number of people living with HIV continues to rise. In 2009, the number reached 22.5 million accounting for 68% of the global total. The Adult (15-49) years prevalence as at 2007 was 5.0% as against 7.2% in 2005. The total Adult and child death due to AIDS in the sub-Sahara Africa were estimated at 1.3 million in 2009 as against 2.4 million in 2005 (UNAIDS, 2010).

The number of people living with HIV worldwide continued to grow in 2008, reaching an estimated 33.4 million [31.1 million–35.8 million]. The total number of people living with the virus in 2009 was more than 20% higher than the number in 2000, and the prevalence was roughly three fold higher than in 1990 (UNAIDS, 2008). In 2009, an estimated 2.6 million [2.4 million–3.0 million] new HIV infections occurred while 1.8 million [1.7 million–2.4 million] deaths were estimated due to AIDS-related illnesses worldwide. The epidemic appears to have stabilized in most regions, although prevalence

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continues to increase in Eastern Europe and Central Asia and in other parts of Asia due to a high rate of new HIV infections. Sub-Saharan Africa remains the most heavily affected region, accounting for 68% of all new HIV infections in 2009.

The following is the Global summary of the AIDS epidemic as at December 2009 as stated by UNAIDS 2010.

- Adults and Children living with HIV = 33.3 million
- Adults and Children newly infected with HIV = 2.6 million
- Percent Adult Prevalence (15-49years) = 0.8%
- AIDS related deaths among Adults and Children = 1.8 million.

Table 2.1: Global Statistics on HIV Prevalence (UNAIDS, 2010)

Region	Adults & children living with HIV/AIDS	Adults & children newly infected	Adult prevalence*	AIDS-related deaths in adults & children
Sub-Saharan Africa	22.5 million	1.8 million	5.0%	1.3 million
North Africa & Middle East	460,000	75,000	0.2%	24,000
South and South-East Asia	4.1 million	270,000	0.3%	260,000
East Asia	770,000	82,000	<0.1%	36,000
Oceania	57,000	4,500	0.3%	1,400
Central & South America	1.4 million	92,000	0.5%	58,000
Caribbean	240,000	17,000	1.0%	12,000
Eastern Europe & Central Asia	1.4 million	130,000	0.8%	76,000
North America	1.5 million	70,000	0.5%	26,000
Western & Central Europe	820,000	31,000	0.2%	8,500
Global Total	33.3 million	2.6 million	0.8%	1.8 million

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2.2.2 National pandemic of HIV and AIDS

The HIV pandemic in Nigeria is believed to have started in the 1980s with the first AIDS case reported in 1986. Like many other developing countries, Nigeria has passed through several phases in her response to the epidemic of HIV/AIDS. The stages included an initial period of denial; a largely medical response; a public health response; and recently a multi-sectoral response that focused on prevention, treatment and impact mitigation (National Policy on HIV/AIDS, 2003). Nigeria as a country faces many challenges in dealing with its HIV/AIDS pandemic. Factors fuelling the epidemic of HIV/AIDS are largely behavioural, hence, public education which would engender positive behavioural change therefore plays a key role in curtailing the spread of HIV infection. In Nigeria, the pandemic of HIV countinues to grow despite concerted efforts to control it. Sentinel surveillance among antenatal clinic attendees rose from 1.8% in 1991 to 5.8% in 2001 (FMOH, 1995; 2001; 2003) and recently to 4.4% in 2005; 4.6% as at 2008 and 4.1% in 2010 (NACA, 2010).

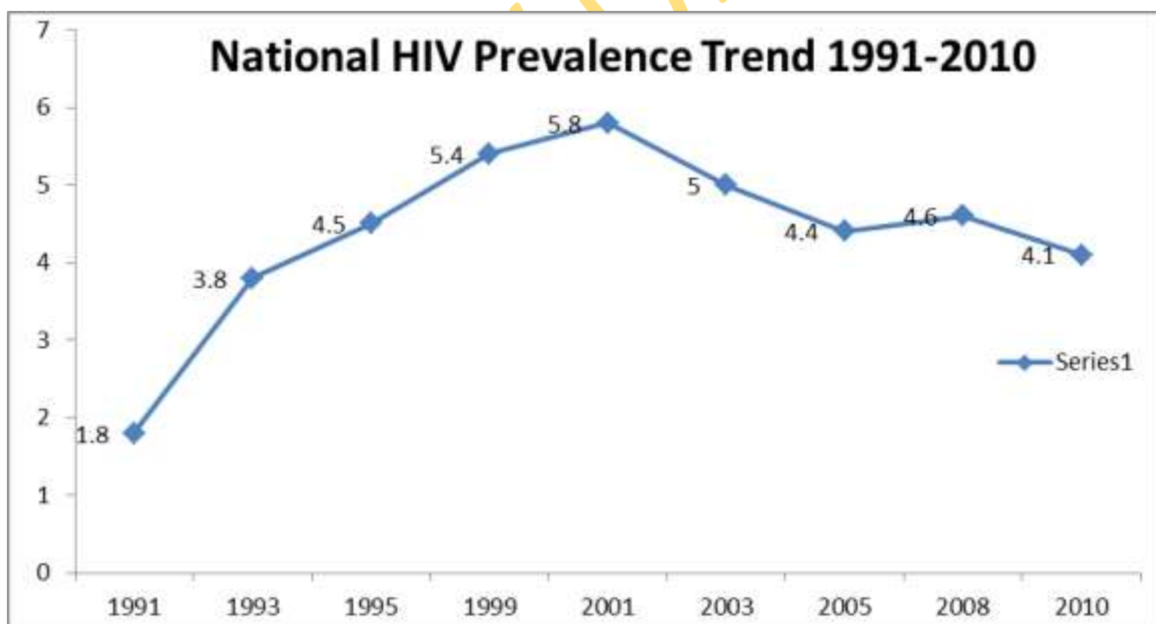

Figure 2.1: National HIV Prevalence Trend 1991-2010

Source: GLOBAL AIDS RESPONSE Country Progress Report Nigeria GARPR 2012

For the twenty six year period dated 1986 till December 2011, that AIDS was first reported in Nigeria, 3,459,363 people now live with HIV and an estimated 1,449,166

require ARV. 388,864 new infections occurred in the year ended 2011 and records show 217,148 AIDS related deaths. Between 1991 and 2001, Nigeria witnessed an increase in the prevalence of HIV in the country. The first case of AIDS in Nigeria was reported in 1986 thereby establishing the presence of the epidemic in the country. Consequently, and in line with guidelines from the World Health Organization (WHO), the government adopted ANC sentinel surveillance as the system for assessing the epidemic. The national HIV Seroprevalence level, obtained from sentinel surveys of antenatal care attendees, increased from 1.8 percent in 1991 to 5.8 percent in 2001 and then declined to 5.0 percent in 2003 and further to 4.4 percent in 2005. This was followed by a rise to 4.6 percent in 2008 and then a recent decline to 4.1 percent in 2010 (GARPR, 2012). Although most-at-risk populations contribute to the spread of HIV, heterosexual sex, particularly of the low-risk type, still makes up the bulk of infections (about 80 percent). Mother-to-child transmission and transfusion of infected blood and blood products are generally estimated as ranking next as common routes of infection; arguably, each of these two are believed to account for almost ten percent of infections. Even as HIV prevalence in the general population has decreased from the 1990s, it has risen in sex workers and men having sex with men, hence, who have become very important bridge groups (GARPR, 2012).

In the country, women below the age of 49 years have the highest HIV prevalence rates and mother–to-child transmission now accounts for 10% of new infections. The North central zone has the highest prevalence rates per zone while urban areas had more HIV prevalence than rural (GARPR, 2012). Three strategies namely: abstinence, faithfulness and the use of condoms have been adopted to prevent further transmission in the community based on the high proportion of cases transmitted via sexual intercourse (NACA, 2012).

Nigeria commenced response activities as soon as the first case of HIV/AIDS was diagnosed. This was expanded in 2000 with the establishment of the Presidential Council on AIDS and the National Action Committee on AIDS (NACA) in 1996. By 2001 it had become clear that the complexity of the HIV/AIDS epidemic required a developmental, holistic, coordinated and multi-sectoral approach (NACA 2004). The strong political commitment of the President of Nigeria to fight HIV/AIDS served as a powerful catalyst

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and motivator for establishing a supraministerial and sectoral body, the National Agency for the Control of AIDS (NACA).

A national policy on HIV/AIDS was launched in August 2002 to give policy direction and to make a policy statement on the transformation of NACA from a Committee to a full-fledged agency that is well positioned to scale up the fight against the epidemic. In 2001, with the passage of NACA bill by the National Assembly, NACA becomes a self accounting and multisectoral co-ordinating body with the responsibility to steering national efforts towards providing comprehensive prevention and care services in the country. A number of plans including the HIV/AIDS Emergency Action Plan (HEAP) the HIV/AIDS Health Sector Plans and the National Strategic Framework (NSF) have been developed and implemented with focus on scaling up access and quality of HIV/AIDS services to infected and the affected. These include a wide range of interventions such as Behaviour Change Communication, Family Life Health Education, HIV Counseling and Testing (HCT), Blood safety, Prevention of Mother to Child Transmission (PMTCT), Home Based Care (HBC), Anti-Retroviral Treatment, adequate treatment of sexually transmitted infections and support for orphans and vulnerable children. The need to implement large scale Behavioural Change Communication (BCC) programmes that would encourage individuals to reduce their risk of HIV acquisition and reduce the stigmatization and discrimination that have typified societal responses was also identified as crucial for the success of a national HIV prevention programmes (Kanki, 2006).

National HIV/AIDS Response:

As a result of the devastating impact of HIV/AIDS, the President of Nigeria declared HIV/AIDS a national emergency in 2000 (Mogae, 2004). The government instituted a strategy, the Nigeria National Strategic Framework for HIV/AIDS (2003–2009) to respond to the deadly scourge through several activities and projects. Figure 2.1 illustrates the different players involved in the fight against HIV/AIDS and the coordinating structure in implementing the strategic framework. Their different roles are highlighted hereafter:

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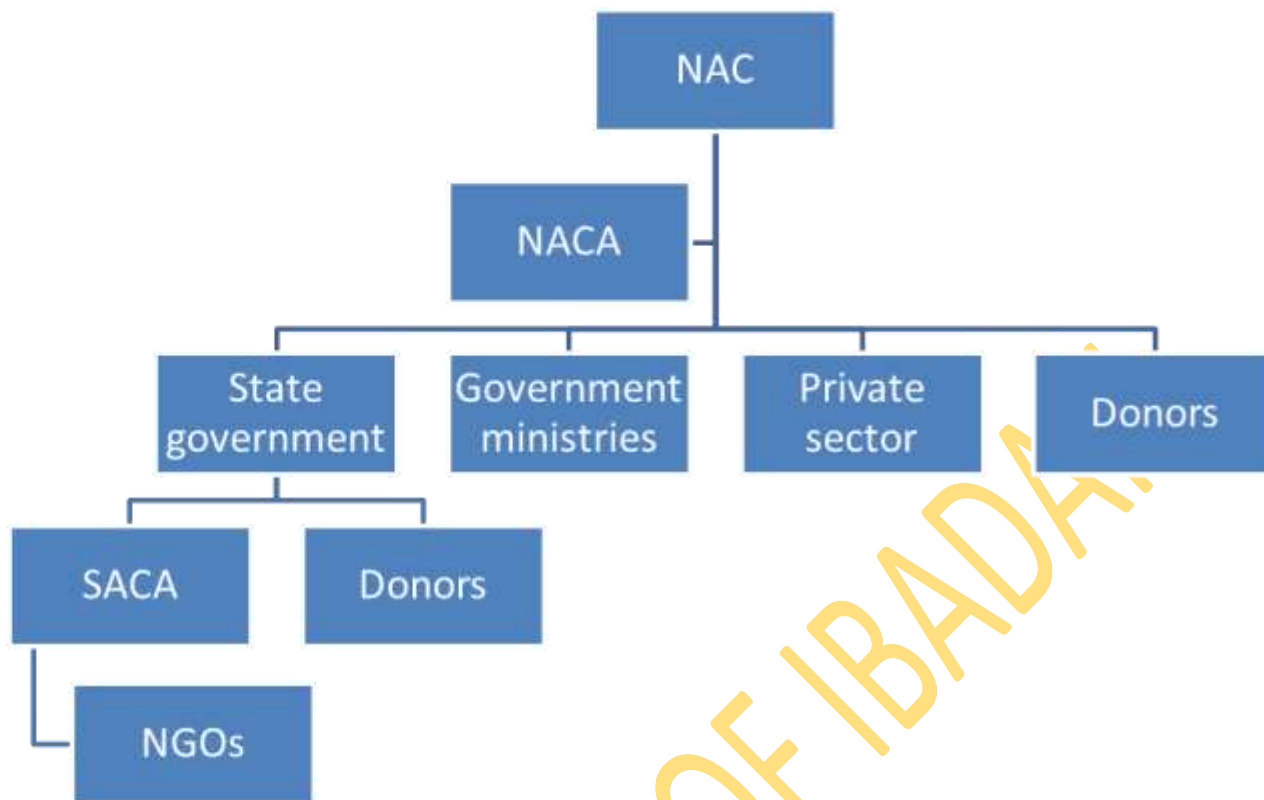

Figure 2.2: The Coordinating structure for national HIV/AIDS response (NACA, 2004)

- National AIDS Council (NAC)

This is the highest policy making body charged with the responsibility of policy formulation, ratification and endorsement for the prevention and control of the epidemic and is chaired by the President (NACA, 2004).

- National Agency for the Control of AIDS (NACA)

NACA is the secretariat of NAC. It is tasked with responsibility of coordinating the implementation of the strategic framework. The key roles of NACA include among others the following:

a). identifying key strategic priorities in the war against HIV/AIDS,

b). developing and supporting programmes and policies that can deliver on these priorities, and

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c). developing tools and mechanisms to monitoring and evaluating progress in the war on HIV/AIDS (NACA, 2004)

- Government ministries

Different government ministries and departments carry out different AIDS related activities but generally current government interventions involve prevention of HIV/AIDS infections through

a) Behavioural Change Communication (BCC) programmes

b) Prevention of Mother to Child Infection (PMTCI) infections

c) Provision of Anti-Retroral Virals (ARVs) treatment

d) Care of orphans who have lost their parents to HIV/AIDS

e) Mitigating the impact of HIV/AIDS, managing the legal and ethical environment concerning HIV/AIDS.

- Donors

The donors include international development agencies for example USAID, DFID and UNAID plus the other UN related organizations like UNDP through their own intervention programmes or through partnership with government to implement or fund some government interventions.

- Private sector

Private entities such as pharmaceutical companies like Pfizer, Mobil and MTN among others are also involved in the intervention through the provision of subsidized drugs, funding research into the efficacy of the drugs used in the treatment of the disease, and funding other interventions. Different private sector companies such as banks, mining companies, and telecommunication companies also have their own HIV/AIDS policies aimed at managing this scourge in the work place.

- NGOs

Despite the concerted efforts by all the players in the fight against the scourge, there is still a gap in the provision of the HIV/AIDS related services. Local and international NGOs have come in to augment the efforts of all the stakeholders and fill in the gap in the intervention to fight HIV/AIDS.Most of the local and international HIV/AIDS NGOs in Nigeria are affiliated to various organisations based on their operations whose roles include to (BONASO, 2006):

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a) Coordinate the civil society response to HIV/AIDS and facilitate an enabling environment for their activities.

b) Mobilise resources for its members, strengthen the capacity of NGOs and serve as a mouth piece for its entire members.

c) Facilitate sharing of information, experiences and best practices within their member organizations.

Affiliation to an umbrella organisation is very advantageous to all the stakeholders as illustrated below:

a) It provides a common forum to articulate their views in a coordinated way.

b) Make the interests of members of the umbrella organization known to the stakeholders that matter.

c) It also provides a peer review mechanisms within civil society and makes tracing and communication to and between members much easier.

The local NGOs in Nigeria are carrying out activities including, Behavioural Change Communication (BCC), Care and Support of the Sick (CSS), Socio–Economic impact Mitigation (SEM) through care of the widows, orphans and other vulnerable children and Advocacy for Human Rights (HRA) of people living with HIV/AIDS and those affected by the pandemic. The local NGOs play a huge role by bringing the much needed services to the communities in which they operate (Hans, 2003). Helen et al., (2005) identify the various strengths of the local NGOs to include the following:

a) They understand better the needs of the community and how HIV/AIDS is perceived and can appropriately talk about it and initiate interventions understood within the context of the community. This is very important due to cultural differences and the associated privacy and stigma attached to the HIV/AIDS condition.

b) The local NGOs because of their size, operating structure and closeness to the community are more flexible as opposed to government bureaucrats, to respond to community needs and priorities (Ramiah and Reich, 2006).

c) The local NGOs are also better mobilizers of the community to respond to the challenges community may be facing such as HIV/AIDS and are usually cost effective in delivery of services as opposed to government departments. The quick

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response is as a result of the fact that they work in community and with the community.

The activities of these organizations are normally funded by donors who include among others international development agencies such as World Bank, UNDP, USAID, philanthropic bodies such as the Bill and Melinda Gates Foundation, the private companies such as, pharmaceutical companies. The NGOs solicit for funding from donors through proposals detailing the project plan: the donors require that the activities are carried out in specified duration based on the budget they provide to achieve the specified objectives so as to contribute to overall goals of fighting the AIDS scourge.

At the strategic level NGOs partners with NACA as the voice of the civil society in the fight against the scourge. NACA channels any funds or assistance to the civil society organizations at the community through the umbrella body of these NGOs.

2.2.3 Oyo State HIV and AIDS Epidemic

The first case of HIV/AIDS in Oyo State was reported in 1987 from Oke-Ogun area (Saki) of the State, and since then there has been a gradual but steady increase in the number of people who had tested positive to the virus. Presently, cases of HIV infection have been reported in almost every town and villages in Oyo State and currently, three out of a hundred people in Oyo state have the virus. The Sero-prevalence rate for the State has been on the rise since 1992 to 2001 while it started to decline from 2003 to 2010 when the last survey was conducted (FMOH, 2010).

The following is the trend of HIV/AIDS Prevalence in Oyo State since 1992;

- 1992 - 0.1%
- 1994 - 0.2%
- 1996 - 0.4%
- 1999 - 3.5%
- 2001 - 4.2%
- 2003 - 3.9%
- 2005 - 1.8%
- 2008 - 2.2%
- 2010 - 3.0%

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Federal Ministry of Health (FMoH), 2010

As in other places in Nigeria, unprotected heterosexual intercourse accounts for about 85% of HIV transmission in Oyo State, whilst the rest is through mother-to-child-transmission and blood transfusion. The most at risk groups include, Sex Workers, Youths (in-and-out of school, especially between the ages of 15 and 24years), uniformed personnel and un-informed individuals. (OYSSP, 2010)

The factors fueling the spread of HIV/AIDS epidemic in Oyo State among others are: poverty, high incidence of risky sexual behaviour, inadequate STI prevention, diagnosis and management, stigmatization, blood safety inadequacies and inadequate care and support services for people living with the virus (OYSPOA, 2004). The need to curtail the spread and mitigate the impact of the epidemic has been accorded top priority by the past Governments and Administrations in the state since the discovery of the first case in 1987 (though with few sporadic interventions carried out in the State). Notable of such interventions were the annual celebration of the World AIDS Day coordinated by a unit designated as HIV/AIDS unit at the State Ministry of Health and few other random interventions carried out by the non government organizations in the State (OYSMOH Report, 2001)

The sero-prevalence rate for the State has been on the rise since 1992 to 2001 while it started to decline from 2003 to 2008 and rose again in 2010 when the last survey was conducted by the FMOH as shown in Table 2.2

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Table 2.2 Oyo State HIV Prevalence rates by site 2003 – 2010

SITES	2003	2005	2008	2010
Ibadan	1.7%	1.0%	0.3%	3.7%
Ogbomoso	3.7%	1.3%	3.3%	4.3%
Saki	6.4%	3.3%	2.7%	3.3%
Ado-Awaye	-	2.0%	2.0%	0.7%
Lagun	-	1.3%	2.7%	0.7%
State Average	**3.9%**	**1.8%**	**2.2%**	**3.0%**

Federal Ministry of Health (FMoH), 2010

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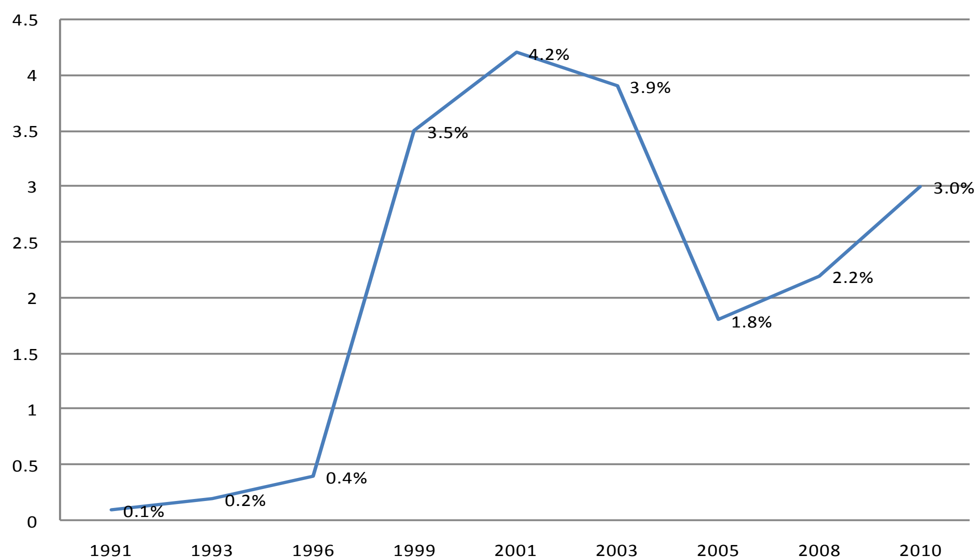

Figure 2.3: Trend of Oyo State HIV Prevalence rates 1991-2010

To respond to this pandemic, the Federal and State Government of Nigeria put in place various programmes aimed at controlling and mitigating the impact of HIV/AIDS among the populace. One of such intervention programmes is the provision of technical and financial support to non-governmental organizations working on HIV/AIDS through a multisectoral effort at community level (FMoH, 2010).

2.3 Partnership with Non-Governmental Organizations on HIV and AIDS response

The response of Non-Governmental Organisations (NGOs) to HIV/AIDS is usually through project interventions having a set objective and defined time framework and budget to achieve. The projects which the local NGOs implement have a large number of stakeholders that include: donors, beneficiaries of the project activities (for example, people living with HIV/AIDS, orphans), the community where the project is implemented and government at various level. The stakeholders require accountability in terms of the use of resources and impact of the project, transparency and good project

performance. Hulme and Edward (1995) quoted in Crawford and Bryce (2003), define accountability within the context of NGOs, as the means by which individuals or organizations report to recognized authority and are held responsible for their actions. They further discuss that accountability entails transparency in decision making and honest reporting of how and what resources have been used and what has been achieved by the project. It is important that there is accountability of the resources so that donors are motivated to commit more funds. Other stakeholders also "own" the project if it is accountable to them and is not seen as a money making venture for a few individuals. Avina (1993) distinguishes between short-term functional accountability, that is, accounting for the use of resources and immediate impact and strategic accountability: accounting for the impacts that NGOs actions have on the actions of other organizations and the wider environment.

Accountability by Non Governmental Organizations with respect to funds and grants secured for project implementation has been a critical issue in the recent times. UNAIDS (2004) expressed accountability in the aid context as a phenomenon with three dimensions, the vertical, downward and horizontal. The vertical dimension is the upward accountability by the NGOs to the donors in terms of resource use and results of the projects. The downward accountability is to the beneficiaries, those directly or indirectly affected by the disease. The horizontal dimension to accountability entails accountability within and across partnerships, donor to donor, public/private sector. There is unanimity among the different authors that the NGOs should be accountable to all the stakeholders of the projects they implement inclusive of the beneficiaries who are normally looked at by the implementers as people who are fortunate that the project was conceived hence they should not ask questions.

Project performance in the context of this research is defined as the extent to which the project had implemented its planned activities and attained its set objectives within the budget provided (PMI, 2004). Good project performance entails that the project covers its scope within schedule, budget limit and attained its set objectives.

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Effective monitoring and evaluation of projects is usually one of the ingredients of good project performance. It provides means of accountability, demonstrating transparency to the stakeholders and facilitates organizational learning through documenting lessons learned in the implementation of the project and incorporating the same in the subsequent project planning and implementation or through sharing experiences with other implementers.

Employing other organizations as partners is a useful and cost effective method to broaden the reach and scope of a programme and that was the rationale for the partnership between the Oyo State Action Committee on AIDS and the funded non-governmental organizations to increase and expand the frontiers of response to the pandemic of HIV and AIDS using a multi-sectoral and multi-dimensional approach. Maibach, Van Duyn & Bloodgood (2006) explain that partners can serve as a powerful and sustainable distribution channel. The foundation of the partnership approach is the value of collaboration between organizations that share the same and common interests and reach diverse audiences in order to achieve outcomes that neither could achieve alone Hasnain-Wynia, Margolina & Bazzoli (2001).

Oyo State Agency for the Control of AIDS like many other organizations worked with partners or intermediaries to implement programmes and activities that will reduce the further spread of HIV at the community level among different groups of people and coalitions by giving grants to non-governmental organizations, faith based organizations, private companies and support groups of people living with HIV with a view to reaching a wider audience with programmes and intervention to reduce the spread of HIV and mitigate its impact among the populace of Oyo State (Oyo SSP, 2010).

Non-governmental organizations are made up of ordinary citizens who organize themselves outside of government and the public service to deal with specific issues and concern that normal governmental process cannot address by itself (Global AIDS Epidemic Report, 2006). At the other end of the spectrum, non-governmental organizations include, faith based, women's groups, youth groups, professional

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associations, farmers' groups and other special interest associations, business enterprises and labour unions, private foundations and the media.

In most countries, non-governmental organizations' initiatives were the foundations on which the national response to HIV/AIDS were built and it is non-governmental organizations which remains at the forefront of prevention, care and support programmes, particularly among the most vulnerable and hard-to-reach populations. (Report on Global AIDS epidemic, 2006). This corroborated the reason why Oyo SACA was in partnership with non-governmental organizations to reach the unreached and the hard to reach segment of the populace with HIV prevention information and education.

A look back at history showed that non-governmental organizations have engaged in advocacy to press for a large number of policy objectives, including better access to health care and more cheaply priced drugs. For example, in 1987, the AIDS coalition to Unleash Power was launched by gay and lesbians activists in New York. Through public protests, the members drew attention to their claim that excessive profits earned by pharmaceutical companies on AIDS medications limited access to treatment and slowed the process of drug approval, thus placing lives unnecessarily at risk. The Coalition also campaigned for public education on the epidemic and an end to AIDS related discrimination. This early activism helped create the foundation for more affordable treatment initiatives.

A joint survey conducted in 2004 by the Paris-based treatment rights group, sidaction, and UNAIDS and WHO, found that non-governmental organizations are still the main provider of health care in many African countries, where the burden of HIV is heaviest. Though, to a large extent, the role played by civil society is often underestimated because it is not systematically measured. Yet, it is clear that without the non-governmental sector's participation including the work of vast numbers of volunteers at community level, many of the strategies and targets set by countries and the international community for responding to HIV would have been unattainable.

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Malawi's National AIDS Committee set AIDS education to youth as its top priority activity by implementing a project titled "A generation free of AIDS"; involving developing AIDS education materials for public and private schools of Malawi. It was concluded that Multi-sectoral efforts involving collaboration among public and private sectors can be successful in developing appropriate and acceptable materials for educating young people about AIDS prevention (Dupree, Mkwinda, Kalilani, 1990).

2.3.1 Funding for HIV/AIDS response

A lot of funds and other resources have been committed in the fight against HIV/AIDS globally (Halmashaw and Hawkins, 2004). According to UNAIDS (2006) an estimated US$6.1 billion was spent on HIV/AIDS related programmes globally in 2005, an estimated US$15 billion was required to adequately respond to the challenges of the scourge in 2006 of which only about US$8.2 billion had been committed. Most of these funds have been committed by developed nations and philanthropic bodies to initiatives such as the Global Fund to fight AIDS Tuberculosis and Malaria (GFATM) (Avert, 2005).

The president of United States of America in 2003 announced The President's Emergency Plan for AIDS Relief (PEPFAR) in which he committed up to US$15billion for 5years (Myra, 2005). The 15 focus countries eligible for the PEPFAR initiative includes Nigeria among other 12 sub-Saharan countries and other hard hit countries (Myra, 2005).A lot of funds have been spent and more are being committed to the response to the epidemic of HIV/AIDS in Nigeria in particular by the different stakeholders engaged in the response.

Between February, 2004; when Oyo State was granted no objection for participation in the World Bank/IDA credit project and December, 2007 a total sum of ₦158, 408, 776.00 million was disbursed as grants to Forty One (41) civil society organizations in the State, with each of the 41 non-governmental organizations receiving an average of ₦ 4million.

It is evident that significant amount of funds have been committed in this fight against HIV/AIDS globally and Nigeria. Specifically the different NGOs have different sources of funding, therefore it is quite difficult to document the actual amount of funds that

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NGOs in Nigeria have accessed over the period of time they have been involved in the fight against HIV/AIDS. Nevertheless it is evident that a significant amount of resources have been provided to the NGOs. As a result there is need for these funds to be effective in achieving the objective for which they were disbursed or else they just go down the drain. There is need to demonstrate that the funds actually did achieve what they were disbursed for. It is not prudent in the fight against HIV/AIDS to commit more and more funds without value for money in terms of impact. It is even highlighted that total funds committed are not sufficient to adequately respond to the scourge. The expenditure of these funds is at the expense of other priorities in the country, the further reason why there should be impact of their use.

2.4 The Role of Behavioural Change Communication in HIV prevention

Over the last half decade, behaviour change communication has become a central objective of public health education intervention,much moreso as the influence of prevention within the health services has increased. Behaviour change communication (BCC) is the strategic use of communication to promote positive health outcomes, based on proven theories and models of behaviour change. BCC employs a systematic process beginning with formative research and behavior analysis, followed by communication planning, implementation, and monitoring and evaluation. Audiences are carefully segmented, messages and materials are pre-tested, and both mass media and interpersonal channels are used to achieve defined behavioural objectives. (Family Health International FHI 360, 2011).

Many health conditions are caused by risk behaviours, such as problem drinking, substance use, smoking, reckless driving, overeating, or unprotected sexual intercourse. The key question in health behaviour research is how to predict and modify the adoption and maintenance of health behaviours. Fortunately, human beings have, in principle, control over their conduct. Health-compromising behaviors can be eliminated by self-regulatory efforts, and health-enhancing behaviours can be adopted instead, such as physical exercise, weight control, preventive nutrition, dental hygiene, condom use, or accident prevention. Health behaviour change therefore refers to the motivational,

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volitional, and actional processes of abandoning such health-compromising behaviours in favor of adopting and maintaining health-enhancing behaviors (FHI, 2011).

2.4.1 Health Education

Health education aims primarily at learning experiences and the voluntary actions people can take, individually or collectively, for their own health, the health of others, or the common good of the community. Defining health education as "any combination of learning experiences designed to facilitate voluntary actions conducive to health" (Green and Kreuter, 1999); emphasizes the importance of multiple determinants of behaviour. It also suggests an appropriate matching of determinants with multiple learning experiences or educational interventions. Health education is a systematically planned activity, and can thus be distinguished from incidental learning experiences. Further, this construction of health education draws attention to voluntary behavioural actions taken by an individual, group, or community with the full understanding and acceptance of the purposes of the action-either to achieve an intended health effect or to build capacity for health.

Health education can be seen as enveloped by health promotion, with its aim of complementary social and political actions that can achieve the necessary organizational, economic, and other supports that enable the conversion of individual actions into health enhancements and quality-of-life gains. In essence, the task for health promotion, beyond health education, is how to make more healthful choices easier choices. The commitment to an educational approach to health promotion is part practical necessity, part political expediency, and part philosophical commitment to provide for informed consent and voluntary change before attempting to change social structures and ecologies (Douglas, 2006)

Health Education as defined by Green et al (1991) is combinations of planned activities that enable or empower people to voluntary behave in ways that promote health, prevent disease and recover from illness. It is a systematic goal oriented and strategic activity which includes social support and modelling, skills and resource development and the acquisition of knowledge and clarification of values. It is also described as a learning

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process that should lead to action (King, 1986). It entails planning of health intervention from a point of view of diagnosis, in which case, factors responsible for the problem situation as well as those related to the desired outcome are investigated before designing intervention. In similar vein, Tennakoon, 1987; wrote that health education aims at community diagnosis and health development by improving people's knowledge, attitudes and practice to stimulate action.

According to WHO 1987; of very great significance is the powerful role of health education in promoting the involvement of the people in their own health care and in carrying out these roles, requires a reorientation to the techniques of social analysis, new educational methods which aims to enable people to identify and assess problems as well as to have confidence in solving those problems and new ways of negotiating solution to health problems. Acquiring right information and stimulating people towards positive desired health promoting and disease prevention action is no doubt the essence of any health programme.

The HIV and AIDS pandemic is a major global health emergency affecting all region of the world. It is the worst the world has ever faced and it still remains the greatest threat to human health and development (UNAIDS 2004). It is a health problem that is behaviour engendered. The modes of transmission of HIV are typically behavioural in nature and it is widely believed that health intervention integrated with health education component has a great role to play in providing people with appropriate information for the necessary desired behavioural change. The epidemiologic pattern of HIV infection, with sexual behaviour, use of contaminated skin piercing instrument, transfussion of unscreened blood and mother to child transmission as the principal modes of transmission clearly indicated that behaviour modification is central to HIV prevention (Kanki, 2006).

2.4.2 HIV Risk Behaviours in Nigeria:

The HIV epidemic in Nigeria is complex and varies widely by region. In some states, the epidemic is more concentrated and driven by high-risk behaviours, while other states have more generalized epidemics that are sustained primarily by multiple sexual partnerships in the general population. Youth and young adults in Nigeria are particularly

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vulnerable to HIV, with young women at higher risk than young men. There are many risk factors that contribute to the spread of HIV, including prostitution, high-risk practices among itinerant workers, high prevalence of sexually transmitted infections (STI), clandestine high-risk heterosexual and homosexual practices, international trafficking of women, and irregular blood screening (2008 Country Profile: Nigeria, USAID).

Although the majority of Nigerians are familiar with HIV/AIDS, risky practices are widespread in young persons, female sex workers (FSW) and commercial drivers, indicating the need for improved intervention programs in these populations. Primary prevention interventions targeted at vulnerable populations is one of the most realistic strategies for controlling further spread of HIV in the country. In Nigeria as elsewhere, personnel in the military are an important target for primary prevention interventions because they have a high risk of exposure to sexually transmitted infections (STI) including HIV.

Nwokoji and Ajuwon (2004) assessed HIV/AIDS knowledge and HIV sexual risk behaviours in the Nigerian uniformed services by surveying 480 military personnel in Lagos, Nigeria. The results revealed that although the overall knowledge score was high (7.1 on a 10 point scale), 52% of the respondents believed that there was a cure for AIDS and that one can contract HIV by sharing personal items with an infected person. The majority of the respondents (88%) reported having lifetime multiple partners ranging from 1-40 with a mean of 5.1. Thirty two percent said that they have had contact with a commercial sex worker in the past six months and 40% had not used a condom on that occasion. Nwokoji and Ajuwon (2004) concluded that the Nigerian uniformed services constitute a potential bridging group for the dissemination of HIV into the larger population because members of the uniformed services live and interact freely with the civilian population.

Similarly, a study carried out by Adedimeji, 2007 among sexually-active urban young slum dwellers in Ibadan, Nigeria showed that although the sexually-active respondents demonstrated basic knowledge of HIV/AIDS and high risk perception, risky behaviour

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was common and protective behaviour was poor among them. About 48% of males and 12% of females had multiple partners, 29% of males and 38% of females were engaged in transactional sex. Only 14% of males and 5% of females used any form of protection, resulting in the high rates of sexually transmitted infections reported by 27% of males and 10% of females.

Long Distant Drivers (LDDs) are another set of most at risk groups. By the nature of their vocation, being separated from home for a number of days LDDs do have non-marital sexual partners (including sex workers) mainly along the transport routes. Experience of STIs is common. Targeting LDDs is essential as they are likely to transmit HIV from high-risk behaviour to their partners at home thereby constituting a bridge between the FSWs and their other partners (PSRHH, 2004).

2.4.3 HIV Risk Behaviours in Oyo State:

As in other places in Nigeria, unprotected heterosexual intercourse accounts for about 85% of HIV transmission in Oyo State, whilst the rest is through mother-to-child-transmission and blood transfusion. The most at risk groups include, Sex Workers, Youths (in-and-out of school, especially between the ages of 15 and 24years), uni-formed personnel and un-informed individuals (OYSPOA, 2004). The factors fueling the spread of HIV/AIDS epidemic in Oyo State among others are: poverty, high incidence of risky sexual behaviour, early sexual debut, poor knowledge on reproductive health and HIV preventive measures, inadequate STI prevention, diagnosis and management, stigmatization, blood safety inadequacies and inadequate care and support services for people living with the virus (OYSPOA, 2004). The target groups for intervention as highlighted in the Oyo State Strategic Plan (2008-2012) are; Women and Children, Youths, Most at risk persons such as long distance drivers, transport workers, artisans, sex workers, intravenous drug users (IDUs) and orphans and vulnerable children.

Population prevalence in Oyo State is 3.0%. HIV prevalence is higher in urban areas than rural areas.The rates for condom use in men and women at last sex are lower than the national average (NARHS, 2007) and a study found that a considerably low proportion of male and female adolescents regularly use condoms (Adedimeji 2007). Knowledge about

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HIV in the population is high however comprehensive knowledge about the disease is low. A study amongst men found that a majority had heard of HIVAIDS however several misconceptions such as transmission of HIV/AIDS by mosquitoes and through sharing of clothes were prevalent. Higher proportions of men (39%) report high-risk sex compared to females (7%) and a study done amongst men found that 48% of them had had 2 or more sexual partners in the last 12 months (Omokhodion 2007). A survey among drug users in Ibadan revealed that 30 (27%) of the 112 drug users surveyed were past or current injectors (Adelekan, 2006).

A study carried out by Oladepo 2000, on sexual attitudes and behaviour of male secondary school students in rural and urban areas of Oyo State, Nigeria, showed that mean age at first sexual intercourse was 13.5 years among the 19.9% who had ever sex. Having had sex before was associated with increasing age and number of fathers' wives. A positive male dominance attitude was common among rural, older and sexually experienced youth. Only 26.2% of sexually experienced youth had used condom. Perceived self-efficacy was the only factor associated with condom use while reproductive health knowledge among them was low.

A study among students aged 15-19 years found that the average age for the first sexual experience occurred at 15.8 years for males and 16.3 in females. Of the 450 students studied, 159 (35.3%) had experienced sexual intercourse before. Of the 120 students (26.7%) who became sexually active a month before the survey, 34 (28.3%) had multiple sexual partners (2 or more). Consistent condom use was reported in only 22 (19.8%) of the sexually active students (Fawole 1999a). A study found that siginificantly more monogamous men than polygamous men in urban locations had extra-marital partners. Similarly, more rural men in monogamous unions had extra-marital partners compared with their polygamous counterparts (Lawoyin 2001). A study amongst men found that 30% of them had casual sex partners. Of these, only 59% used condoms during the last sexual intercourse with casual partners, 48% had 2 or more sexual partners in the last 12 months with 21% having more than 4 (Omokhodion 2007a).

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Like many other developing countries, Nigeria has passed through several phases in her response to the epidemic of HIV/AIDS. The stages included an initial period of denial; a largely medical response; a public health response; and now a multi-sectoral response that focus on prevention, treatment and impact mitigation interventions (National Policy on HIV/AIDS, 2003). Nigeria as a country faces many challenges in dealing with its HIV/AIDS epidemic. Factor fuelling the epidemic of HIV/AIDS are largely behavioural, hence, public education which would engender positive behavioural change therefore plays a key role in curtailing the spread of HIV infection. The need to implement large scale Behavioural Change Communication (BCC) programmes that would encourage individuals to reduce their risk of HIV acquisition and reduce the stigmatization and discrimination that have typified societal responses was also identified as crucial for the success of a national HIV prevention programmes (Kanki, 2006).

Educational materials are learning or teaching aids (CDC, 2006). They can be used to reach masses of people, to reinforce or illustrate information given in a one-on-one setting, or serve as references to remind people of information they received earlier. Materials also teach skills by providing hands-on experience or by illustrating a step-by-step approach. Effective materials can also influence attitudes and perceptions. It therefore became expedient for stakeholders to mount up public health education strategies and techniques with behavioural change communication components that would inform, educate and influence people's attitude, knowledge and behaviour which in turn would help them to make informed decisions regarding their sexual and reproductive health. Pivotal to achieving this goal is the designing, production, distribution and utilization of appropriate health education materials by various stakeholders, which are intended to reinforce learning and consequently achieve the desired behavioural change at community level.

2.4.4 Concept of Behaviour Change Communication

Behaviour change communication (BCC), an integral part of the IEC, is a process of interacting with target group to develop tailored messages, using variety of communication channels to promote and sustain behaviour change (FHI, 2002). BCC is a process because it involves series of activities, but, it is not specific event. Participation

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of the target group in planning intervention is a critical component of BCC because it ensures that appropriate communication channels are used to influence adoption of specific behaviours. Behavioural change communication through IEC can be defined as the process through which tailored HIV/AIDS messages are provided through a variety of communication channels to communities in order to ensure positive and sustained behaviours. This is done so that members of the community can protect themselves from HIV/AIDS infection through less risky actions, offer more support and care to the infected and the affected and reduce discrimination and stigma of the infected and affected in the community (FHI, 2004). Under BCC projects several activities can be scheduled by the NGO such as video shows, drama shows with HIV/AIDS messages, radio messages and drama, dissemination of information through peer groups, talks on HIV/AIDS to the communities, distribution of IEC materials such as posters, flyers, caps, T-shirts and setting up of billboards, voluntary counselling and testing for HIV/AIDS.

Behaviour is a critical component in the relationship among health, disease and quality of life. Behaviour can add or decrease a person's years of potential life (Green and Kreuter, 1991). In the US, half of the mortality from diseases is attributed to behaviours and lifestyles (Green and Kreuter, 1991). Examples of behaviours that require change through BCC intervention are smoking of tobacco products, early initiation of sexual activities, discrimination of persons living with HIV/AIDS and low and inconsistence use of condoms. Through information communication and education activities FHI (2004) and other authors argue that effective BCC projects can play a big role in the fight against HIV/AIDS as illustrated below:

a). Increase knowledge by ensuring that people are given basic facts about HIV/AIDS in a language or visual medium or any other medium they can understand or relate to. The media could be radio, drama, songs television, dances, and art. Empowering the communities with basic facts about HIV/AIDS is very important: there are a lot of misconceptions and falsehoods about HIV/AIDS. The communities need to know what HIV/AIDS is, how it is spread, and how it is prevented so that they can adopt positive lifestyles.

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Liskin (1989) noted that since HIV/AIDS first emerged globally, the role of behaviour change has been recognized as critical to the control of the pandemic. The phrase "education is the only vaccine against AIDS and was commonly aired during the early years to control the epidemic. Against this background, considerable efforts and energy were devoted to implementing communication programs to educate people about HIV transmission modes and prevention strategies. The underlying assumption of these early activities was that improving people's knowledge about the infection and disease would lead to avoidance of risky behaviours. According to the information, education, and communication (IEC) model by UNFPA, 2001, clear information presented in an appropriate format and language would persuade those at risk to protect themselves from the virus. Similarly, the U.S. Centers for Disease Control and Prevention (2004) noted, "IEC campaigns are often better at imparting knowledge and information than they are at inspiring behaviour change". In sub-Saharan Africa, for example, the level of AIDS awareness has increased significantly over the years, with more than 90% of people in the worst affected countries reporting awareness of the virus. There is little evidence to suggest, however, a concomitant decrease in HIV-related risk behaviours in most countries on the subcontinent. The awareness achieved is usually shallow and includes neither accurate knowledge nor the development of the skills needed to protect individuals from infection (Scalway, 2002). In 2003 the National Demographic and Health Survey (NDHS, 2003) showed wide gaps between awareness and correct knowledge of HIV transmission and the appropriate methods of prevention.

b). Effective BCC can stimulate community dialogue by encouraging community discussions on the basic facts of HIV/AIDS and the underlying factors that contribute to the epidemic, such as risk behaviours and risk settings such as bars coupled with alcohol abuse. The community can come up with bye laws or even lobby government to regulate the risk activities and environments in their communities. They could for example lobby for a regulation of alcohol business in their communities. The consumption of alcohol has been recognized as a key determinant of sexual risk behavior, and indirectly, as a contributor to HIV transmission. Cross-sectional studies conducted among adults in Guateng province of South Africa by Morojele 2006, have shown that alcohol use is

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associated with HIV infection. Additional studies have discovered associations between alcohol consumption and unprotected sex, timing of sexual debut, and multiple sex partners, all of which lead to an increased risk for HIV infection (Stratten 2007 and Khan 2008).

c). Reduce stigma and discrimination through accurate information communication and education about HIV/AIDS that addresses stigma and discrimination and attempts to influence perceptions and behaviours towards those infected and affected by the scourge. Stigma and discrimination of those affected and infected by HIV/AIDS is mostly as a result of lack of accurate information about the disease (Kalichani and Simbayi 2003: andValdiserri, 2002). Stigma helps to drive the epidemic underground because people fear to test for their status and even when they test they cannot come out openly about their status if they find they are infected because of fear of discrimination (Kalichani and Simbayi 2003). Bond et al. (2002) argues that stigma negatively affects all aspects of HIV/AIDS prevention, diagnosis (testing), treatment and care. It is imperative that if we are to have a substantial headway in the fight against the epidemic we need to defeat stigma and discrimination and its subsequent effects by arming communities with accurate information on HIV/AIDS and attempt to change their perceptions and behaviours about HIV/AIDS. The Malawi BRIDGE Project (2008), is an example of project that has shown positive effects of the behavior change communication strategy in reducing stigma and discrimination against people living with and affected by HIV/AIDS in Malawi communities. Due to personal and powerful accounts of individuals infected with HIV and behavior change strategy that engages the audience by humanizing those living with the disease, there has been a significant reduction of stigma observed toward people living with HIV, increased use of voluntary counseling and testing services, and increased membership in support groups for people living with HIV. The program has also had a significant impact on national media, encouraging new production methods at radio stations, increasing capacity and knowledge on HIV/AIDS among producers, strengthening radio station management response to HIV/AIDS, increasing donor support for other health programming at the radio stations, increasing understanding of personal

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risk and vulnerability to HIV/AIDS among the general population, and increasing involvement of the general Malawian population in HIV and AIDS issues.

d). BCC can motivate individuals and communities to demand more information on HIV/AIDS and appropriate services. Such services would include counselling and testing services from governments or donors, care and treatment for the sick and those infected with other sexually transmitted infections, demand for more condoms. Effective BCC is known to result in more people seeking to voluntary know their HIV status which is very important tool in the fight against HIV/AIDS. Effective BCC is also associated with increased use of mainstream services in health such as treatment of STIs, screening for tuberculosis (Keating et al., 2006). The same Author reported that the VISION Project carried out in three states of Nigeria, Bauchi, Enugu and Oyo states, reached a large portion of the population for reproductive health and HIV prevention information with increased HIV/AIDS awareness and uptake of services due to exposure to mass media programmes that target rural populations, females, and unmarried individuals, and disseminate information on where to obtain condoms. He recommended that improvements in HIV/AIDS prevention behaviour are likely to require that these programmatic efforts be continued, scaled up, done in conjunction with other interventions, and targeted towards individuals with specific socio-demographic characteristics.

e). BCC also empowers communities with life saving skills such as negotiating for safer sex and delay in sexual activities, skills of proper and consistent condom use to prevent infections (Keating et al., 2006). An example was the Thailand 100% Condom programme- a strategy devised in 1989 to promote condom usage among those engaging in commercial sex in the Ratchaburi province where HIV prevalence was rising among young Thai men from 0.5% in late 1989 to 3% in late 1991. It was discovered that the majority of new HIV infections were occurring through commercial sex and to address this alarming trend in new infections, Thai public health officials devised this strategy the 100% Condom Program to promote condoms use in all establishments of sex workers in the province. Condom use was promoted through mass media, peer education, and outreach programs, and condom quality was ensured through the Ministries of Public

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Health and Industry. Approximately 60 million condoms a year were provided free of charge, primarily at sex establishments. When this program was implemented, the rates of sexually transmitted infections dropped. A number of studies, as well as surveys of sex workers, found that condom use in brothels exceeded 90%. Among approximately 2,000 sex workers interviewed in one study looking at the effectiveness of the program, 97% reported always using condoms with clients they saw once, while 93% reported always using them with clients they saw repeatedly. Consistent condom use with one-time clients was around 96% in all sex establishments and more than 99% in massage parlors. This point to the notion that the 100% Condom Program was most effective due to various channels of behaviour change communication that were utilised to target all the people involved-sex workers, brothel owners and clients.

2.4.5 Stages of Behaviour Change

Behaviour change is a complex process that may include several stages in many individuals. The Transtheoretical Model of Behaviour Change (TM) provides the theoretic underpinning for this intervention. This model was developed to explain how new behaviours are acquired and the mechanism by which people make purposive behaviour change (Parson et al, 2000). According to the TM, people move through a process of change that is determined by degrees of motivation and behaviour (Kalichman, 1998; Prochaska et al, 1992). The TM describes a framework for understanding the processes of change, stages of change, self-efficacy and decisional balance and is a means of tailoring education and intervention approaches for health behaviour change (Prochaska et al, 1994).

The stages of change model recognize that for most persons, a change in behaviour occurs gradually with an individual moving from being unintersted, unaware or unwilling to make a change, a stage referred to as precontemplation, to considering a change - contemplation to deciding and preparing to make a change. Genuine, determined action is then taken and over time, attempts to maintain the new behaviour occur. Relapses are almost inevitable and become part of the process of working towards adopting a change. These five stages of change as developed by Prochaska and colleaques (1983) are also known as Transtheoretical Model.

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1. Precontemplation Stage- A stage in which individuals are not currently thinking about making a positive change in health behaviour. It is a stage of unawareness and patients do not even consider changing their risky behaviour. Smokers who are in denial may not see that the advice to stop smoking applies to them personally. Patients with high cholesterol levels may feel immune to the health problems that strike others. Obese patients may have tried unsuccessfully so many times to lose weight that they have simply given up.
2. Contemplation Stage- It is a stage in which an individual is aware of the behaviour and is thinking about making a positive change in that behaviour. An individual becomes ambivalent about changing at this stage. Giving up an enjoyed behaviour causes him/her to feel a sense of loss despite the perceived gain. During this stage an individual assess barriers such as time, expense, hassle, fear, as well as the benefits of change.
3. Preparation Stage- During the preparation stage, individuals prepare to make a specific change. They may have tried and intend to continue. They may experiment with small changes as their determination to change increases. For instance, trying to use a condom before sex by randy youths, sampling low-fat foods or a move toward greater dietary modification by an obese. Switching to a different brand of cigarttes or decreasing their drinking signals that they have decided a change is needed.
4. Action Stage- An individual has initiated a change in his/her health behaviour and over time attempts to maintain the new behaviour occur. Any action taken by individual at this stage should be praised and rewarded because it demonstrates the desire for lifestyle change.
5. Maintenance and Relapse Prevention Stage- At this stage individuals make several attempts at maintenance of the new behaviour. Discouragement over ocassional slips may halt the change process and result in the individual giving up. However most people find themselves recycling through the stages of change several times before the change becomes truly established.

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A study conducted by Essien, 2005 on HIV risk-reduction intervention among the Nigerian Uniformed Services on readiness to adopt condom use with casual partners assessed the stages of behavior change for condom use among Nigerian uniformed services personnel as part of a situationally-based HIV/AIDS risk reduction intervention for this population. The intervention aimed to increase condom use with regular and casual partners. Data were collected on reported sexual behaviors, condom beliefs, stages of change for condom use, and sexual risk behaviors with casual partners. Five stages of change readiness and in relation to condom use were assessed, precontemplation (not considering the behavior change in the near future nor recognizing the need for change or feeling that change is possible), contemplation (actively considering condom use but lacking the short term intentions to do so), preparation (having a proximal goal to use condoms and making commitments and initial plans to make this behaviour change), action (using condoms consistently and adopting strategies to prevent relapse) and maintenance (using condoms consistently and consolidating the change and integrating it into one's lifestyle). Relapse is also considered at which time the individual may return to the precontemplation, contemplation or action stages.Participation in the intervention resulted in increased condom use with casual partners at 6 and 12-months follow-up assessments. Specifically, 36% of the participants in both regiments reported that they hadn't even thought of using condoms with a casual partner at baseline. However, a positive intervention effect was observed in the intervention, but not the control regiment at the 6-months (40% vs. 0.9%) and 12-months' (46.8% vs. 4.3%) follow-up assessments ($p<0.05$). These data confirm that a situationally-based intervention with uniformed service personnel in West Africa has a significant and powerful impact on reported readiness to engage in HIV-preventive activities with casual partners, and specifically, condom use. Similarly, Nwokoji and Ajuwon (2004) also concluded that the Nigerian uniformed services constitute a potential bridging group for the dissemination of HIV into the larger population because members of the uniformed services live and interact freely with the civilian population.

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2.4.6 Steps Involved in Behaviour Change Communication

BCC is a planned process aimed at bringing about sustained change in the behaviour and attitude of a target group. There are seven distinct steps involved in the process (ILO, 2011; FHI, 2003).

First Step: Problem Identification

BCC intervention must be based on existing problem, which programme managers have identified. The following are examples of behavioural problems that require BCC interventions

1. Pregnant women do not register at all for ante-natal care (ANC)
2. Discrimination against persons living with HIV/AIDS
3. Low and inconsistence use of condoms
4. Low utilisation of voluntary counselling and testing (VCT) services
5. Mothers do not use treated bed nets

Second Step: Audience Segmentation

Audience or population segmentation is a process of identifying a group or groups of persons who exhibit the behaviour being targeted for change (ILO, 2011; FHI, 2003).. Segmentation may be done by gender, age, location, ethnicity and language. The segment may be primary or secondary target. A primary target is a group whose behaviour we want influence. A secondary target is a group whose approval or support is required to reinforce the behaviour of the primary target. For example, nurses who discriminate against persons living with HIV/AIDS in Oyo State may be primary targets, while administrators are secondary target.

Third Step: Formative Research on Factors Associated with Behaviour

Formative research is a process of identifying reasons for the persistence of the behaviour being targeted for change. Formative research is required to fully understand the reasons for the persistence of the behaviour, context of the behaviour and existing media habits of the targets. Since the essence of the research is to understand context of behaviour, qualitative methods are better suited to collect these types of data. Examples of

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qualitative methods are focus group discussion, key informant interviews and observation.

Fourth Step: Development of Objectives, Messages and Channels

At this stage of the process, the objectives of the programme, messages and channels are developed. The messages to be developed must have the following characteristics if they are to influence and sustain behaviour change. Messages must be simple, clear and specific about the behaviours targets are expected to adopt and sustain. In developing the message, there is need to work with experts such as graphic artists, and some considerations should be given to the appropriate channels to disseminate the messages. Some of the channels may be print in nature such as poster, handbill, and brochure or electronic such as jingles. It is recommended that multiple channels be used to convey messages since each channel has its strength and limitations.

Fifth Step: Field Testing of Draft Material and Messages

- Comprehension
- Attraction
- Persuasion
- Acceptability
- Revision

Sixth Step: Launching of the intervention

- Implement interventions as planned
- Sequencing of activities
- Coordination
- Synergy of channels

Seventh Step: Monitoring and Evaluation

- Monitor
- Inputs and outputs
- Pulse of audience
- Evaluate

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- Gauge effects
- Consider revision
- Feedback revision

BCC is a systematic process of planning, implementing and evaluating intervention activities aimed at initiating and sustaining behaviour change. Multiple BCC interventions are better than single intervention. However, BCC should be implemented in the context of other activities because BCC alone may not be sufficient to stimulate and sustain behaviour change (ILO, 2011; FHI, 2003).

2.4.7 Information, Education and Communication

Information, Education and Communication (IEC) can be defined as an approach which attempts to change or reinforce a set of behaviours in a "target audience" regarding a specific problem in a predefined period of time. It is multidisciplinary and client-centred in its approach, drawing from the fields of diffusion theory, social marketing, behaviour analysis, anthropology, and instructive design. IEC strategies involve planning, implementation, monitoring and evaluation. When carefully carried out, communication strategies help to foster positive practices individually and institutionally, and can contribute to sustainable change toward the desired behaviour (Seshu, 2011; WHO, 2001).

2.4.8 Information, Education and Communication Planning

Information, Education and Communication (IEC) succeeds when it is planned with a **comprehensive strategy**. This means having clearly articulated objectives, keeping the client at the centre of what is being designed, conducting appropriate research, undertaking audience segmentation, carefully crafting and testing messages, knowing and using appropriate channel choices, and planning for monitoring and feedback. It is important to remember that **everything cannot be changed at once**. Also, it is important to focus on what is relevant or not relevant, and consider not only on information but also the "knowledge-behaviour gap". IEC interventions are more cost-effective when there are clear **links with health care service delivery programmes** rather than when they are conceived as stand-alone IEC projects.

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A study carried out by Ajoko, 2001 among secondary school students in Ibadan South West Local Government Area of Oyo State showed that participation of students in the planning process for development of educational materials-flipchart enhanced its value among members of the target group. He also documented that the involvement of young people in the planning process for developing educational materials enhanced their confidence and skills as future peer educators.

2.4.9 Information, Education and Communication Implementation

Actively **involving the target audience** in the design, implementation and monitoring of a project is critical. Listening to local language, custom and experience, negotiating the relevance of an intervention with the audience and making sure the intervention addresses reality "on the ground" is of utmost importance. It is important to establish linkages and relationships with, and actively involve, traditional healers and local support groups, and recognize the important role each plays and share information with them. A study carried out by Goni, 2000 in Ibadan metropolis documented that involvement of target audience-health care workers at the health facility in the process of development of IEC materials enhanced the use of the materials among them. He further stressed that participation in the implementation process increased their skills, self confidence and encouragement to utilize the materials developed.

Health communication encompasses the study and use of communication strategies to inform and influence individual and community decisions that enhance health. It links the domains of communication and health and is increasingly recognized as a necessary element of efforts to improve personal and public health (National Cancer Institute [NCI], 1989; Piotrow, Kincaid, Rimon, et al., 1997; Jackson, and Duffy, 1998). Health communication can contribute to all aspects of disease prevention and health promotion and is relevant in a number of contexts, including (1) health professional-patient relations, (2) individuals' exposure to, search for, and use of health information, (3) individuals' adherence to clinical recommendations and regimens, (4) the construction of public health messages and campaigns, (5) the dissemination of individual and population health risk information, that is, risk communication, (6) images of health in the mass

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media and the culture at large, (7) the education of consumers about how to gain access to the public health and health care systems, and (8) the development of telehealth applications (Jackson, and Duffy, 1998; HHS, 1999; Northouse, and Northouse, 1998; Maibach, and Parrott, 1995; Ray, and Donohew, 1990; Freimuth, Stein, and Kean, 1989; Atkin, and Wallack, 1990; Backer, Rogers, and Sopory, 1992; Harris, 1995).

It has been observed that the main goal of health communication strategically is to improve health. For individuals, effective health communication can help raise awareness of health risks and solutions provide the motivation and skills needed to reduce these risks, help them find support from other people in similar situations, and affect or reinforce attitudes. Health communication also can increase demand for appropriate health services and decrease demand for inappropriate health services. It can make available information to assist in making complex choices, such as selecting health plans, care providers, and treatments (NCI, 1989). For the community, health communication can be used to influence the public agenda, advocate for policies and programs, promote positive changes in the socioeconomic and physical environments, improve the delivery of public health and health care services, and encourage social norms that benefit health and quality of life (Piotrow, Kincaid, Rimon, et al., 1997).

The practice of health communication has contributed to health promotion and disease prevention in several areas. One is the improvement of interpersonal and group interactions in clinical situations (for example, provider-patient, provider-provider, and among members of a health care team) through the training of health professionals and patients in effective communication skills (Jackson, and Duffy, 1998; HHS, 1999). Collaborative relationships are enhanced when all parties are capable of good communication.

Another area is the dissemination of health messages through public education campaigns that seek to change the social climate to encourage healthy behaviours, create awareness, change attitudes, and motivate individuals to adopt recommended behaviours (Maibach, and Parrott, 1995; Atkin, and Wallack, 1990; Backer, Rogers, and Sopory, 1992). Campaigns traditionally have relied on mass communication (such as public service

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announcements on billboards, radio, and television) and educational messages in printed materials (such as pamphlets) to deliver health messages. Other campaigns have integrated mass media with community-based programs. Many campaigns have used social marketing techniques.

Attributes of effective Health Communication

- *Accuracy*: the content is valid and without errors of fact, interpretation, or judgement.
- *Availability*: the content (whether targeted message or other information) is delivered or placed where the audience can access it. Placement varies according to audience, message complexity, and purpose, ranging from interpersonal and social networks to billboards and mass transit signs to prime-time TV or radio, to public kiosks (print or electronic), to the internet.
- *Balance*: Where appropriate, the content presents the benefits and risks of potential actions or recognises different and valid perspectives on the issue.
- *Consistency*: the content remains internally consistent over time and also is consistent with information from other sources (the later is a problem when other widely available content is not accurate or reliable).
- *Cultural competence*: The design, implementation, and evaluation process that accounts for special issues for select population groups (for example, ethnic, racial, and linguistic) and also educational levels and disability.
- *Evidence based*: Relevant scientific evidence that has undergone comprehensive review and rigorous analysis to formulae practice guidelines, performance measure, review criteria, and technology assessments for telehealth applications.
- *Reach*: The content gets to or is available to the largest possible number of people in the target population.
- *Reliability*: The source of the content is credible, and the content itself is kept up to date.
- *Repetition*: The delivery of/access to the content is continued or repeated over time, both to reinforce the impact with a given audience and to reach new generations.

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- *Timeliness*: The content is provided or available when the audiences are most receptive to, or in need of, the specific information.
- *Understandibility*: The reading or language level and format (including multimedia) are appropriate for the specific audience.

For health communication to contribute to the improvement of personal and community health during the first decade of the 21st century, stakeholders, including health professionals, researchers, public officials, and the lay public, must collaborate on a range of activities. These activities include (1) initiatives to build a robust health information system that provides equitable access, (2) development of high-quality, audience-appropriate information and support services for specific health problems and health-related decisions for all segments of the population, especially underserved persons, (3) training of health professionals in the science of communication and the use of communication technologies, (4) evaluation of interventions, and (5) promotion of a critical understanding and practice of effective health communication

2.4.10 Target Audience Involvement and Segmentation

Thackeray and Brown (2005) stated that the primary focus of a health promotion programme is the target audience. It is very much important to learn as much as possible about the individuals who make up the target audience in order to tailor the programme most effectively. A viable way of doing this is through audience segmentation. Audience segmentation is the division of priority populations into sub groups that share similar qualities or characteristics. Moreover, Slater, Kelly and Thackeray (2006) pointed out that the goal of this is to segment the intended populations on characteristics that are relevant to the health behaviour to be changed and to organize the programmes effort around these groups of similar individuals. Kutner, Greenberg, Jin and Paulsen (2006) found that adults with below basic or basic health literacy were less likely than adults with higher health literacy to get information about health issues from written sources like books, magazines, and more likely than adults with higher health literacy to get a lot of information about health issues from radio and television. They concluded that written brochures or pamphlets are often not the best way to provide people with health information particularly those who are more likely to have low health literacy.

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Another important lesson learned is the need to prioritize programme activities. Not everyone is at equal risk of contracting HIV. Identifiable groups of people who are engaged in behaviours which facilitate the spread of HIV can be targeted for priority prevention activities. These behaviours include having multiple sexual partners and sharing injecting equipment. People with a high prevalence of other sexually transmitted diseases also need to be targeted.

The groups at high risk may differ from city to city and area to area. It is important for each national or district-level programme to evaluate the risk determinants and identify the populations that may be at high risk of infection so that appropriate strategies to reach such populations can be developed on a priority basis.Groups of individuals who share common high-risk behaviour might include, among others, commercial sex workers and their clients; injecting drug users; people with STDs; migrant workers; transportation workers - especially truck drivers; street children; and the military. Other general groups, such as women who have limited access to information and services or youth, also need special emphasis. Targeted interventions among these populations, given the current epidemiological situation in the Region, will have the greatest impact on limiting the further spread of HIV (WHO, 2006)

2.5 Behavior Change Communication Material Development- Process and Guidelines

The process of developing the materials involves careful validation and employs beneficiary group representatives as well as outsiders in conceptualisation and development. It was documented that pre-literate people generate family-based strategies to decipher written information that they consider important, suggesting that print-based material for non-literate populations can be part of an effective communication strategy. In order to personalise risk and consider information relevant, beneficiaries must immediately recognise an attempt to communicate specifically with them. In-depth validation processes involving dialogue among “insiders” allows the development of response to the epidemic and a broadening of risk perceptions while minimising fear and discrimination. It was recommended that the development of voice and risk perception should be prioritised when developing culturally targeted educational materials. Broad

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beneficiary group decision-making should include representation, consultation, presentation, language and content.

2.5.1 Needs Assessment

Needs assessment is practically ubiquitous today among planners and designers, often identified as the first step in any planning or design process. Over the past four decades, there has been a proliferation of models for needs assessment with dozens of models to choose from. What nearly all models share is a definition of needs assessment as identification of a "gap" - but a gap in *what* differs from model to model. Kaufman (1996) considered as the "father of needs assessment, first developed a model for determining needs defined as a gap in results. This particular emphasis in results focuses on the outcomes (or ends) that result from an organisation's products, processes, or inputs (the means to the ends). Kaufman argues that an actual need can only be identified independent of premature selection of a solution (wherein processes are defined as means to an end, not an end unto themselves). To conduct a quality needs assessment according to Kaufman, you first determine the current results, articulate the desired results, and the distance between results is the actual need. Once a need is identified, then a solution can be selected that is targeted to closing the gap. Kaufman's model in particular identifies gaps in needs at the societal level, what Kaufman calls "Mega" planning, along with gaps at the Macro (or organizational) and Micro level (Kaufman, 1996).

Hawe, Degeling & Hall (1990) in their opinion stated that needs assessment is the first step in planning any health promotion initiative. It is the process of identifying and analysing the priority health problem and the nature of the target group for the purpose of planning any health promotion action. According to them, needs assessment is an important process to

- identify as much relevant information as possible to guide the development of best practice programs and activities
- ensure that programs and activities are planned, are as effective as possible and are most likely to achieve their goals and objectives
- ensure that communities are engaged in identifying their needs.

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Bradshaw (1972) further suggested four different types of needs namely: normative need, expressed need, comparative need and felt need. He pointed out that it is essential to tap into each dimension of needs to increase the chance of constructing a comprehensive picture of community problems. Findings from this study show that different approaches were used in the need assessement process for the project; majority of the NGOs used focus group discussions to conduct the needs assessment while some used rapid assessment and questionaire method to assess the needs of the target population. A few of the organizations used the fora of meetings and advocacy visits to assess the needs of the target groups at the various communities; this is similar to the position of Hawe, Degeling and Hall (1990).

Leigh, et al. (1998), conducted a comparison of the major needs assessment models in 2000 based on the level of organizational planning each addressed and the direction of linkages between the levels of planning. Gupta et al. (2007), developed a model focused at the community level they termed community needs analysis. Their model involves identifying material problems/deficits/weaknesses and advantages/ opportunities/strengths, and evaluating possible solutions that take those qualities into consideration. This is different from Kaufman's Mega model that focuses on identifying societal-level needs.

Health programme needs assessment involves assessing the needs that people have in order to live in; an ecologically sustainable environment, a community that maintains and develops viable social capital, a way that meets their own economic and financial requirement and in a manner that permits political participation in decisions that affect them. Community needs assessment as a technique thus forms a part of an Ecologically Sustainable Community Economic Development (ESCED). It forms a first step in any project that aims to secure: Ecological enhancement: minimizing ecological impact or ameliorating any ecological damage, Social vitality: building a community that meets all the social and human needs of its members, Economic resilience: "shock-proofing" local "green" business enterprises as much as possible, Political participation in ways that ensure the participation of people in political decisions that affect them. Community needs assessment has especial usefulness in action-learning projects, and in ensuring that

organizations meet green objectives of: social justice, participatory democracy, non-violent resolution of conflict and ecologically sustainable development.

The US National Cancer Institute (2001), opined that needs assessment is the foundation for the communication plan. It provides a clear picture of the health problem or concern, the programmes stakeholders and participants, the programmes priorities, mission, goals and interventions. It provides a context and framework for developing materials and deciding what is to be communicated.

The goal of needs assessment process is to identify the health needs, educational needs and resource needs of the target population (Simons-Morton, 1997). Once identified programme planners can use the information to design health education and health promotion programmes that are tailored to their specific groups. Conducting a needs assessment can save money, because a well targeted programme is more likely to be accepted by the target population and become successful, thus saving money on a programme that would have had to be abandoned.

The WHO suggest a nine step framework for conducting a needs assessment (WHO, 2000). These steps provide a useful direction in the conduct of an acceptable needs assessment for any health promotion programme. The steps are outlined as follows;

i. Decide when to conduct the needs assessment
ii. Review available sources of information to decide what information has to be collected and what is already available
iii. Decide how to collect the information
iv. Develop an action plan that includes cost estimates and approximate time frames
v. Identify and train the assessment team
vi. Collect information and data.
vii. Analyze information and data
viii. Interpret analysis to identify priority needs and possible intervention strategies and resources
ix. Report on the outcome of the needs assessment to all stakeholders.

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The Centres for Disease Control and Prevention (CDC) developed the Planned Approach to Community Health (PATCH) in the mid-1980s. PATCH can be used in a variety of health education and health promotion situations. It provides a general structure for the needs assessment, programme planning and evaluation process that emphasises community involvement and linkages among a variety of agencies and services associated with the community. PATCH is a general guide consisting of five steps; mobilising the community, collecting and organising data, choosing health priorities and target groups, choosing and conducting interventions and conducting evaluation.

2.5.2 Message Conceptualization and Development

Health education or health literacy is defined by Selden, Zorn, Ratzan and Parker 2000*;* as the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions. Health literacy expands beyond reading and writing skills to include the ability to comprehend and access health information in order to make informed decisions about healthy behaviours, self care and disease management. Effective health communication contributes to health promotion and disease prevention. Disseminating health messages through health promotion programmes and campaigns can create awareness of an issue, change attitudes toward a health behaviour, encourage and motivate individuals to follow recommended health behaviours. While health communication alone cannot change behaviour, understanding its role and how its principles can be used in a health promotion programme will increase the likelihood that a programme will succeed (Parker, Ratzan and Lurie, 2003).

According to CDC (2006), educational materials are learning or teaching aids that can be used to reach masses of people, to reinforce or illustrate information given in a one-on-one setting, or serve as references to remind people of information they received earlier. Materials also teach skills by providing hands-on experience or by illustrating a step-by-step approach. Effective materials can also influence attitudes and perceptions. Development or selection of educational materials is directed by several considerations as stated below by the Centres for Disease Control and Prevention;

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- What is the public information objective? Is it to inform, demonstrate, persuade, or remind? These considerations determine how educational materials are designed and used.
- Who is the target audience? Where (which channels) can they be reached? Are there any target audience preferences for types of materials (e.g., non-print for low-literacy audiences, fotonovelas for Latinas)?
- What is the specific message? Is it a skill, an attitude to be considered, medical information, a negotiation approach, or a synopsis of previous instruction?
- What materials are already available? Will they fit the audience, channel, and objective? Can they be purchased? Reproduced? Modified?
- What financial, staff, and other resources are available for materials development? Should development be handled in-house or by contract?

Paul, Redman and Sanson-Fisher (2004), stated that printed materials have been a primary mode of communication in public health education. Three major approaches to the development of these materials-the application of characteristics identified in the literature, behavioural strategies and marketing strategies-have major implications for both the effectiveness and cost of materials. However, little attention has been directed towards the cost-effectiveness of such approaches.

To develop effective messages and materials that are well understood, accepted and used by the target audience, the following guidelines are recommended by the (US National Cancer Institute, 2001)

- Ensure that the message is accurate; make sure that the information provided is factual. It is always good to have the materials reviewed by experts on the topic.
- Be consistent, consistency is critical to a programme success and ultimately to its identity. Make sure that the messages in all materials are consistent not only with the communication strategy but also with one another.
- Be clear, keep the message simple and clear. Do not use a lot of technical terms. Make sure that the intended audiences' tasks are clear and understandable.
- Make sure that the materials are relevant. Talk about the programmes benefits. The formative research or needs assessment will provide insight into what the intended audience values.

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- Ensure that materials are credible. Use formative research or needs assessment to guide decision about whom to use as a spoke person.
- Create appealing materials. Ensure that materials are appealing and eye-catching, so they grab the attention of the intended audience.

The need to have extensive information about the community people or target group for whom the messages are intended was evidenced by Goni, (2000). He stated that the incorporation of community knowledge and values into the content of materials encourage learners to analyze new information in the light of their previous experience and learning. This was supported by Haywood, (1989) who stated that materials are beneficial in so far as they require learners to analyze new information relative to their own prior knowledge and values. So, it is imperative that educational materials must reflect individuals or groups' socio-cultural values and reality and this can be done effectively by actively involving learners in analyzing health situations and come out with something tangible acceptable to them that will lead them to designing appropriate and effective message (Aubel and Sia, 1995).

2.5.3 Pre-test of concepts, messages and materials

CDC defined pretesting as the testing of planned public information strategies, messages, or materials before completion and release to help assure effectiveness. Pretesting is used to help make sure that messages and materials will work. It is important to test messages and draft materials with target audiences. Also, testing with media or other "gatekeepers" is a good idea, e.g., Project directors or others who can influence whether messages and materials are used. Pretesting can help determine whether messages and materials are: understandable, relevant, attention-getting, memorable, appealing, credible and acceptable to the target audience. The most frequently used pre-test methods include: focus groups, self-administered questionnaires, central location intercept interviews, individual interviews, theatre-style testing, readability testing and gatekeeper review.

Communicating effectively to an intended audience is a key factor in developing successful health promotion programmes. In communicating with programme participants it is essential to know how the audience members view their health and what they are being asked to do or not do. One way to understand different audiences and

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create programmes, materials and messages that resonate with them is to develop and pre-test concepts, messages and materials to see which ones have the most meaning for them and motivate them to action.

Pretesting can be used for accessing comprehension, attention and recall, gauging sensitive or controversial elements. Understanding of health messages and materials is essential as a prior condition to acceptance. Questions about audience sensitivity to subject matter may arise in developing health messages, pretesting can help predict whether messages may alienate or offend target audiences. For health messages to take effect, audience members must understand the problem, accept its importance in their lives and agree with the value of the solution for them (Brown, Lindenberger and Bryant, 2008).

Pretesting is one way to ensure that the intended audience will understand the materials developed and act on their message. It is to determine what message or what material best fulfils the health needs of the audience. It is necessary to pre-test draft materials with intended audience, some people believe they can skip this because they have tested the concepts and have had professionals review the contents, so to expedite the process; they go from draft material to final production with no review or input from the intended audience. This is a big mistake because one never knows what detail in the finished piece might be problematic to the target audience. In the long run this round of pretesting will save valuable time and money.

Salazar (2004), pointed out that posters must first attract audience attention to work. These messages are rarely seen or heard in an isolated environment and they must compete with other materials of advertisement for attention. It is best to test concept with intended audience to ensure that the message appeals to them, that they understand the message and that they are willing to act on the message, using a variety of data collection methods like focus group, in-depth interviews, or one on one interviews. Equally, the message concepts needed to be tested not only with the primary audience but also with the stakeholders and gate keepers who are programme partners that may be involved in

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material distribution and determine whether the materials would be used or not by the target audience (Brown, Lindenberger and Bryant, 2008).

Akinwande (1993), suggested the use of focus group discussion and individual face to face interview as methods of conducting effective pre-test of IEC materials. Based on the responses, messages, illustrations as well as colours of the materials may need to be modified. Similarly, Ajoko, 2001 exemplified the benefits of pre-testing exercise among secondary school students in Ibadan South West Local Government Area of Oyo State. Pre-testing according to him enabled the target group-students to contribute to the development of IEC materials. It helped them to identify difficult words, sentences and ideas that were not clear and made suggestions for improvement. The pre-testing of IEC materials made it more logical, internally consistent and generally acceptable to the target group members.

2.5.4 Implementation and utilization of BCC materials

Presenting information in plain language is an integral component of improving health literacy. Plain language is defined as communication that the audience can understand the first time they read or hear it. The essence of plain language is a focus on audience, clarity and comprehension. Using clear and concrete words in a straightforward manner is the best way to organize information, particularly health content. Written material in plain language means that the members of an audience can find what they need, understand what they find and use what they find to meet their needs. When people are able to fully understand and act on health information they are better able to manage their conditions and make health decisions (Kutner, Greenberg, Jin and Paulsen, 2006).

The use of Behaviour Change Communication (BCC) materials among health workers was found more effective when they participated in the process of design and development of the materials (Goni, 2000). He also found that BCC materials becomes more than just a supportive piece of paper but a focal point for discussion, dialogue and interaction and that it can actually stimulate interest and participation in the topic of concern. Oba Ladapo of the Positive Life Association of Nigeria (2007), also reported that BCC materials such as handbills, posters, brochures, manuals, flip charts, stickers, t-

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shirts, face caps, banners provide information on HIV and AIDS basic facts. It also provides information on prevention strategies and helps to reinforce information provided in training programmes, raise demand for counseling services and link clients to services. It provides additional information for the client's useand helps to support the delivery of the services. The epidemiologic pattern of HIV infection-with sexual behavior, use of contaminated skin piercing instruments, and mother-to-child transmission as the principal modes of transmission-clearly indicates that behavior modification is central to HIV prevention. The current absence of curative immunological, pharmacological, and related medical interventions against HIV/AID Smakes behavioral interventions more critical than for many other diseases of public health importance. To ensure maximum impact, behavioral interventions must be examined critically and avenues for strengthening them within national programs and community initiatives must be continuously sought (Fatusi, 2004).

In Cambodia for example, the rise in the garment industry has led to an influx of young women from rural areas seeking work in cities. This mass migration is leading to health challenges, as these women become more vulnerable to abuse and exploitation. Vulnerability is also linked to a lack of knowledge about sexual health issues, HIV transmission and how to seek appropriate health services. From 2003 to 2007, the International Labour Organization (ILO) and the US Department of Labour carried out an HIV/AIDS Workplace Education Programme targeting female garment factories workers.The programme used peer education approach to help young women increase their awareness about health and HIV/AIDS issues, so they could reduce vulnerabilities and stigma and discrimination against HIV+ people in the workplace. The programme also developed IEC materials to promote positive health seeking behaviour: the most challenging aspect of which was developing educational materials for the women's male sex partners, so that they would use condoms. The programme was a success, raising female workers' awareness about HIV and increasing their health-seeking behaviour. Key to this was application of a "gender lens" in the development of IEC materials. Stigma associated with women carrying condoms decreased through the "Smart girl carried condom" campaign and challenged men to use condoms through "A good

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husband protects the health of his family". The main lesson is that gender-specific HIV messages at the workplace produce results.

2.5.5 Outcome Evaluation

The notion of evaluation has been around a long time, in fact, the Chinese had a large functional evaluation system in place for their civil servants as long ago as 2000B.C. Evaluation can be seen as synonymous with tests, descriptions, documents or even management. Many definitions have been developed, but a comprehensive definition presented by the Joint Committee on standards for Educational Evaluation (1994), holds that evaluation is "systematic investigation of the worth or merit of an object" This definition centre on the goal of using evaluation for a purpose, to determine the usefulness, the benefit or advantage of a programme or project. Similarly, evaluation was defined as the use of social research methods to systematically investigate a programme's effectiveness. This definition further highlights the need to determine how effective and beneficial a project has been (FHI, 2005).

Project evaluation is a systematic method for collecting, analyzing, and using information to answer questions about projects, policies and programs, particularly about their effectiveness and efficiency. In both the public and private sectors, stakeholders will want to know if the programs they are funding, implementing, voting for, receiving or objecting to are actually having the intended effect, and answering this question is the job of an evaluator (Administration for Children and Families (2010) The Program Manager's Guide to Evaluation. *Chapter 2: What is program evaluation?)* Program evaluation may be conducted at several stages during a program's lifetime. Each of these stages raise different questions to be answered by the evaluator, and correspondingly different evaluation approaches are needed. Rossi, Lipsey and Freeman (2004), suggest the following kinds of assessment, which may be appropriate at different stages:

- Assessment of the program's cost and efficiency
- Assessment of the program's outcome or impact (i.e., what it has actually achieved)
- Assessment of how the program is being implemented (i.e., is it being implemented according to plan?)

- Assessment of program design and logic/theory
- Assessment of the need for the program

In 1999, the Center for Disease Control and Prevention (CDC) published a six-step framework for conducting evaluation of public health programs. The publication of the framework is a result of the increased emphasis on program evaluation of government programs in the US. The six steps are as follows;

1. Engage stakeholders
2. Describe the program.
3. Focus the evaluation.
4. Gather credible evidence.
5. Justify conclusions.
6. Ensure use and share lessons learned.

Fertman and Allensworth (2010), defined program evaluation as the systematic collection of information about a health promotion programme in order to answer questions and make decisions about the programme. The types of programme evaluation are formative evaluation, process evaluation, outcome evaluation and impact evaluation. In essence evaluation means answering some very basic questions and then reporting back to interested individuals, groups or stakeholders what was found. The impact evaluation measures the immediate effects of a health promotion programme and the extent to which the programmes goals were attained, that is whether impacts were achieved that could lead to the programmes ultimate desired outcome like increased physical activity that could lead to a desired health status change.

David Osborne and Test Gaebler in 'Re-inventing Government' (Addison Wesly, 1992) stated that, ''if you do not measure results you cannot tell success from failure; if you cannot see success, you cannot reward it; if you cannot reward success, you are probably rewarding failure. If you cannot see success, you cannot learn from it; if you cannot recognize failure, you cannot correct it; if you cannot demonstrate results, you cannot win public support'' The need to measure performance with the view to identify and document best practices in project intervention for futures replications was underscored by the above quotation.

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The national tool developed for monitoring and evaluating HIV/AIDS responses described evaluation as a mechanism designed to determine the value of specific interventions which lead to improved decision making and better returns on investment (NNRIMS-2004). According to Burt et al (1997), evaluation can document what project accomplishes, provide evidence of project's impact and effectiveness in reaching its goal, describe what kinds of participants benefit the most (and least) from project activities, generate information on what strategies work best, how projects should be structured, and how to overcome obstacles, and document project costs and, in some studies, assess the value of benefits. While evaluating an IEC implementation programme, Gonni (2000), observed that IEC materials boosted and improved clients' understanding of health matters, that the materials were instrumental in creating awareness or enlightenment on health programmes, enhanced communications and educated and empowered clients as regards health seeking behaviours. He further noted that some problems associated with IEC programme implementation were inadequate supply, unavailability of materials especially in local languages, lack of funds to produce adequate number of materials and inadequate knowledge of programmers in its use.

This information, according to the Author can be used to determine if the project is accomplishing objectives, for whom, and how; plan and manage project by getting feedback to identify areas that are operating according to plan and those that need attention and development, identify unmet needs and gaps in service for those the project seeks to reach, publicize project accomplishments, and raise funds for project continuation, expansion or replication. Project as stated by the Joint Committee on Standards for Educational Evaluation (1994). It provides the opportunity of examining the extent to which project goals and objectives have been met and the extent to which the component contributes to the success or failure of the overall project.

Types of Evaluation: There are two main types of evaluation as presented by the Joint Committee on Standards for Educational Evaluation (1994),

1. Formative Evaluation
2. Summative Evaluation

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Formative Evaluation: The purpose of formative evaluation is to assess initial and ongoing project activities. Formative evaluation begins during project development and continues throughout the life of the project. Its intent is to provide information to monitor and improve the project. It is usually done at several points in the development life of a project and its activities. According to evaluation theorist Bob Stake, "when the cook taste the soup, that's formative; When the guest taste the soup, that's summative." Under formative evaluation, there are implementation evaluation which seeks to assess whether the project is being conducted as planned; and progress evaluation which seeks to assess progress in meeting the goals of the project.

Summative Evaluation: The purpose of summative evaluation is to assess a matured project's success in reaching its stated goals. Summative evaluation is sometime referred to as impact or outcome evaluation. It frequently address many of the same questions as progress evaluation, but it takes place after the project has been established and time frame position for change has occurred.

Methods of Evaluation

The following are methods of conducting summative evaluation as posited by K. Kumon (1993):

Rapid appraisal methods: These are quick, low cost ways to gather the views and feedback of beneficiaries and other stakeholders in order to respond to decision makers' need for information.

1. Record review – A review of the proposals, work-plans, records of activities and final report of project activities.
2. In-depth Interview – A series of open ended questions posed to individuals selected for their knowledge and experience in a topic of interest. Interview as qualitative, in-depth and semi-structures. They rely on interview guides that list topics or questions.
3. Focus Group Discussion – A facilitated discussion among 8-12 carefully selected participants with similar background. Participant might be beneficiaries or programme staff. The facilitator uses a discussion guide. Note takers record comments and observations.

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Participatory Method: Participatory methods provide active involvement in decision making for those with a stake in a project, programme or strategy and generate a sense of ownership in the monitoring and evaluation results and recommendations as posited by Guijt and Gaventa (1998).

Beneficiary Assessment: Involves systematic consultation with project beneficiaries and other stakeholders to identify and design development initiative, signal constraints to participation and provide feedback to improve service and activities.

A comprehensive evaluation will include all of these activities. Sometimes, however, the questions raised, the target audience for findings, or the valuable resources limit the evaluation focus to one or two of these activities. Any of these evaluations can include estimation of how much the project or value of benefits (cost-benefits analysis) or the efficiency with which alternate projects achieve impacts (cost-effectiveness analysis).

Need for Evaluation

An important aspect of the evaluation is that it provides opportunity for learning. Programme managers are therefore expected to always document both positive and negative lessons as important source of information about improving programme performance (M&E of HIV/AIDS in Nigeria, 2006). Evaluation of development activities provides government managers and civil society with better means for learning from past experience, improving service delivery, planning, allocating resources and demonstrating results as part of accountability to key stakeholders (World Bank, Operations Evaluation department, 2004).

Through mid 2004, the World Bank committed $2.5billion for prevention, treatment and mitigation of HIV/AIDS in 62 countries, more than that half of it to Africa. Since, political commitment has risen, institutions have been created and services expanded. However, little is known about the effectiveness of government and civil society responses in the local context because of lack of evaluation. (Ainsworth, Martha et al 2005).

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Similarly, it was noted by NMRIMS, 2004; that one of the major challenges facing National response to HIV/AIDS epidemic in Nigeria is evaluation of programmes and reporting of HIV/AIDS activities and their impacts (NMRIMS-2004). In the same vein, the need to evaluate programme activities has been described as very important in the light of increased resources and increased activities occurring, and the need to have an understanding of the magnitude of the national response, determining what the gaps are, what has succeeded and why, in order to ensure that the country's response is cost effective, lacking in gaps and maximizes on successful initiatives (NMRIMS-2004).

There is no doubt, infusion of funds and technical assistance to non government organizations and civil society has increased access to and use of HIV/AIDS services particularly in low resource settings as evidenced by Mabirizi David et al, 2005. In view of the fact that, non governmental organizations still remains the main providers of health care in many African countries where the burden of HIV is heaviest (Sidaction et al, 2005); however, it is very important to ensure that money is used effectively by these civil society organizations to improve people's lives and slow the course of the epidemic (Global Report on AIDS epidemic, 2006). Peter Piot 2005 stated that "community initiatives must be a priority for our support, because they are the foundation for a sustainable response owned by the people who have the most to lose and the most to gain".

2.6 Conceptual framework

PRECEDE Model

Public health and health promotion programs can help to improve health, reduce disease risks, manage chronic illnesses, and improve the well-being and self-sufficiency of individuals, families, organizations, and communities. But not all health promotion programs and initiatives are equally successful. The programs that are most likely to succeed are based on a clear understanding of the targeted health behaviours and their environmental context. They are developed and managed using strategic planning models, and are continually improved through meaningful evaluation. Theories of health behaviour can play a critical role in all of these areas.

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Theory can help us during the various stages of planning, implementing, and evaluating an intervention. Program planners use theories to shape the pursuit of answers to Why? What? and How? That is, theories can be used to guide the search for reasons why people are or are not following public health and medical advice, or not caring for themselves in healthy ways. They can help pinpoint what you need to know before developing or organizing an intervention program. They can provide insight into how you shape program strategies to reach people and organizations and make an impact on them. They also help you identify what should be monitored, measured, and/or compared in the program evaluation.

Theories can help us understand the nature of targeted health behaviours. They can explain the dynamics of the behaviour, the processes for changing the behaviour, and the effects of external influences on the behaviour. Theories can help us identify the most suitable targets for programs, the methods for accomplishing change, and the outcomes for evaluation. Theories and models explain behaviour and suggest ways to achieve behaviour change.

Models that support program planning processes include Green and Kreuter's PRECEDE-PROCEED model. Processes such as these are what get the job done. These processes involve research, thought, and action at all stages. Theory directs our research strategy (what to look for), intervention goals (what to achieve), and what might explain outcomes of interventions. Theory also helps us think of ideas we might never have considered.

The **PRECEDE** framework which guided the implementation of policy is a model developed by Lawrence Green and his colleagues for problem solving and the facilitation of health education programme planning. The acronym **PRECEDE** means "Predisposing, Reinforcing and Enabling Constructs in Educational\Environment Diagnosis and Evaluation" (Parent et al 2004). The **PRECEDE – PROCEED** model emphasizes planning intervention by focusing on the expected outcomes of actions based on epidemiological, social, behavioural, environmental, educational, organizational, administrative and political diagnoses of a socio-health and\or educational situation. The stages in the construction of a systemic model for analyzing the problem that interests us,

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that is the evaluation of health education materials developed by non governmental organizations (NGOs) under the Oyo State World Bank Assisted HIV/AIDS Programme. **PRECEDE** model helps in the understanding of NGOs'knowledge of HIV and AIDS and their ability to developed IEC materials that are appropriate in targeting a specified population. This demonstrates that **PRECEDE** is best applied when one narrows in of the specific antecedents of behaviour instead of putting generic variables in the framework i.e. the need to find out what really influences a specific group or population.Because the model views health behavior as influenced by both individual and environmental forces, it has two distinct parts: an "educational diagnosis" (PRECEDE) and an "ecological diagnosis" (PROCEED). The PRECEDE acronym stands for Predisposing, Reinforcing, Enabling Constructs in Educational/Environmental Diagnosis and Evaluation.

Developed in the 1970s, this component of the model posits that an educational diagnosis is needed to design a health promotion intervention, just as a medical diagnosis is needed to design a treatment plan. The activities involved at this stage include needs assessment among the target population to document gap in knowledge and issues surrounding HIV and AIDS that are intended to be included in the materials which are culturally acceptable.

PROCEDE stands for Policy, Regulatory, and Organizational Constructs in Educational and Environmental Development. This element was added to the framework later, in 1991, to take into account the impact of environmental factors on health. This refers to government and other parastatals involved in policy on HIV and AIDS, fund and other resources, organisational structure of NGOs who are the implementers of the projects.

Together, these two components of the model help practitioners plan programs that exemplify an ecological perspective. PRECEDE-PROCEED has nine steps. The first five steps are diagnostic, addressing both educational and environmental issues. These include: (1) social assessment, (2) epidemiological assessment, (3) behavioral and environmental assessment, (4) educational and ecological assessment, and (5) administrative and policy assessment. The last four comprise implementation and

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evaluation of health promotion intervention. These include: (6) implementation, (7) process evaluation, (8) impact evaluation and (9) outcome evaluation

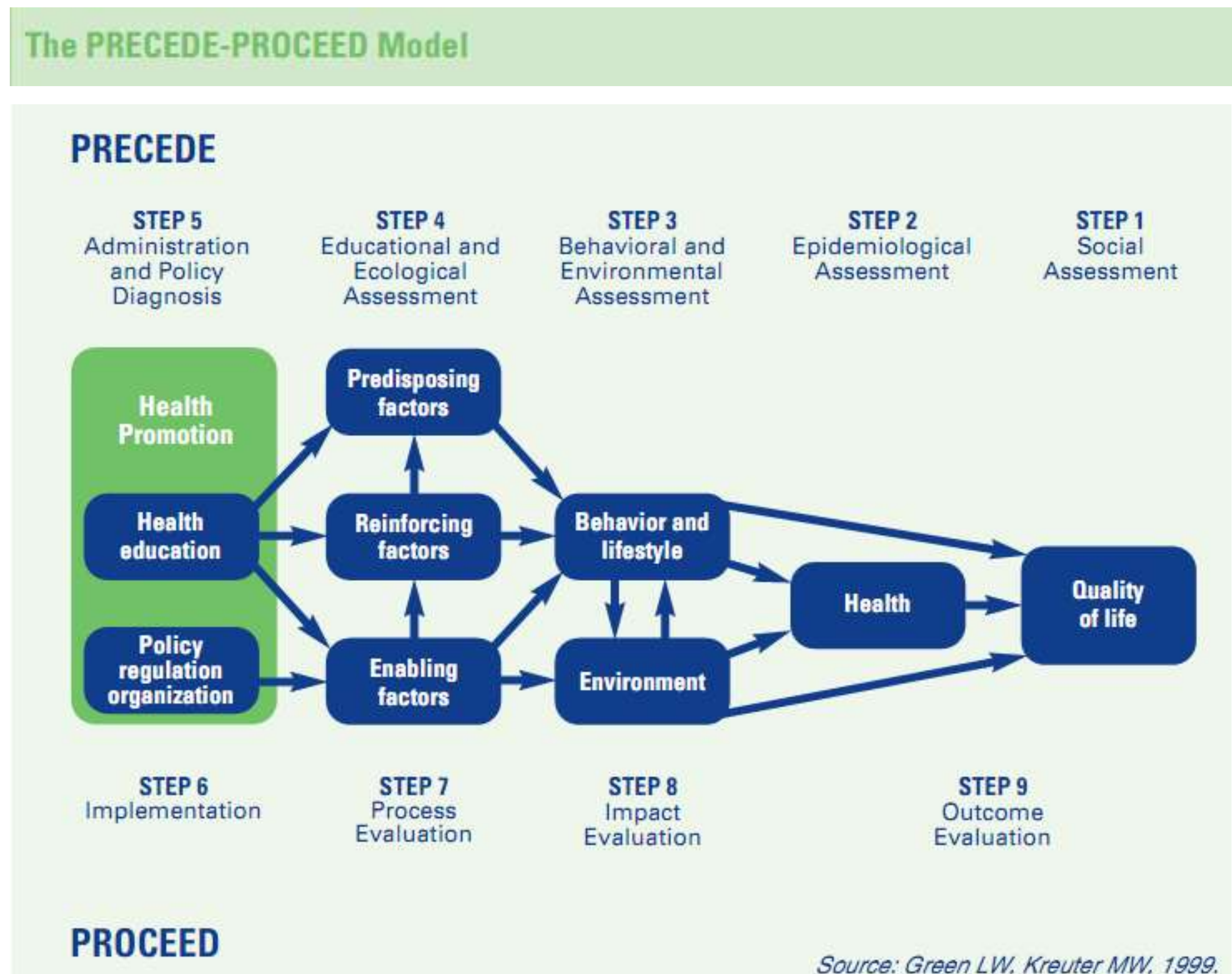

Figure 2.4 The PRECEDE-PROCEED Model

The flow chart of the model (Fig. 2.3), developed by its originators, shows a circular process. It starts (on the upper right) with a community demographic and quality-of-life survey, and goes counterclockwise through PRECEDE's four phases that explain how to conceive and plan an effective intervention. PROCEED then picks up with the intervention itself (described here as a health program), and works *back* through the first five phases, evaluating the success of the intervention at addressing each one (The process evaluation in Phase 7 looks at whether the intervention addressed the concerns of Phase 4 as planned. The impact evaluation of Phase 8 examines the impact of the

intervention on the behaviors or environmental factors identified in Phase 3. And the Outcome evaluation of Phase 9 explores whether the intervention has had the desired quality of life outcome identified in Phases 1 and 2). Eventually, the process arrives back at the beginning, either having achieved the desired quality of life outcome, or to start over again, incorporating the lessons of the first try. The arrows in the flow chart demonstrate the effects of each phase's issues on the next one to the right.

2.6.1 Application of the Model to the Study

PRECEED-PROCEED model is a form of logic model which combines assessment, intervention planning and evaluation into one framework or model. The PRECEDE stands for Predisposing, Reinforcing, and Enabling Constructs in Educational/Environmental Diagnosis and Evaluation. As its name implies, it represents the process that precedes, or leads up to, an intervention. The PROCEED aspect spells out Policy, Regulatory, and Organizational Constructs in Educational and Environmental Development, and, true to its name as well, describes how to proceed with the intervention itself.

During the planning stage for intervention under the study, needs assessment was conducted by the project coordinators using various methods and approaches such as; focus group discussion, baseline survey, rapid assessment, questionnaire, advocacy and planning meetings with the target communities. The needs assessment methods were employed by the project coordinators to learn about the target community's perceived and actual needs to identify the existing gaps in knowledge, attitude, behaviour and practices as related to HIV prevention. The behavioural and environmental assessment identifies behavioural and environmental factors that promote transmission of HIV like; unprotected sex, sharring of sharp instrument, transfusion of unscreened blood and mother to child transmission of HIV. Knowledge and practice on the use of condom as a protective measure against transmission of HIV by target communities especially among the female sex workers and youths was also assessed at the planning stage of intervention.

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The three types of influencing factors considered under the process evaluation phase are;

• Predisposing factors, which motivate or provide a reason for behaviour; they include knowledge of programme managers and coordinators of NGOs, their attitudes, cultural beliefs about HIV and AIDS, the skills in conducting needs assessment and developing IEC materials and messages that will be able to reach their target audiences and which are culturally acceptable.

• Enabling factors are those factors which enable persons or organizations to act on their predispositions; these factors include available resources (human and materials), supportive policies and enabling environment, assistance, and services. To a large extent, the organizations studied had enabling environment with financial, material and technical suppot from the State Agency for the Control of AIDS.

• Reinforcing factors, which come into play after behaviour has been initiated; they encourage repetition or persistence of behaviors by providing continuing rewards or incentives. Social supports, through strenghetening of consensus building are considered reinforcing factors. Some of the target groups for whom interventions were made especially the female sex workers were followed up to encourage and support them on continuous and consistent use use of condoms with their clients.

In the final diagnostic step of PRECEDE-PROCEED, Administrative and Policy Assessment, intervention strategies reflect information gathered in previous steps; the availability of needed resources; and organizational policies and regulations that could affect program implementation. The four remaining steps of PRECEDE-PROCEED comprise program implementation and evaluation. Before Implementation (Step 6) begins, plans were prepared for evaluating the process (Step 7), impact (Step 8), and outcome (Step 9) of the intervention. Process Evaluation gauges the extent to which a program is being carried out according to plan. Impact Evaluation looks at changes in factors (i.e., predisposing, enabling, and reinforcing factors) that influence the likelihood that behavioural and environmental change will occur. These were measured in terms of number of IEC material distributed, number of BCC workshop and talk show held, number of people reached with BCC information. Lastly, outcome evaluation looks at whether the intervention has affected health and quality-of-life indicators measured in

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terms of number of people seeking health services such as STI and HIV treatment in all the facilities, number of target audiences demanding for and using condoms, number of people self-reporting use of condom at last sexual act, number of people seeking VCT services, number of zero discrimination behaviour such as willingness to share meal with PLWH and percentage of young people reporting to delaying sexual debut.

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CHAPTER THREE

METHODOLOGY

This chapter describes the design and scope of the study, and description of the study sites. It also describes the study population, study variables, the methods and instruments of data collection and data analysis. Finally, it explains the limitations of the study.

3.1 The Design and Scope of Study

This is a process evaluation study which employed the use of qualitative methods to collect information on the process of conceptualization, development, production and utilization of behavior change communication materials produced and utilized by the non-governmental organizations in Oyo State for HIV prevention. The study was a descriptive cross-sectional survey. Random sampling technique of balloting was used in selecting 20 out of the 40 funded NGOs. The study was designed to access the degree of compliance with the various processes of planning, implementing and evaluation of the behavioural change communication materials produced by the non-governmental organizations for HIV prevention intervention in Oyo State.

3.2 Study sites

The study sites were the project offices of twenty Non-Governmental Organizations (NGOs) based in the Ibadan metropolis. The Twenty NGOs were categorized into five groups based on the types of target audience each focussed for intervention. The five groups of target audience are; Female Sex Workers, Youths, Women, Mission Birth Attendants and People Living with HIV. There were four NGOs in each category (The details of each NGO in terms of organizational goal, vision and missions are on Appendix 1).

3.3 Study Design

The study was a descriptive cross-sectional survey. It was aimed at evaluating the process of development of behavior change communication materials employed for HIV prevention intervention programmes by the Non Governmental Organizations in Oyo State, Nigeria.

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3.4 Study population

The study population was categorized into primary and secondary target groups.

i.)The primary target groups were the twenty (20) programme officers of selected twenty (20) Non-Governmental Organizations (NGOs) that implemented Behaviour Change Communication programmes on whom the indepth interview guide was administered. Fourteen of them were males while the remaining six were females. They were aged between 30 and 61 years. Some (13) of them had post secondary education ranging from OND/NCE to Bachelor degree and post graduate degree education. Majority (17) of them had ten (10) years and above NGO working experience.

ii.)The secondary target groups were sub-divided into five groups. They are; female sex workers, in-school youths, mission birth attendants, market women and people living with HIV. They were the beneficiaries of BCC project interventions at community level and were the groups targeted with focus group discussion under the study. Each of the five target groups was homogenous and the composition was between 8 and 10 members in each of the target groups.

3.5 Sampling

The list of the forty (40) non governmental organizations that implemented BCC programme was obtained from the State Agency for the Control of AIDS. The list of the NGOs was analysed into five distinct groups of targets focused for intervention with eight NGOs in each group. The name of each of the twenty NGOs in each group was written in a piece of paper, folded and scrambled in a carton box. Four NGOs were randomnly selected from each of the five groups by the research team members one after the other making a total of twenty NGOs randomnly selected for the study.

3.6 Instruments for data collection

In this study, qualitative and quantitative methods of data collection were used to assess the level of compliance by the NGOs to the basic BCC material development procedures. The qualitative methods used were In-depth Interviews and Focus Group Discussion while checklist was used to quantify the level of compliance to standard procedure by the NGOs.

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a.) In-depth Interview (IDI) guide was used to collect information from twenty project coordinators of NGOs on the process of development, production and utilization of BCC materials used during the project (Appendix II).

b.) Focus Group Discussion (FGD) guide was also used to facilitate discussion among the five target groups identified with the project at the community level on the output of the BCC materials in terms of involvement in the processs of the design, appropriateness, suitability, adequacy and relevance of the materials (Appendix III).

c.) A checklist was used to assess compliance with each of the following seven stages of educational materials development by the NGOs, in line with the WHO model: Needs Assessment (NA); message conceptualization; design; pre-testing; production procedure; implementation and outcome evaluation (Appendix IV)

3.7 Validity and Reliability

A number of steps were taken to ensure the validity and reliability of the instruments used. The instruments-IDI, FGD guides and checklist were validated through the review of relevant literature on the subject matter. The instruments were assessed and corrected by the Project Supervisor. This was followed with an in- house review of the same instruments among the members of academic staff of the department of Health Promotion and Education, College of Medicine, University of Ibadan, Ibadan. This was done with a view to clarify the questions designed and ensure that they addressed the relevant variables in the study. The instruments were pre-tested for content and construct validity among four (4) project coordinators of Non Governmental Organizations who share similar characteristics with the study population. The study population and the project coordinators of NGOs wherein the instruments were pre-tested were similar in that they were beneficiaries of the World Bank support for HIV programme intervention in the State, the two categories developed and used BCC materials for their programme intervention and had similar target audiences.Pre-testing of the instruments was done to confirm their reliability. Each instrument was administered with a view to assessing the clarity of the questions fielded and the level of understanding and comprehension of the questions by the respondents. Comments were noted, reviewed and used to correct, remove or restructure some of the questions. Analysis of pre-test data was done using

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thematic approach and themes were reviewed and clarified to improve the final instruments used.

Training was conducted for the research assistants (RAs) to ensure that they had adequate understanding of the instruments prior to the commencement of data collection under the supervision of the project Supervisor. The training focused on the objectives and importance of the study, sampling process, how to secure respondents' informed consent, basic interviewing skills and how to review questions contained in the instruments to ensure completeness. The RAs were involved in the pre-testing of the instruments in order to create an opportunity for them to acquire practical interviewing skills. The researcher checked the instruments administered and responses from each respondent daily.

3.8. Method of Data Collection

The study was carried out within a period of four weeks. Four trained Research Assistants (RAs) were employed for data collection exercise. The RAs worked in pairs of two. They were graduate and post graduate students experienced in qualitative data collection.All the interviews with the project coordinators were conducted in English Language. Each interview took between 45-60 minutes.The procedure for data collection included administration of the checklist on the project coordinators to assess first and foremost, the level of adherence to the basic standards of BCC material development such as; needs assessment, message conceptualization, material design, pre-testing, material production, implementation and outcome evaluation. This was followed with In-depth interview with the project coordinators. The interview focussed on the processes and activities carried out in each stage of the development process as earlier hihglighted in the checklist. Five Focus group discussions were also organized for the five NGO target groups. Each focus group discussion had between 8 to 10 target group members and each group was facilitated by a pair of the research team. Each focus group session lasted between 45 and 60 minutes. Disussions were tape recorded and supported by note taking.

The data collection process involved the following steps:

i. Identification of each Non Governmental Organization

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ii. Identification of the Project Coordinator for each organization for formal introduction and to seek permission to conduct the study.
iii. Administration of instrument to each respondent.
iv. Tape recording of responses.

3.9 Data Analysis

The data for the study were collected using Checklist, In-depth Interview and Focus Group Discussion guides. After the data were collected, the following steps were followed:

1. Responses of the project coordinators to each of the stages of development as highlighted on the checklist were tabulated and analyzed using percentages to determine the level of adherence to each stage by each organization. Similarly, responses by the project coordinators from the IDI were transcribed on paper from the recorded tapes and typed on clean sheet of paper from which themes were picked and summarised.
2. The FGD data collected from the groups of target audience were transcribed from the recorded tapes, typed on clean sheet of paper and themes were sequentially arranged and analyzed using the thematic approach.

3.10 Ethical considerations

The Office of the Oyo State Agency for the Control of AIDS was informed and consent was obtained for the conduct of the study (Appendix D). Participation in the study was voluntary and the adequate steps were taken to ensure that the study participants were informed about the objectives of the study, assured of confidentiality of any information given before their consents were given in written form signed and thumb printed.

3.11 Limitation to the study

Twenty out of the forty organizations supported by the Oyo SACA could only be listed for the study due to financial constraint as there was no form of any financial support from any source for the study. This in a way limited a comprehensive evaluation of the organizations and the robustness of the study findings which would have been possible if

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the whole forty organizations were involved in the project with financial support from the Oyo SACA.

At the initial stage of the data collection process, some (four out of twenty) study participants were not willing to give all information required by the researcher for one reason or the other. Efforts were made to reduce this problem by assuring the participants that information given by them would be kept confidential and that no name would be recorded. They were also assured that the results of the study would not be linked with their establishments or organizations. Eventually all the twenty project coordinators participated in the study.

Ascertaining the authenticity of responses provided by the interviewees is often a daunting challenge (Okoye, 2006). This study however is no exception. It is possible that some of the responses volunteered by participants are not true reflections of reality in their organizations or in terms of what they did or did not do. It has been assumed that since participation is voluntary, and necessary ethical issues were given consideration, then all the responses provided which formed the basis of the findings in this study are assumed to be correctly and honestly made. Efforts were, however, made to verify and ascertain some claims by looking through and sighting the records and documents relating to the BCC material development process undertaken by their respective organizations. In addition, since the BCC component of the project was not implemented in isolation, it was difficult to solely attribute the positive findings made from the study to the effect or impact of the materials produced and used by the non-governmental organizations.

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CHAPTER FOUR

RESULTS

This chapter contains three major components of the study results. The first section contains the analysis of the checklist used to assess the level of compliance to basic standards of developing behaviour change communication materials by the NGOs. The second section provides the qualitative findings from the in-depth interview with the project coordinators while the third section presents qualitative findings from the focus group discussions held with the various target audiences.

4.1 Findings from the Checklist:

4.1.1 Socio Demographic Characteristics of NGOs Project Coordinators

Findings from the checklist administered on the CSOs' project coordinators revealed that majority of the coordinators were between ages 41-50years (60.0%). Majority (70.0%) of them were male. The three-top from the list of educational qualification of the coordinators are: post-graduate (35.0%), secondary education (35.0%) and undergraduate (20.0%). Some (40.0%) of the coordinators had spent between 11-20 years in NGO and social development work at the time of the study.

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Table 4.1.1: Socio-demographic characteristics of the NGOs' Project coordinators

(n=20)

Variable	Frequency	Percentage (%)
Age (years):		
30-40	4	20.0
41-50	12	60.0
51-60	2	10.0
61 andabove	2	10.0
Sex:		
Female	6	30.0
Male	14	70.0
Educational status:		
Secondary education	7	35.0
OND/NCE	2	10.0
Bachelor degree	4	20.0
Post-graduate degree	7	35.0
Years of experience:		
1-10	3	15.0
11-20	8	40.0
21-30	5	25.0
31 and above	4	20.0

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4.1.2 Compliance by NGOs with Seven stages of BCC material development

A total of 20 NGOs were assessed on the level of compliance with basic standards in the development of BCC materials for HIV prevention. Seven main stages of BCC material development as recommended by the WHO were examined: needs assessment, message conceptualization, material design, pre-testing, production procedure, implementation and outcome evaluation. From the list of NGOs compliance with the material development stages, two out of them carried out all the seven stages of BCC material development according to the WHO model, giving an overall compliance rate of ten percentage. Examining the compliance rate for each of the seven stages, all the organizations carried out needs assessment,that is 100% compliance rate, using different methods such as focus group discussions, advocacy meetings, baseline survey, rapid assessment, questionaire and retreat. The message conceptualization stage was carried out by all the twenty organizations but only thirteen of them involved the target audience in the development process, thereby giving a sixty five percentage (65%) of compliance (see table 4.1.2). The material design stage was also carried out by all the organizations thus giving a hundred percentage rate of compliance.

The aspect of pre-testing of materials with the involvement of target audience was carried out by sixteen organizations (80.0%), very few (25.0%) of them carried out material production with inputs from the target audience. Most (90.0%) of the organizations distributed the behaviour change communication materials with the involvement of target audience, while eighty five percent carried out outcome evaluation of the programme (table 4.1.2).

All the four NGOs that focused on in-school youths involved their target group in the development process (100.0%). Among the NGOs that focused on market women and those focused on people living with HIV/AIDS, seventy-five percent each involved target audience. Half (50.0%) of NGOs that focused on missionary birth attendants (MBAs) involved their target audience while only one-quarter of NGOs that focused on female sex workers involved target group members in the BCC material development process on the reason that "*the FSWs are a mobile population and it was very very difficult to track them down for any meaningful intervention*".

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Table 4.1.2: Number of NGOs that Involved Target Groups in material development process

S/N	Stages of material development	Compliance rate			
		Yes	%	No	%
1	Compiance with all material development stages	2	(10.0)	18	(90.0)
	Need assessment	20	(100.0)	0	(0.0)
	Message conceptualization	13	(65.0)	7	(35.0)
	Material design	20	(100.0)	0	(0.0)
	Pretesting	16	(80.0)	4	(20.0)
	Material production with involvement of target audience	5	(25.0)	15	(75.0)
	Implementation/Distribution with involvement of target audience	19	(95.0)	1	(5.0)
	Outcome evaluation	17	(85.0)	3	(15.0)
2	**Involvement of target audience by NGOs**				
	In-school youths focused NGOs	4	(100.0)	0	(0.0)
	Market women focused NGOs	3	(75.0)	1	(25.0)
	Female sex workers focused NGOs	1	(25.0)	3	(75.0)
	People living with HIV/AIDS focused NGOs	3	(75.0)	1	(25.0)
	Missionary birth attendants focused NGOs	2	(50.0)	2	(50.0)

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4.2 Findings from In-depth Interviews (IDIs)

4.2.1 *Needs Assessment:*

All the project coordinators of the twenty organizations interviewed (IDI session) recalled that adequate planning was carried out before project implementation. One of the essential steps in planning which was undertaken was the needs assessment and all of them reported involvement of target groups in the planning stage. Few of the coordinators that participated in the IDI session declared that their organizations used focus group discussions to conduct needs assessment while many of them reported that they used rapid assessment, baseline survey, advocacy meetings, retreat and questionaire methods to assess the needs of the target population. One of the project coordinators from CEREHAD said; *''Yes, we did need assessment, we used focus group discussion with the male out of school youths (MOSY) and the female out of school youths (FOSY) and sex workers and the reason for that was for us to ensure that the materials that will be produced is evidence based and acceptable to the target group and met their needs''.*

Majority of the NGOs' coordinators recalled that planning meetings were held with the target audience in the process of development of the materials. They recalled that the target groups were segmented according to age, sex and educational status for the purpose of developing appropriate messages for each of the target groups. The importance of needs assessment was emphasized by all the organization for the purpose of determining the areas of need or gap in knowledge of the target audience, meeting those needs and planning interventions that are evidence based, reliable and acceptable to the target audience. However, the number of non governmental organizations that involved target audience in the need assessment process is presented in the chart below. (figure 4.1)

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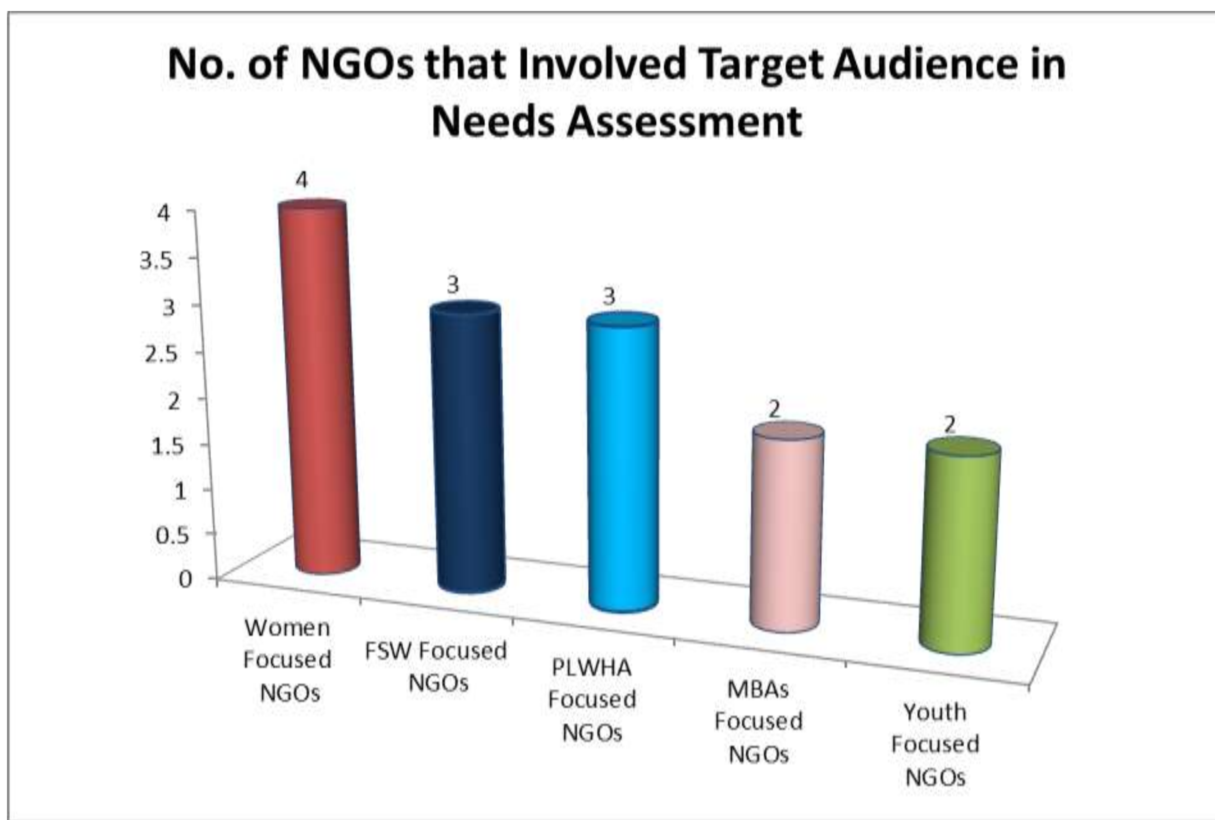

Figure 4.1: Number of Non Governmental Organizations that involved target audience in needs assessment

4.2.2 ***Message Conceptualization and Development*:**

Greater number of the IDI participants (16/20) established the fact that they developed messages used on materials based on the needs assessment conducted while a few (4/20) adapted the existing materials. More than half of the organizations (13/20) involved target audience in the message conceptualization process and a large proportion (16/20) of the participants admitted that they used Yoruba and English languages interchangeably in message conceptualization and development with a few (4/20) exception using pidgin english, particularly for the target group members who were non-Yoruba speaking and who could neither speak nor understand English language especially those who carried out intervention among female sex workers.

4.2.3 *Pretest of messages and materials:*

From the interview held with IDI participants, a very good number (16/20) of the NGOs' coordinators acknowledged that they pre-tested their BCC materials before final production while few did not. All the participants also testified that they involved the target group in the process of pre-testing the materials. Reasons advanced for pretesting by majority of the participants (I6/20) were to determine whether the materials were relevant to the needs of the target audience, whether the messages were clear enough to be understood, whether the materials were culturally and socially acceptable and attractive to the target audience.

4.2.4 *Material Production:*

Only a few (5/20) from the coordinators interviewed affirmed involvement of their target groups in material production. Good number (14/20) of IDI Participants reported that the production of the materials was the exclussive preserve of the management of their organizations, while a few of them disclosed that the target group members were involved to some extent. On the types and quantities of materials produced, majority of the participants (17/20) reported that the commonest materials produced by the organizations were posters, handbills and stickers which were produced in thousands of copies, next to that were T-Shirts and fez caps produced in hundreds, some also produced souvenirs like keyholders, calendars, jotters and bead emblems in hundreds and very few number produced billboards. All the participants stated that various measures taken to ensure that the materials produced were relevant to the needs of their target groups. Common to all the respondents were; conduct of needs assessment, pre-testing, use of appropriate messages, use of local languages and use of live and real pictures of local people that target groups can easily identify with (see appendix I).

When asked about the process of message conceptualization and material production, one respondent from Educare Trust Limited responded *"Yes, the target groups were very much involved in the ideas generation and needs assessment, in fact they were the ones that distributed copies of the questionaire. They were part of the advocacy visits, they were involved in the planning of the health awareness workshop and community mobilization.The language used was mainly Yoruba because our target audience were*

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out-of school youths and they were predominantly Yoruba speaking people, though we had in-school youths too but we had different materials made in English for them.We carried out the pre-test of the materials, we invited an expert to do it for us.Yes, the target group members were involved right from the planning stage, the choice of contractor for the production was our own but we picked from their local areas. The materials were produced at Iseyin.We produced posters 1,000 copies, fliers 1,000copies, T-Shirts 1,000copies, Fez caps 1,000copies and some key holders, calendars and banners.What made our materials relevant to them was that we had meetings with different stakeholders, the pictures and the language we used were culturally acceptable because we used pictures of youths, local volunteers with bright and attractive colours throughout'' (see figure 4.2 & 4.3)

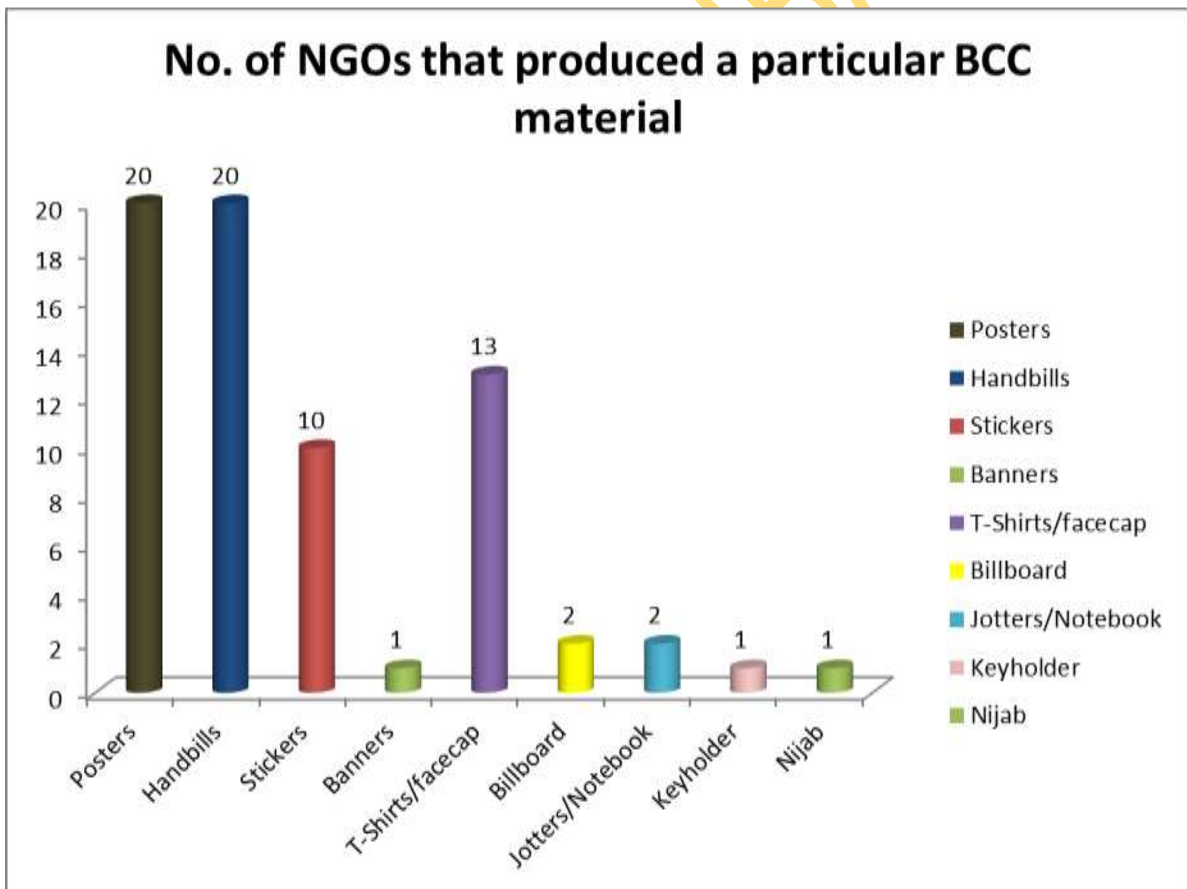

Figure 4.2: Number of NGOs that produced a particular BCC material

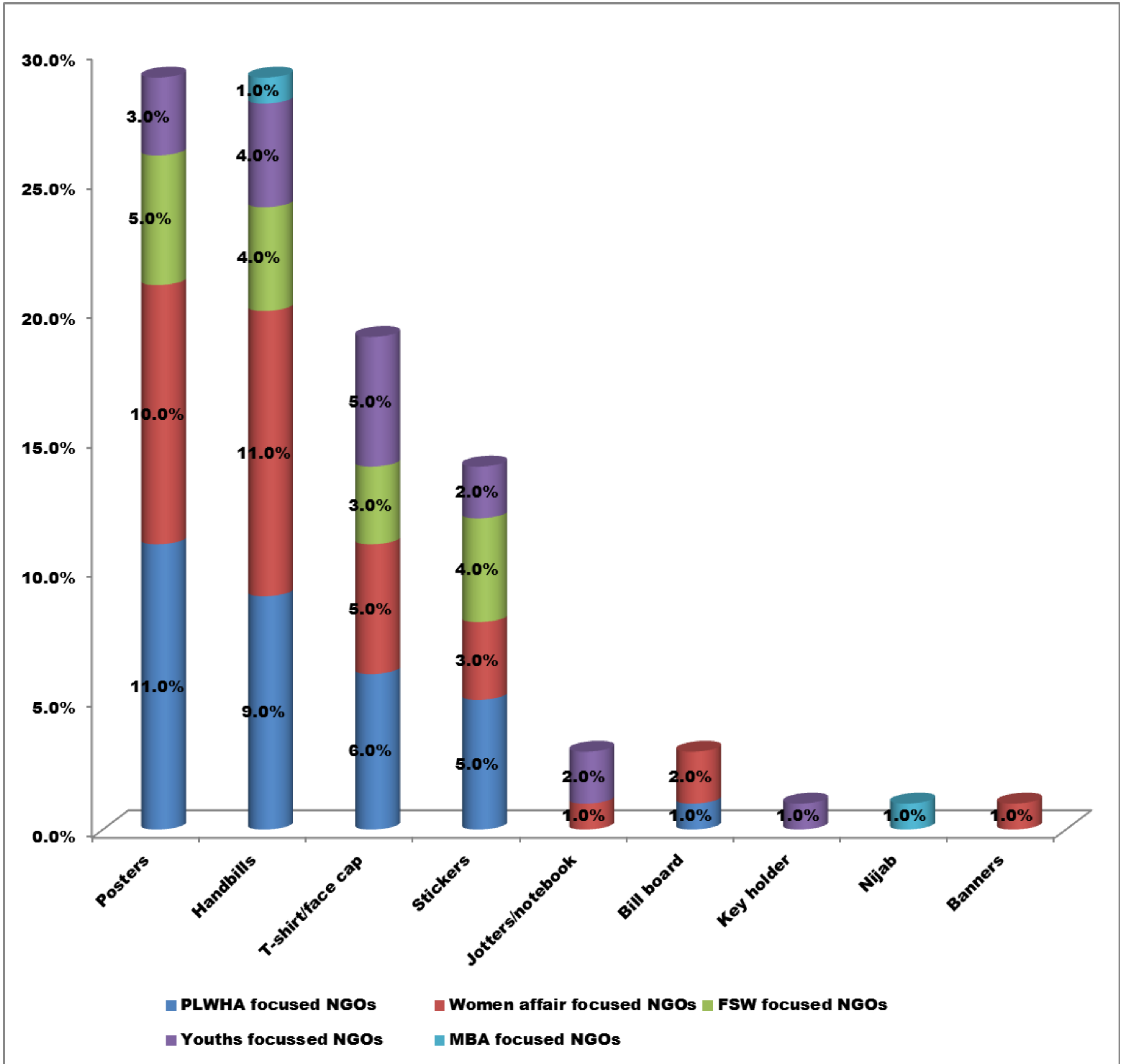

Figure 4.3: Proportion of BCC materials produced by groups of NGOs

4.2.5 *Material distribution and Utilization:*

All the NGOs' coordinators reported that they distributed BCC materials using several methods and channels. Five methods of material distribution such as; use of target audience, use of NGO staff, interpersonal outreach, community outreaches and workshops/meetings were employed by the NGOs, though at varying degree. 40% of the organizations used target audience, 25% used interpersonal contacts, 20% used community outreaches, 10% used NGO Staff while only 5% used workshops and meetings. Among these NGOs, PLWHA focused NGOs took the lead (39.0%) in the distribution of the materials using the five methods earlier stated while the MBA focused NGOs used the least, only two methods out of the five. Different methods used by the NGOs was discribed in figure 4.4 below according to their proportion. PLWHA focused NGOs used more (22.0%) target audience method than other methods identified in the report and apart from MBA focused NGOs that used less (1.0%) target audience as a means of distribution, it was found that use of target audience was a significant method used by all the NGOs. Among other methods frequently used by the NGOs was the interpersonal method used by PHWHA focused NGOs (8.0%) and FSW focused NGOs (5.0%) while instances of using community outreaches as method of material was the same among all the NGOs (4.0%) respectively.

One of the respondents from PLAN said; *''Yes. We involved our target group members in the distribution of the materials and some of them were trained as peer educators with the use of the materials but not specifically on distribution, there was no schedule for distribution, we distributed during the programme activities like sensitization meetings and training workshop. We distributed plenty but we still have few copies in stock, It was a continouos activity''.* Another respondent from the PriHEMAC said *''Yes the target audience was involved. The people who went for the training took the materials and gave to those trained for further distribution at the community level. No specific training was conducted on distribution, they just distributed to people they get in touch with and there was no specific schedule. It was when we have programme that we seized the opportunity to distribute the materials to them. All the materials were distributed and it lasted for only one week''.*

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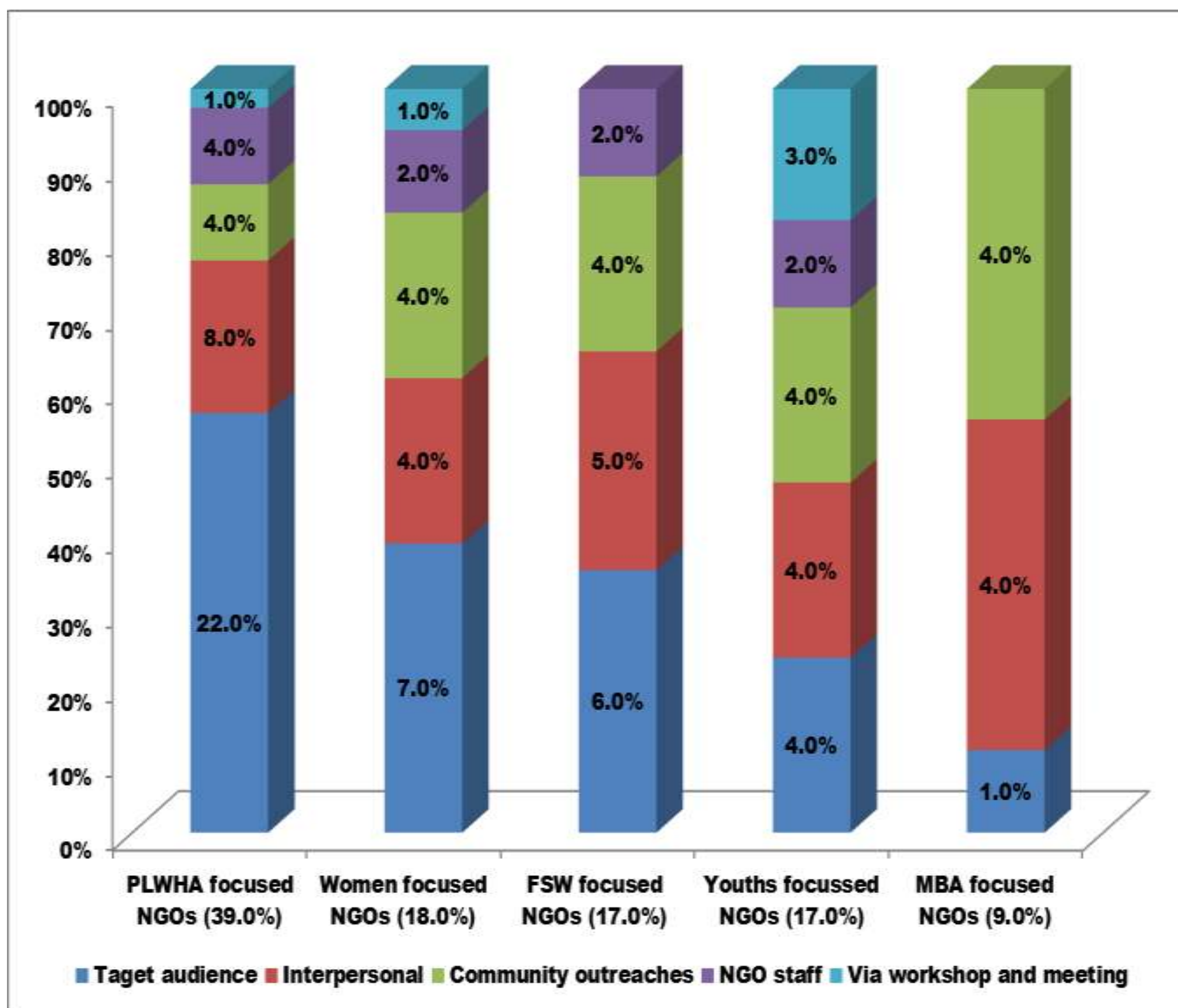

Figure 4.4: Methods of distribution of BCC materials by group of NGOs

4.2.6 Outcome Evaluation:

Many of the organizations carried out evaluation of the behaviour change communication materials used either, in whole or as a part of the entire project evaluation, using one method or the other. Some of the respondents disclosed that they used informal type of evaluation such as observation, questionning, focus group discussion, monitoring and supervisory visits and feed back survey. Questionnaire (58.8%) was found to be the mostly used methods of evaluation by the organizations as reported by the participants,

followed by observational techniques, monitoring & evaluation and focus group discussion (11.8% respectively) (see figure 4.5).

When asked about the outcome of the evaluation, majority of the organizations reported positive behavioural changes observed among the target groups which was attributed to the behaviour change communication materials used, though not in isolation, but in relation to the entire project components implemented by each organization. Reasons for not conducting evaluation of materials as given by some organizations were due to lack of financial resources and time constraints. One of the respondents from SWAAN said; *''We did evaluation together with the target group members and they measured their sucess themselves by asking them questions and through the expert we hired.The programme was successful and it had positive impact on the targets because some of them (FSWs) that were trained had already left the sex work for alternative trade and they are doing well where they are while those of them that were still in business are practising* ***''No Condom, No sex''*** *principle that we taught them through the materials especially the stickers distributed''.*

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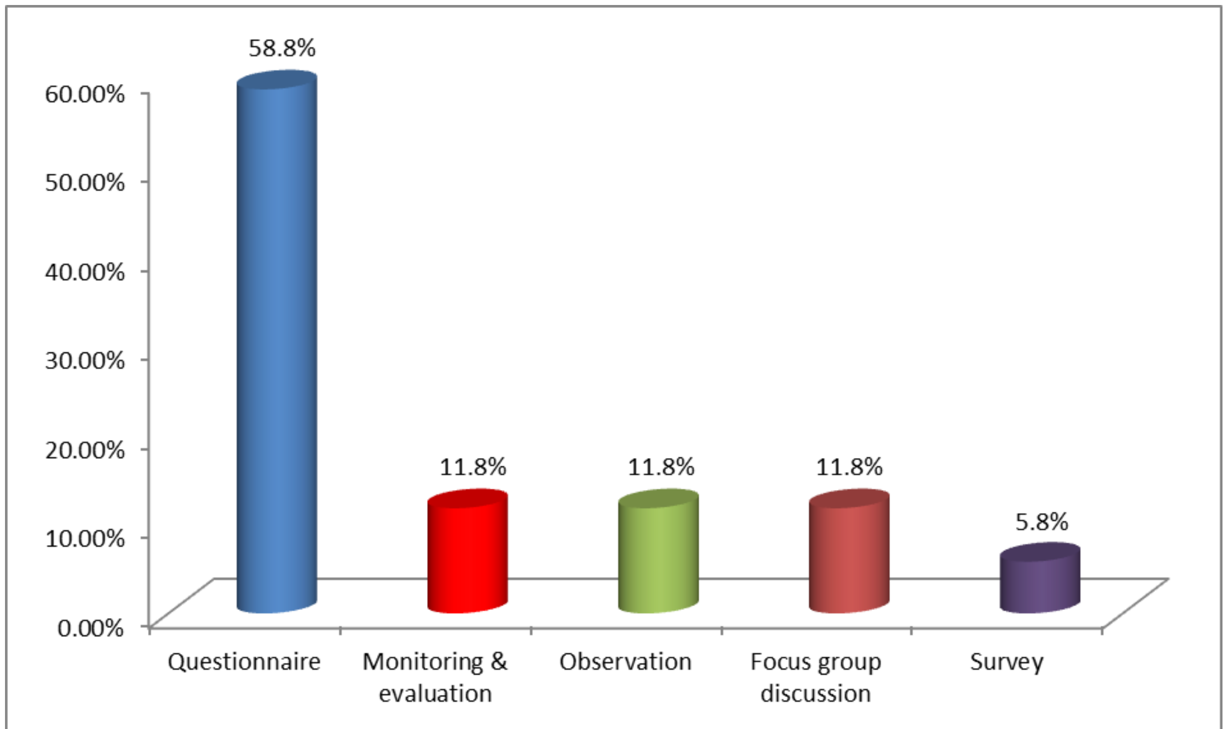

Figure 4.5: Methods Used for evaluation of BCC materials by the NGOs.

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4.3 Findings from Focus Group Discussions (FGDs)

Focus group discussions were conducted among five different target groups of ten to twelve members each focussed for intervention by the organizations studied. All the participants joined actively in the discussions, shared their ideas and experiences and provided recommendations as appropriate. The findings are as follows;

4.3.1 Planning for Behaviour Change Communication material development

Majority of the respondents were able to recall the names of the organizations that came to work in their communities, some even mentioned the names of the key officers of the organizations. One of the participants in one of the group discussion said; *''Yes, many people don come here before like Aunty Iyabo, Brother Tunde and Mama CEREHAD too don come here. When they come here that time they tell us to protect ourselves from HIV and AIDS that make we dey use condomand make we no dey allow men to have sex with us without using condom''.*

Majority of the participants in the focus group discussion said they were involved in the planning process for the development of the materials used to disseminate HIV prevention information. Many of them equally said that they were involved in the need assessment carried out by the respective organizations. Out of all the five target groups, only the female sex workers target group said they were not involved in the planning.When asked were you involved in the planning for HIV and AIDS educational materials used by the organization that worked with you? One of the participants in the female sex worker group said; *''They no dey select us o, they just call everybody together, they call one person and that one would call other ones, we all go gather like this, sometimes they use this New Eden primary school over there and there they go teach us, na dem dey tell us, we no dey do am for them, na dem they do their thing for themselves. They say when we see people wey no understand we go put them thru make them no sex flesh to flesh make them no contact HIV/AIDS, so we dey take this posters to show them tell the person make them no fall victim''.*

Another participant from PLWHA said;*''Yes, they involved us because during that programme they involved us in the process of development of HIV/AIDS materials.*

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Before that programme, there were many posters with messages that were very killing, stigmatising and discriminatory. They even scared people away from us instead of showing love and care for us but when that programme came, they involved us and they asked us what messages that we will like to see and what are the proper ways to present them to our people, so the messages we have now are friendly and not stigmatising. Since that time you cannot see where they will write or address us as victims of HIV but people living positively''.

4.3.2 Message conceptualization and material production.

Majority of the participants in all the five groups affirmed that they were involved in the process of message conceptualization and to some extent in behaviour change communication material production. Opinion of the members of the Female sex worker target group differed on this, they said that the materials were just brought to them and it was asumed that the messages will be understood by them. In their words, one of the participants said*; ''This poster wey dey write No Condom No sex, na dem come give us and they tell us how to use the posters. They know say everybody understand pidgin english that is why they made the thing forus in pidgin english. The woman dey come everytime to teach us about prevention of HIV/AIDS. We know say HIV dey transmit through sex without condom so if you use condom you no fit get am. They also say through barber shop and wen you use blade and somebody come share am with you, you fit contact am. They also said through environment a dirty environment you fit get am there. You fit get am thru injection wey dey no sterilize also through blood transfussion wen dey take somebody blood, another one is thru womb if you get pregnant now you fit go to Doctor to protect the child from getting HIV''.*

Another participant said*''Yes they involved us because during that programme they involved us in the process of development of HIV/AIDS materials. Before that programme, there were many posters with messages that were very killing, stigmatising and discriminatory. They even scared people away from us instead of showing love and care for us but when that programme came, they involved us and they asked us what messages that we will like to see and what are the proper ways to present them to our people, so the messages we have now are friendly and not stigmatising. Since that time*

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you cannot see where they will write or address us as victims of HIV but people living positively''. When asked about the types of educational materials used to train them and the type of language used, majority of them recalled the use of posters, handbills and the two languages mostly used interchangeably were English and Yoruba. One of participants from the FSW group said; *''They gave us materials like posters and handbills. They held meetings with us, They bring to us some materials to teach us how to fix condom and then dey educate us say when we see somebody wey look like AIDS patient make we no dey run away from am make shame no kill am, we should comfort and console the person. Then dey use mouth to tell us and also posters. They still dey use handbills to teach us about HIV/AIDS. Then they give us at times if it reach two if it reach four, any amount we fit collect for their hands and we paste them on our walls. If you go outside now you look at our doors, on the walls you go see all the posters even for our rooms we dey hang them there, so if anybody come to see us and say he no go use condom we go tell him to look at what they write for the poster so he go dey go and so he no dey come''*.

4.3.3 Material distribution and utilization

On materials distribution, majority of the participants recalled that they were involved in the process. They recalled that the materials were given to them to distribute to their peers, mates family members and relations and whoever they come in contact with. Majority of them reported that they were not trained on distribution, but they said the materials were effectively distributed as directed by the various organizations that worked with them. One of the participants from the FSW group said;*''They gave us materials like posters and handbills. They held meetings with us, They bring to us some materials to teach us how to fix condom and then dey educate us say when we see somebody wey look like AIDS patient make we no dey run away from am make shame no kill am, we should comfort and console the person. Then dey use mouth to tell us and also posters. They still dey use handbills to teach us about HIV/AIDS. Then they give us at times if it reach two if it reach four, any amount we fit collect for their hands and we paste them on our walls. If you go outside now you look at our doors, on the walls you go see all the posters even for our rooms we dey hang them there, so if anybody come to see*

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us and say he no go use condom we go tell him to look at what they write for the poster so he go dey go and so he no dey come''; another participant from the PLWHA group said; *'' yes during that programme they involved us in the process of development of HIV/AIDS materials. Before that programme, there were many posters with messages that were very killing, stigmatising and discriminatory. They even scared people away from us instead of showing love and care for us but when that programme came, they involved us and they asked us what messages that we will like to see and what are the proper ways to present them to our people, so the messages we have now are friendly and not stigmatising. Since that time you cannot see where they will write or address us as victims of HIV but people living positively. We also used those materials to speak to our support group members especially the ones on Drug adherence for Persons Living with HIV/AIDS produced by PLAN''*

4.3.4 Outcome Evaluation

Majority of the participants could not remember whether any evaluation was done or not after the programme. Only a few of them said the project coordinators came back after some time to ask them some questions on what they were taught. However when asked about some basic information on the major routes of HIV transmission and modes of prevention, their responses were very positive and encouraging. Here are some of the responses some of the participants gave;*''They said abstinence is the best way of preventing HIV, but if you are a married woman you cannot abstain from sex but you have to be faithful to your husband and your husband too should be faithful to you. We are told to avoid multiple sex because through multiple sex you can get HIV. We are taught that condom if it is used properly and correctly it can prevent HIV and other diseases like gonorhea or syphillis that may be contracted through sex. We are also told to ensure that blood is screened before we get blood transfussion in the hospitals. Some people can catch HIV through the mother to the unborn child, but if the woman go to hospital and do the test she will be told what to do to protect the child right from the womb. They said that woman should not give the baby any breastmilk but food, that is the infant food''*.

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4.4.4 Involvement of Target audience

Generally, the level of involvement of target audience in the process of behaviour change communication material development was found low particularly in the areas of message conceptualization and actual material production. Responses from majority of the participants in the five focus group discussions revealed that they were not involved as expected, the only area of involvement was in the distribution of the materials.This was revealed by some of the participants as said by one of them *''This poster wey dey write No Condom No sex, na dem come give us and they tell us how to use the posters. They no say everybody understand pidgin english that is why they made the thing for pidgin english. na dem dey tell us we no dey do am for them na dem they do their thing for themselves The woman dey come everytime to teach us''*. Out of all the five group discussions held, the group of persons living with HIV and AIDS and the group of mission birth attendants under the faith based organization reported full involvement of their members in the development processes of the materials.

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CHAPTER FIVE

DISCUSSION

This chapter discusses the findings in the study – the findings from, the checklist administered on organizations, in-depth interviews with project coordinators and Focus Group Discussions held with the target audience. Areas to be discussed include the seven stages of BCC material development; needs assessment, message conceptualization, material design, pre-test, material production, implementation and outcome evaluation as complied with by the non governmental organizations studied. The chapter ends with conclusions and recommendations.

5.1 Discussion on findings

Generally, a low level of compliance to basic standards of behaviour change communication material development process by the non-governmental organizations was observed. This could be attributed mostly to existing gap in knowledge, practice and skills among the project coordinators on development of appropriate BCC materials. The gap analysis in knowledge and skills pertaining to BCC material development among the non-governmental organizations as carried out by this study was equally emphasised by Rouda and Kusy, (1995) who affirmed the need to perform a "gap" analysis to identify the current skills, knowledge, and abilities of people, and the organizational and personal need. The findings of this study have shown the areas of strength and weaknessess that need to be addressed for the development of objective, appropriate and result oriented BCC materials for target groups.

5.1.1 Needs Assessment

From the indepth interviews (IDI) conducted, all the programme coordinators of the twenty organizations interviewed reported that planning for the development of BCC materials was carried out before the actual project implementation. Planning according to the coordinators entailed activities like; focus group discussion, advocacy meetings, rapid appraisal, questionnaire, retreat and baseline survey conducted with involvement of selected members of the various target groups. These in other words were also referred to as Needs assessment. Majority of the participants affirmed that their organisations developed BCC messages from the needs assessment conducted while some adapted the

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existing materials. This assertion is similar to a child health BCC strategy developed in Timor –Leste which took into account existing IEC experiences and materials already developed for child health in the country through a consultative and participatory process. The strategy facilitated evidence-based interventions for health promotion, disease prevention, and treatment through communication interventions, activities, and development of messages that are culturally relevant and meaningful to local people in the country (BCC for Child Health-Timor-Leste, 2008). Similarly, World Health Organisation Regional Office for South-East Asia states that; effective development of IEC materials/programme is based on planning and preparatory activities. It was found that one of the essential steps in planning undertaken was the needs assessment and it was done with the involvement of target groups (WHO, 2006; Accessed Oct 2010). This is supported by Rouda and Kusy, (1995) who affirmed the need to perform a "gap" analysis to identify the current skills, knowledge, and abilities of people, the organizational and personal needs. They further stressed the need to identify area of priorities and importance of possible activities and the cost of identifying the causes of performance problems and/or opportunities; identify possible solutions and growth opportunities (Rouda and Kusy, 1995 accessed in Oct 2010).

Findings from the FGDs show that majority of the participants were involved in the planning process and needs assessment for the development of health educational materials used to disseminate HIVprevention information. Many of them attested to the fact that they were involved in the needs assessment carried out by the respective organizations though at varying degree of involvement. Some of them were interviewed either individually or in a focus group. Of all the five groups studied only the female sex workers target group said they were not involved in the planning or needs assessment. This may be due to the mobile nature of the sex work which may not necessarily make the sex workers available for the needs assessment.

Lee, Chan, Ho, Wong and Ng (2004) also pointed out the importance of conducting needs assessment before implementing any health programme. They stated further that a needs assessment is recommended to be carried out before planning as it could help to identify the needs of the people targeted for intervention. Aubel and Sia, 1995 also

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recommended involvement of target groups in educational material development as imperative to reflecting individuals or groups socio cultural values and reality. So it is imperative that needs assessment be conducted before BCC material development is carried out. It is equally important to ensure ative involvement and participation of the target audience for whom the messages are intended so that their values and opinions may be considered for desired results and impacts.

5.1.2 Message Conceptualization and Material Design

Majority of the participants reported that BCC messages were conceptualized from the needs assessment conducted and issues relating to HIV transmission among the target groups, while some adapted the existing BCC materials on related topics. Many of the organizations also involved the target groups in the process of message conceptualization and design of the BCC materials. This assertion is similar to a child health BCC strategy developed in Timor –Leste which took into account existing IEC experiences and materials already developed for child health in the country through a consultative and participatory process. The advantage of this is that it provides a learning platform from which experiences from individual stakeholders are harvested for development of a better and richer material meeting the needs of the target audience.

Use of locally acceptable and easily understood media of communication like Yoruba, pidgin and simple English languages were employed by the organizations to convey messages to their target audience. This was with the view to ensure communication, understanding and comprehension of the messages. The finding is consistent with Pincus (1989), who reported that messages need to square with environmental and situational realities and must relate to individuals value system and levels of understanding. This was also in line with WHO (1988) which stated that picture and message should match the topic of the talk, drawings should be easy to understand, people and things in posters should resemble local conditions as much as possible.

Understanding messages contained in BCC material is essential as a prior condition to acceptance of those materials and the consequent desired behaviour change. Comprehension measures not only the clarity of the content, but also the way in which it

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is presented. Complicated or technical vocabulary may be responsible for the target audience's failure to understand the message. Or, perhaps the target audience fails to understand the message because the type face is too small, making it difficult for the target audience to read the message. Moreover, IEC materials should be attractive. If an IEC material is not attractive, individuals may not pay much attention to it. As suggested by some individuals, attractiveness can be achieved through the use of sounds -music, tone -in the case of radio; visuals-color and illustrations -in the case of graphics; movement, action, illumination, and animation in the case of video (Ken, 2011).

The findings from the study showed that the target groups of the NGOs understood the messages and contents of the BCC materials developed for intervention by the NGOs. They were able to recall the titles of the posters and the key messages and information therein. Information on routes of HIV transmission and four basic ways of HIV prevention and control such as, abstinence, mutual fidelity between married partners, use of condoms correctly and consistently and avoidance of sharing use of sharp objects were easily recalled by the target group members. Use of complicated or technical vocabulary too difficult to comprehend was not mentioned by the members during the focus group discussion held with them. This corroborates the fact that if messages must be acceptable to the target population, it must be simple, clear and unambigouous, not offensive, believable and must not generate discord among the target audience. The materials should indicate clearly what the health promotion intervention wants the target audience to do. Most IEC materials promote a message that ask, motivate, or induce members of the target audience to carry out or cease a particular action. This was corroborated by Ken 2011 that successful IEC materials transmit a message that can be done by the target audience and correct and well packaged information supported by an effective service delivery is at the heart of IEC material development (UNDP, 1993).

Findings from a study by the World Health Organisation Regional Office for South East Asia, WHOSEA, (2000) also pointed out that when developing coomunication tools for a programme, it is important to call in communication professionals, if available, for every step in the process. It opined that the followings steps are essential in material development: conduct targeted behavioural research, design messages, choose media and

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channels, develop IEC materials and pretesting of materials. Cost and cost effectiveness of materials should also be taken into consideration, then such materials could be disseminated and utilised.

It is generally believed that the success and impact of IEC materials depends largely on the understanding of the target audience by the IEC material design team. Working with target audience members throughout the development of IEC materials, and in developing usage strategies for those materials, helps to ensure that IEC materials meet the needs of the intended target audience. As suggested in one of the production guidelines for IEC materials, the following are the commonest steps a) selecting the most appropriate IEC material, b) developing a creative brief, c). preparing draft / prototype IEC materials -(or adapting existing materials), d) pretesting draft / prototype or adapted IEC materials, e) assessing pretest results and revising IEC materials and f) monitoring the use and impact of IEC materials (Ken, 2011)

5.1.3 Pre-testing

Majority of the organizations reported that pretesting of BCC materials was conducted with the involvement of target audience. This was done with the view to determine the relevance of the materials to the needs of the target audience. It was also meant to test the clarity of the messages for comprehension and the socio-cultural acceptability of the materials. Methods of pretesting employed were focus group discussion, one to one interview and public display of materials for comments from members of target group. This is in line with the comment of Akinwande, 1993 which posited that pretesting of BCC material by target group members offer opportunity to reflect their views and ideas and thereby modify the materials appropriately.

5.1.4 Material Production

Findings from the study showed that majority of the non governmental organizations did not involve target group in the process of material production. This was perceived as exclussive preserve of the programme coordinators. On the types and quantities of materials produced, the commonest materials produced were posters, handbills and stickers produced in thousands of copies, next to that was the T-Shirts and face caps

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produced in hundreds, some also produced souvenirs like keyholders, calendars, jotters and bead emblems in hundreds and very few number produced billboards. On the use of language in message delivery, majority of the organizations reported use of Yoruba and English languages while organizations which focused on FSW used pidgin English to communicate to their various target audiences. Similarly, live and real pictures of local people whom target audience can easily identify with were made use of in the material production. The finding is consistent with Pincus (1989), who reported that messages need to square with environmental and situational realities and must relate to individuals value system and levels of understanding. This was also in line with WHO (1988) which stated that picture and message should match the topic of the talk, drawings should be easy to understand, people and things in posters should resemble local conditions as much as possible.

5.1.5 Implementation and utilization (Material distribution)

Findings from the IDI with programme coordinators on the process of material distribution showed that all the five groups of organization used target audience as a method or vehicle for material distribution

(see figure 4.3). It is important to note that the group of NGOs that focused intervention on the people living with HIV used target audience as a method of material distribution more than all other organizations, followed by the group of NGOs that focused intervention on Women, FSW, Youths and Mission Birth Attendants in that decscending order. The group of NGOs that focused intervention on people living with HIV underscored the importance of the need to involve target audience in the implementation of their programme. They understood the fact that programme succeed when target beneficiaries are major players. This could be attributed to the knowledge, skills and passion the programme coordinators had for the target audience.

Findings from an IEC Mapping and Communication intervention among People Living with HIV/AIDS in Cambodia corroborated the fact that it is important to involve PLWHAs in the entire development and distribution process so that the materials accurately reflect and meet their needs. The goal of the project was to empower as many

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PLWHAs as possible and encourage them to take an active role in seeking out information and sharing it with others. To ensure that the materials are speaking to the target audience, PLWHAs should be involved throughout the process, from focus group discussions, material development, testing the effectiveness of the materials, to sitting on the advisory committee and distributing the end product. This according to the study will result in a IEC material that is designed by and for PLWHAs, a first of its kind in Cambodia.

In the same vein, findings from the FGDs on health educational materials distribution, all the participants in the five groups said they were actively involved. The materials were given to them to distribute to their peers, mates, family members and relations and whoever they come in contact with. Even though they were not trained on distribution but they said the materials were effectively distributed as directed by the various organizations that worked with them. The finding is corroborated by **Van Rompay**, **Madhivanan**, **Rafiq**, **Krupp**, **Chakrapani** and **Selvam, (2008) are of the view that t**he materials designed or developed through involvement of the target population will offer people practical and culturally appropriate choices consistent with the ABC approach to lower their risk of sexual HIV transmission.

WHO SEA (2000) also affirmed this when it pointed out that planning effective ways to make sure that materials reach their target audiences is as important as producing effective materials. It is often the case that good quality materials never reach those who need them or who could effectively use them. Planning a distribution strategy and setting up a distribution network at the beginning is important. It further pointed out that using materials to support IEC activities, through mass media or for interpersonal communication requires knowing how to use them effectively. Ideally, users will become familiar with different types of material and methods for using them during communication training. At the very least, instructions and suggetstions for use must be supplied along with the materials.

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Although majority of the NGOs did not train the target group members on distribution of the materials before they embarked on distribution and neither was there anything like schedule of distribution, yet they were actively involved in the distribution.

5.1.6 Outcome evaluation

The study findings showed that majority of the organizations carried out evaluation of the IEC materials used either, in whole or as a part of the entire project evaluation, using one method or the other, though, some of them disclosed it was an informal type of evaluation. The methodology of evaluation, whether formal or informal were observation, questionning, focus group discussion, monitoring and supervisory visits and feed back survey, but the widely used methods were questioning and observation and only a few had evaluation report. When asked about the outcome of the evaluation, majority of the organizations reported a positive behavioural change observed among the target groups and this was attributed to the IEC materials, though not in isolation, but in relation to the entire project components implemented by each organization. However, findings from the FGDs indicated that none of the participants was aware of or involved in any evaluation carried out by the organizations who worked within their focal group. The finding is similar with the report of Franco-Australian Pacific Regional HIV/AIDS and STI Initiative (2004) on the 'Review of HIV/AIDS & STI Information Materials' where one of the participants indicated that "We don't know how effective the materials are – the objective is to change behaviour for HIV/AIDS - will the materials as they are, bring about change in behaviour in target groups that materials are produced for?" MoH worker, Fiji.

In a report (CMS, 2008), it was also observed that there is no direct mechanism for monitoring or evaluation of IEC activities. For IEC activities undertaken review meetings are held annually or bi-annually. The impact of the IEC activities is discussed during these meetings and any further recommendations or changes are also discussed. In their study, most of the states did not have any IEC monitoring and evaluation component built into the IEC action plan. However in the States like Gujarat, Tamil Nadu and West Bengal the DLOs informed of doing some kind of impact assessment on their own. In Assam a lot of people reportedly turned up after reading the IEC materials suspecting

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their white patches to be of Leprosy. In Gujarat and Tamil Nadu the Sample Survey Assessment Unit (SSAU) had conducted impact assessment in the districts. The DLO of North 24 Parganas, in West Bengal informed thatthey evaluated the IEC programme on the attendance of self suspected Leprosy patients indifferent Diagnostic Centers. However, full-fledged IEC evaluation never took place.

From the findings of this study, it will be observed that evaluation of IEC materials is an area where many study participants lack the skill and privilege to participate in the evaluation process most especially the target population, hence the expressed need for evaluation skills. According to the Franco-Australian Pacific Regional HIV/AIDS and STI Initiative (2004), this was consistent across both government agencies and community-based organisations: "There is no evaluation of the effectiveness of STI/HIV/AIDS education materials". This issue was also previously identified within the Behaviour Change Communication Training Needs Assessment Report. There is a great deal of HIV/AIDS & STI information material being produced (particularly print-based) and distributed but no evaluation of them occurring. Evaluation is also lacking from other media being used to disseminate HIV prevention information.

5.1.7 Involvement and participation of Target audience

Generally, the level of involvement of target audience in the stages of planning, message conceptualization, production, distribution and evaluation of health educational materials was found very high, though with some degree of variations. For instance, findings from all the twenty organizations studied showed that a good number of them precisely, fourteen out of twenty studied involved the target audiences in the planning process particularly in the needs assessment for health educational material development. Similarly, it was found that majority of the organizations, precisely twelve out of twenty involved their target audiences in the process of message conceptualization and sixteen of them actually carried out pre-test of materials before production with the involvement of target audiences. Only three organizations involved their target audiences in the stage of material production and the reason mostly advanced for this was that it is purely a management responsibility and not that of target audience.

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In the area of material distribution, almost all the organizations involved the target audience except one and the only reason adduced to that was an inexperience in the implementation of IEC project on the part of the programmer. In the area of evaluation, seventeen out of the twenty organizations carried out evaluation whether formal or informal and very few of them involved the target audience.

Findings from the FGDs among target population show that the level of involvement of target audience in the process of health education material development was found low particularly in the areas of message conceptualization and actual material production. Responses from majority of the participants in the five focus group discussions revealed that they were not involved as expected, the only area of involvement was in the distribution of the materials. Out of all the five group discussions held, the group of persons living with HIV and AIDS and the group of mission birth attendants under the faith based organization seemed to be actively involved in the development processes for the materials.

The finding is in sharp contrast to Kelly et al. (2006) and Crane and Carswell (1992) who stated that because they typically originate from or are specifically organized to serve community constituencies, NGOs can respond with culturally sensitive programmes. NGOs are often characterized by relative potential for high levels of community participation in programme development. It is suggested that the target audience should be able to identify with the IEC materials. They should recognize that the message is directed toward them. People will not pay attention to messages that they consider do not involve them. Illustrations, symbols and language should reflect the characteristics of the target audience.

5.1.8 Implications of the findings for Behavior Change Communication programme

There is no doubt that the results of this study will have far reaching implications for planning, development, implementation and evaluation of HIV and AIDS education among non-governmental organisations and target population in the study area and Nigeria at large. Health education is a combination of learning experiences designed to

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facilitate voluntary adaptation of behaviour conducive to health (Green, Krenter, Deeds and Patridge 1980). It is concerned with reinforcing and changing knowledge, attitudes and behaviour of people through effective communication of factual information, with the aim of helping them to ensure an optimum well-being. Health education can therefore be used to bridge the gap between health information development through information, education and communication materials and health practices within the context of HIV and AIDS.

The findings of this study have revealed the level of involvement of target population in the preparation and development of IEC materials aimed at mitigating the impact of HIV and AIDS on different population which should be addressed with appropriate HIV and AIDS education strategies.

Some of the activities that need to be modified relate to conducting needs assessment among target population; this is important as this will enable the IEC messages have a far reaching impact on the target population and at the same time such messages will be culture sensitive and socially acceptable. Messages such as compulsory HIV testing/screening for all applicants and the avoidance of social contact with PLWHAs should be avoided. Intervention strategies such as workplace health education programmes which focus on the causes and route of transmission of the virus most especially as it affects the workplace could be useful. Actions/intentions that are discriminatory in nature need to be changed in order to make workplaces health promoting for the PLWHAs. Such actions/intentions include denial/withdrawal of legitimate benefits from workers who are living with the virus and views that anything expended on them will amount to waste of resources. Strategies such as advocacy, health education programmes and the greater involvement of the PLWHAs (GIPA) in the management of establishment have high potential for being effective. The behavioural antecedents which need to be modified in order to prevent and control HIV and AIDS related stigma and discrimination in workplace include knowledge, beliefs and practices about HIV and AIDS. Strategies such as advocacy for the formulation, implementation and institutionalisation of HIV and AIDS workplace policy could be used successfully to effect this change. Organisations in both private and public sectors could be assisted by

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NIBUCCA in the designing, implementation and institutionalisation of workplace policy on HIV and AIDS.

The findings of this study could be used as a training needs assessment for the design and development of a training curriculum for upgrading the knowledge and skills of programme managers and coordinators in the IEC material development as well as monitoring and evaluation of the impact of such materials aimed at mitigating the effect of the scourge of the disease condition.

5.2 Conclusion

This study is essentially a process evalution assessing the process of message conceptualisation, designing and the level of involvement of target population in the development and production of IEC/BCC materials for behaviour change communication. From the study, it was found that NGOs conducted need analysis of their target population and based on this analysis, messages for the IEC were designed. It was also found that the NGOs were heavily reliant on donors in terms of financing the projects they implemented and the mostly frequently implemented projects were behavioural change communication projects.

The monitoring and evaluation practices of the NGOs were found weak in comparison with the recommended best practices. Most of the best practices were inconsistently done on the projects. Some of the best practices such as use of qualitative indicators were generally not used by majority of the NGOs. This can be explained by the fact that they lacked expertise in monitoring and evaluation as highlighted by the findings.

5.3 Recommendations

The following recommendations were made to address some of the key findings of the study.

5.3.1 Training:

The findings found a critical lack of expertise in needs assessment and IEC/BCC material development as indicated in some projects implemented by the NGOs. There is need for training in this aspect as well as in monitoring and evaluation. Donors in conjunction

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with government and relevant educational institutions should institute programmes to impart HIV/AIDS projects monitoring and evaluation skills amongst the local NGOs. It is imperative that the implementers of these projects have skills in monitoring and evaluating them. Training for staff of non governmental organizations on materials development, pretesting and distribution should:

- Emphasize how to design objectives, messages, and educational material.
- Instruct on how to design, implement, disseminate, promote, and evaluate plans to assure appropriate use of materials.
- Inform about sources of additional information and related services.
- Instruct how to design and conduct pretests, including how to conduct focus groups discussions.
- Provide practice sessions and opportunities for observation before conducting target audience pretests.
- Provide other training as needed (e.g., cultural sensitivity, low literacy materials development, sexuality attitudes, interviewing skills).
- involve project coordinators of organizations that focused intervention among PLWHAs as facilitators in future capacity building programme for experience sharing and exchange of knowledge in best practices as related to BCC programming.

5.3.2 Need for Supportive supervision and monitoring

Supervision of HIV project activities was weak as described by the project coordinators studied. This weak supervision consequently affected the level and quality of service delivery including the BCC materials developed under the project. There is need therefore for the supervising agency, the Oyo SACA and other relevant agencies to institute a functional and systematic supportive supervision mechanism on the project activities implemented by the non-governmental organizations in the State.

5.3.3 More funding to NGOs:

Much as there are huge funds being invested in the fight against HIV/AIDS, very little is trickling down to the grass root NGOs that are at the forefront of combating HIV/AIDS. There is need for the donors to provide more resources to the NGOs, so that their

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activities can have impact. With insufficient funds, monitoring and evaluation is looked at as a luxury and hence the projects do not benefit from it. With more funds the NGOs project coordinators can be trained and retrained on the critical skills that they are lacking especially in project monitoring and evaluation.

5.3.4 Need for a more participatory approach:

There is need for the NGOs to involve all the stakeholders in the design of the HIV/AIDS projects. The beneficiaries should not be passive recipients of the services the project is offering. An active involvement of the beneficiaries such as People Living with HIV will mitigate the challenges of collecting monitoring and evaluation data from them. It has got an added advantage of demonstrating accountability to them and also ensuring sustainability of the project when the donors withdraw funding.

5.4 Suggestions for further study

Further research would be required to determine empirically the actual impact on the performance of the projects and hence the fight against HIV/AIDS by the inadequacies identified in the monitoring and evaluation practices of the NGOs. Since monitoring and evaluating project are integral part of project planning and design, further research should try to investigate the project design and planning practices of the NGOs.

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APPENDICES

APPENDIX I:

LIST OF TWENTY (20) NON GOVERNMENTAL ORGANIZATIONS RANDOMLY SELECTED FOR THE STUDY

S/N	NAME & ADDRESS OF ORGANIZATION	TARGET GROUP	GOAL	MISSION
1	Society for Women and AIDS Africa (SWAN), Nigeria Oyo State Chapter110/112, GAAF Building, Suite B11, Orogun 08023382432,08033244137,swaanoyostate@yahoo.com	Female Sex Workers	To reduce the vulnerability of women to HIV and AIDS through awareness creation, capacity building, advocacy and policy formulation.	To create awareness among women professionals and general women folks especially the vulnerable ones like young women, in-school and out of school female youths, female sex workers and other most at risk groups on the the issues of HIV/AIDS.
2	Centre for Reproductive Health Aromatherapy & Development (CEREHAD). 31, Are Avenue, New Bodija, Ibadan. 02-8103581, 08023431996	Female Sex Workers	To fill the existing gap in knowledge on reproductive health including HIV prevention, control and impact mitigation among the infected and affected members of the populace.	To network with other civil society organizations within and outside the state to inform, educate and communicate appropriate information on sexual and reproductive health matters to the members of the populace with special attention on female sex workers, female out-of school youths and male out-of school youths.
3	Concerned Others 38 iyaolobe Str. Ekotedo, Ibadan. 08033259626, 02-2414447	Female Sex Workers	To ensure access to right information, treatment and services on HIV/AIDS by the most at risk populations like female sex workers in the state.	To provide HIV Counseling and testing services, treatment of opportunistic infections and sexually transmitted infections especially among the most at risk groups like female sex workers.
4	Environmental Health Officers Assoc. of Nig. Women's Wing Oyo State	Female Sex Workers	To reduce the prevalence of HIV infection among women populace like market women, female out of school youths and other	To create awareness on HIV prevention among the general populace and empower the vulnerable and most at risk

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S/N	NAME & ADDRESS OF ORGANIZATION	TARGET GROUP	GOAL	MISSION
	C1-11 shop Arcade, Trans Amusement Park, Bodija, Ibadan. 08055255938		vulnerable groups in the state.	groups like female sex workers through provision of alternative trading and economic empowerment programmes.
5	Christian Health Association of Nig. (CHAN), NICON Insurance Cooperation building, 241 Obafemi Awolowo way Oke-Ado, Molete. 08023422458, kaytoks@yahoo.com	Faith Based Organization	To promote and strengthen health care service delivery especially at the rural areas.	To provide health care services to the less privileged members of the populace especially in the rural areas of the State.
6	World Islamic Peace Foundation No 141 Inaolaji shoping complex, agodi gate, Ibadan 02415035,08052146033, imam_busari@hotmail.com	Faith Based Organization	To mobilize muslim brothers ans sisters for sustainable community development, peaceful co-existence and unity among mankind.	To inform, educate and orient muslim community members for a sustainable community development.
7	People of Faith Gospel Church Arometa Bus-Stop, Sango-Eleyele Rd, eleyele Ibadan 02-8105176,08023657877	Faith Based Organization	Proclamation of the gospel of Jesus Christ to all mankind through preaching, sharring of love and care to fellow human beings.	Provision of care and support services to men, women and children.
8	Justice, Devt. & Peace Comm, Catholic Archdiocese of Ibadan St. Patricks Church Compound Basorun, Ibadan 02-8106594,08033803192, ,jdpcibd@skannet.com	Faith Based Organization	A developed and functional society where individual members are enlightened and empowered to participate in developmental activities.	To create awareness and enlighten members of the populace on health and socio economic and developmental activities especially at the grassroot areas in the spirit of justice, equity and fairness.
9	Primary Health Care & Health Mgt. Centre N4/636A, Opp Sch. Of Midwefery junct., Yemetu, Ibadan. 08033256644,	Youth and community development committees members.	Moving ahead together with strength and commitment to reach the needy where they live and work.	To provide support for implementation of primary health care activities at the grassroot level and train health care providers.

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S/N	NAME & ADDRESS OF ORGANIZATION	TARGET GROUP	GOAL	MISSION
	prihemac@yahoo.com			
10	True Gold Music Company 08023454820; 08034000606; No 8, Alayande Close, Off Awosika Avenue, Old Bodija Estate, Ibadan	In-school Youth	To create awareness on HIV/AIDS and other sexually transmitted infections among in-school youths through effective use of mass media.	To produce audio and visual materials reaching out to in-school youths on prevention of HIV and adoption of abstinence and safer sexual practices.
11	Torch International Co. Ltd 08028457595, olaolawore@yahoo.comCol Fagbure Shopping complex, Customs area, Iseyin	Youth-Secondary school students	Mobilizing youths and families to improve their health and economic status.	Impact mitigation of HIV/AIDS, Training of health workers, poverty alleviation and gender equity.
12	Educare Trust, Nigeria Goshen Superstores building, Coca-cola Area, Sango 08023865772, 02-8106295	Youth-(In and out of school)	To equip youth with knowledge and information required for a responsible adulthood	Training of youths through organizing seminars, workshops and symposia and distribution of literacy materials to effect learning and behavioural change.
13	Positive Life Association of Nigeria Block C3, suites 1&2, Oyo State Trade Fair Complex, Sanngo, Ibadan,08037190628, planigeria@yahoo.com	People Living with HIV	To provide quality care and support for people living with HIV/AIDS to enable them live a quality lifestyle notminding their positive status.	Provision of food materials, drugs and medicines and necessary information on positive living to members of support groups of people living with HIV/AIDS in the State.
14	Goodworker Movement International No Afunlehin Close, Off Opposite Islamic High School Bashorun, Ibadan 08023271294, 08023271294	People Living with HIV and Youth-Injecting drug users.	To make world a better place to live in by actively promoting good behavior and health lifestyles among the youth and others through active Christian influencing.	Using faith based approaches to communicate good moral values, patriotism and leadership qualities to youth.

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S/N	NAME & ADDRESS OF ORGANIZATION	TARGET GROUP	GOAL	MISSION
15	Family Health and Population Action Comm. FAHPAC Comlex, behind Omoyeni Nur/Pry. School, Adesola, Orita Aperin. Ibadan. 08023357142	People Living with HIV	To provide care and support to people living with HIV/AIDS and prevent mother to child transmission of HIV.	Establishing support groups of people living with HIV/AIDS, providing nutritional, educational and psychosocial support to members.
16	Actors Against AIDS Drug Abuse and Social vices 08033884648, 08043460522 Block E3 Trade Fair Complex, Saango-Samonda Rd. Ibadan	People Living with HIV	Creating awareness on HIV/AIDS at community level using acceptable socio-cultural methods and strategies to mobilize people for HIV counseling testing, care and support for people living with HIV and reduction of stigma and discrimination.	Organising drama, songs, folklore and and other behavioural change communication strategies to reach out to people on HIV prevention at community level.
17	Police Officers Wives Assoc., Oyo State POWA Office, Oyo State Police HQ, Eleyele, Ibadan 08037114574,08034737336	Women (Wives of Police Officers)	Reaching out to women folks especially in the police community with HIV prevention information, care and support to people living with HIV and provision of economic empowerment to OVC & care givers.	Community mobilization and sensitization on HIV prevention targeting women folks and young girls who are vulnerable to HIV and other sexually transmitted infections.
18	Assoc. for Rep. & Family Health (ARFH) 815A Army Officer's Mess Rd., Ikolaba GRA, Ibadan 028100164, 08033971908, arfh@skannet.com	Women (Market women)	Catalysing a functional reproductive health system both in the public and private sector.	Capacity building, service provision, advocacy and operation research in reproductive health including HIV/AIDS especially among women of reproductive age group.
19	Society for Health and Development 08037035410No 10 Dele Ajayi Street, Iyana Church, Ibadan	Women-Traditional Birth Attendants (TBAs)	Updating the knowledge and skills of community members on prevention and control of locally endemic diseases.	To enhance the capacity of community members on prevention and control of locally endemic diseases including HIV by creating awareness and educating community members on prevention and control of HIV/AIDS.

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S/N	NAME & ADDRESS OF ORGANIZATION	TARGET GROUP	GOAL	MISSION
20	UMARDET Communication Ltd. 08023516312 No 26, Adenle Avenue, Alafia Layout, Mokola, Ibadan.	Market women including general populace.	Awareness creation and publicity of HIV prevention messages to members of community through the use of visual and behavior change communication materials.	Producing BCC materials like billboards, banners, and souvenirs on HIV prevention information to members of the populace.

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APPENDIX II

Evaluation Checklist on BCC Materials developed for HIV Prevention by NGOs.

S/N	STAGES OF DEVELOPMENT	REMARKS	
		YES	NO
1.	**NEEDS ASSESSMENT (N.A)**		
	NGO Conducted Needs Assessment		
	Methods of Needs Assessment:		
	Reason for Needs Assessment:		
	Target Group Involved in N.A		
	Were Planning meetings held with Target group?		
2.	**MESSAGE CONCEPTUALIZATION (M.C)**		
	NGO Involved Target group in M.C		
	Languages used in message development:		
3.	**MATERIAL DESIGN & DEVELOPMENT**		
	How were the m)aterials developed (Adapted/Adopted/New?		
4.	**PRETESTING**		
	Were materials pretested?		
	Involvement of Target group in pretesting		
	Reasons for pretesting:		
5.	**MATERIAL PRODUCTION**		
	Involvement of Target group?		
	Types of BCC materials produced:		
6.	**MATERIAL DISTRIBUTION**		

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S/N	STAGES OF DEVELOPMENT	REMARKS	
		YES	NO
	Involvement of Target group?		
	Training of target group in material distribution?		
7.	**OUTCOME EVALUATION**		
	Evaluation of BCC materials?		
	Methods of Evaluation used:		

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APPENDIX III

PROCESS EVALUATION OF BEHAVIOUR CHANGE COMMUNICATION (BCC) MATERIALS DEVELOPED AND UTILIZED FOR HIV PREVENTION BY NON GOVERNMETAL ORGANIZATION (NGOs) UNDER THE OYO STATE WORLD BANK ASSISTED HIV & AIDS PROGRAMME IMPLEMENTATION.

INSTRUMENT 2:

In-depth Interview (IDI) Guide for NGO Project Coordinators: You have been considered for this interview based on the involvement and participation of your organization in the Oyo State World Bank assisted HIV/AIDS project. Your role in putting up programmes and activities aimed at reducing the spread and mitigating the impact of the epidemic of HIV and AIDS in the state has been duly recognized. We will appreciate your interest in talking with us on the role of non governmental organizations in the crusade against HIV/AIDS epidemic in Oyo State, particularly in the area of development and utilization of behavior change communication materials as tools for awareness creation on HIV prevention under the World Bank assisted HIV/AIDS project in the state, of which your organization was a beneficiary. I want to assure you that information provided will be treated with utmost confidentiality for the purpose of the research work only and your names are not required.

Do I have your kind permission to continue with the interview? Yes [ ] No [ ]

Organizational Profile:

1a. What is the name of your organization?

lb. What is your designation in this organization?

1c. In what year was the Organization registered?

1d. Can you please state the Address of the Organization?

2a What type of Projects were implemented by your Organization in the last 3 years.

2b. Probe for SACA funded project

2c. What is the title of the project funded by Oyo SACA and implemented by your Organization? Probe for the year of commencement and completion.

3a. In which communities did you implement the SACA funded project?

3b. What target group did your project focused for intervention?

3c. What was the population of the target group?

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4a. What type of health education materials were produced and used by your organization for disseminating l-IIV and AIDS related information to community members under the project?

4b. For each type of health education materials produced and used,

Probe for (i.) title/the message used (ii.) target group, (iii.) number produced, iv.) number distributed, v.) who distributed it? Probe for the amount spent on each item produced?

5. What steps were taken in each of the following processes in the development of the Behaviour Change Communication (BCC) materials?

5a. Planning process: How was the production of each of the materials planned for? What actually went into the planning phase?

5b. Probe for needs assessment- How was it carried out? Why was it carried out and who carried it out?

5c. Probe for involvement of target group in the needs assessment, planning and conceptualization of the messages in the materials.

5d. Were target group segmented according to age group, sex and educational status?

5e. What was the level of involvement of the target group? Were there meetings held? How many times? What was the level of attendance at each meeting?

6. What steps were taken in the process of production of the BCC materials?

6a. Production process: How were the materials produced?

Were the representatives of target group involved in the selection of the supplier/contractor?

6b. What things were done to ensure that the materials were appropriate for the target group?

6bi. Probe for language used?

6bii. Why was it used?

6biii. Who suggested the use of the language?

6ci. Were the materials pretested?

6cii. Who carried out the pre-test?

6d. What key things were taken into consideration to make sure that the materials produced were relevant to the needs of the target group?

Probe for the pictures or images used, were they culturally and socially acceptable? (ii). colours used and (iii). why were they used?

7. What things were done to ensure efficient distribution of the materials produced?

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7ai. Distribution Stage: Who distributed the materials?

7aii. Probe for the involvement of target group in the distribution of the materials

7aii. Were the people trained?

7b. Was there any schedule for distribution?

7c. For how long were the materials distributed?

8ai. Evaluation stage: Did the materials have any effect on the target group?

8aii. How did you know that the materials had effect on the target group?

8aiii. What measures were taken?

8bi. Were there any evaluation carried out to measure the impact of the materials on the target group?

8bii. How was it done?

8biii. What was the outcome of the evaluation?

9. Generally, What can you say about the programme? Was it successful? How did you know? Are the target group followed up? How were they followed up? Any report on follow up?

10. What are the achievements/impacts of the programmes implemented by your organization under the SACA funded project at the focal communities? Probe for coverage?

11.i What were the barriers faced in implementing the BCC component of the project?

1 l.ii What efforts were made to overcome the barriers?

12. What were the best practices that can be derived from this project in terms of planning, implementation and evaluation of health education materials?

13. What recommendations do you have for improving the process of planning, implementation and evaluation of health education materials in future HIV &AIDS programming?

13.i Policy Makers

l3.ii Programmers

13.iii Target Group

Thank you for your time and God bless.

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APPENDIX IV:

PROCESS EVALUATION OF BEHAVIOUR CHANGE COMMUNICATION (BCC) MATERIALS DEVELOPED AND UTILIZED FOR HIV PREVENTION BY NON GOVERNMETAL ORGANIZATION (NGOs) UNDER THE OYO STATE WORLD BANK ASSISTED HIV & AIDS PROGRAMME IMPLEMENTATION.

INSTRUMENT 3:

Focus Group Discussion (FGD) guide for Project Beneficiaries like; Youths, Women, Female Sex Workers, Mission Birth Attendants and People Living with HIV on process evaluation of behavior change communication materials developed and used by non governmental organizations under the SACA funded project in Oyo State.

You all have been considered for this discussion in view of your role as one of the targeted beneficiaries of the HIV/AIDS programmes carried out in this community by non governmental organizations. We will appreciate your interest in talking to us on the activities of these organizations and the impacts of their programmes on the members of your community at large. I want to assure you that every piece of information provided will be treated with utmost confidentiality for the purpose of the research work only and your names are not required.

SN	MAIN QUESTIONS	PROBING QUESTIONS
1.	Do I have your kind permissions to continue with the discussion? Yes [ ] No [ ]	i. In the last 5 years, what organizations have worked in this community? ii. *Probe for the specific organization that worked on HIV and AIDS prgramme in the community.* iii. Can you recall the name of the organization funded by the State Action Committee on AIDS that worked in your community?
2.	We will now focus on the organization mentioned and their activities in this community.	i. In what year did this organization (Name of organization) carried out activities in your community and what type of activities were carried out? ii. If HIV and AIDS is not mentioned, Probe for I-Il V/AIDS programme implementation. iii. What types of health education materials were distributed in the community? iv. How did the organization carried out its activities in the community?
3.	To what extent were you involved in the project implementation?	*Probe for their involvement in:* i. Needs assessments

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		ii. Planning-design and conceptualization of messages. iii. IEC materials development- type of IEC materials developed and produced? iv. Implementation v. Probe for who participated and how they were selected
4.	What are the effects of the BCC materials on the people in this community?	*(a) Probe for:* i. Knowledge gained on mode of transmission of HIV *ii.* Knowledge gained on mode of prevention of HIV *iii.* Knowledge gained on coping skills (PLWHAs) *iv.* Other benefits derived (b) *Probe for skills gained in respect to HIV prevention such as;* i. Abstinence ii. Use of Condom iii. Blood Safety iv. Prevention of Mother to child transmission
5.	i. Overall, what major benefits did members of the target group derived from the programme? ii. Overall, what major benefits did members of the community derived from the programme?	
6.	What are your recommendations for improving the process of planning, implementation and evaluation of BCC materials in this community in the future?	

Thank you all for your participation and God bless.

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APPENDIX V

Summary evaluation of checklist

EVALUATION OF BCC MATERIAL DEVELOPMENT BY NGOs UNDER THE OYO STATE WORLD BANK ASSISTED HIV/AIDS PROJECT.																					
SUMMARY SHEET FOR KII ANALYSIS BY THEMATIC AREAS		NON GOVERNMENTAL ORGANIZATIONS																			
		FSW FOCUSSED				MISSION BIRTH ATTENDANTS				YOUTH FOCUSSED				PLWHA FOCUSSED				WOMEN FOCUSSED			
		SWA	CERE HAD	CON	EHO	CHAN	WIPF	POF	JDPC	PriH E	True gold	TOR	EDU C	PLA	G/W Move	FAP	ACT	POW	ARFH	SHD	UMA
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
S/N	PLANNING FOR MATERIAL DEVELOPMENT																				
1	Conducted Needs Assessment	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2	How was the Needs Assessment carried out?	FGD	FGD	FGD	ADV	BS	MTG	FGD	Q	Q	RA	RA	RA	RA	Q	RTR	FGD	MTG	RA	MTG	Q
3	Reason for Needs Assessment	EB	EB	EB	EB	EB	EB	EB	EB	EB	EB	EB	ACCP	EB	ROU	EB	EB	EB	EB	REL	EB
4	Involvement of Target Group in Needs Assessment	Y	Y	Y	NO	NO	Y	Y	NO	NO	NO	Y	Y	Y	NO	Y	Y	Y	Y	Y	Y
5	Segmentation of Target group members according to Age, Sex or Educational status.	Y	Y	Y	Y	Y	Y	Y	Y	Y	NO	Y	Y	NO	NO	NO	Y	NO	Y	Y	Y
6	Were there Planning meetings held?	Y	Y	Y	Y	Y	Y	Y	NO	NO	NO	Y	Y	Y	NO	Y	Y	Y	Y	Y	Y
	CONCEPTUALIZATION OF MESSAGES & PRODUCTION OF MATERIALS																				
7	Involvement of Target group in the conceptualization of messages for	NO	Y	Y	NO	Y	NO	Y	NO	NO	Y	Y	Y	Y	NO	Y	Y	Y	NO	Y	Y
8	Language(s) used in messages and materials development	E&Pg	E&Pg	E&Pg	E&Pg	Y&E	ENG	YOR	Y&E	Y&E	Y&E	YOR ENG.	Y	YOR ENG	E	YOR ENG.	E&Pg	E&Pg	YOR ENG.	YOR ENG	YOR ENG.
9	Were materials pre-tested and what about the involvement of target group in the exercise?	NO	Y	Y	Y	Y	Y	Y	Y	NO	Y	Y	Y	Y	NO	Y	Y	Y	Y	NO	Y
10	Involvement of Target group members in the production of materials.	NO	Y	NO	NO	NO	NO	NO	NO	NO	NO	NO	Y	Y	NO	Y	NO	Y	NO	NO	NO

	ANALYSIS BY THEMATIC AREAS	SWA	CERE HAD	CON	EHO	CHAN	WIPF	POF	JDPC	PriH E	True gold	TOR	EDU C	PLA	G/W Move	FAP	ACT	POW	ARFH	SHD	UMA
11	Types and Quantity of materials produced	P,H BN STK	P,H	P,H, T/S STK	P,H STK	P,H	P,H Njb Cap	H, NB STK CAL.	T/S, P, & STK	T/S, P&H	T/S, BL	P,H Jott	P,H T/S KH	P,H, T/S STK	P,H, T/S STK	P, T/S	P,H, T/S STK	P,H, T/S STK	H,P, T/S STK.	P,H T/S	P,H BL T/S
12	What things were done to ensure relevance of the materials produced to the needs of the target groups	KNO	U/Lag	PRT	U/Lag	LIVE PIC	INTN	INV	LIVE PIC	CLR MSG	APP MSG	NAS	LIVE PIC	APP MSG	LIVE PIC	NAS	PRT	APP MSG	ADP	PRT	INV
	MATERIAL DISTRIBUTION																				
13	Involvement of Target group members in the distribution of the materials produced	Y	Y	Y	Y	Y	Y	Y	Y	Y	NO	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
14	Any training or instruction on distribution of the materials?	Y	Y	NO	NO	Y	Y	NO	NO	NO	NO	NO	NO	NO	Y	Y	NO	NO	NO	Y	NO
15	How were the materials distributed, any schedule or pattern for distribution	NO	Y	NO	Y	NO	NO	NO	NO	NO	Y	Y	Y	NO	Y	Y	NO	NO	NO	NO	Y
16	How many of the materials produced were distrbuted?	N.E	N.E	ALL	ALL	N.E	ALL	ALL	ALL	ALL	ALL	ALL	E	ALL	N. E	ALL	ALL	ALL	ALL	N.E	ALL
17	For how long were the materials distributed?	1yr	On	2yrs	2mths	On	8mths	1yr	2yrs	1wk	1day	1yr	30min	1yr	3yrs	3mths	2yrs	1yr	1yr	1yr	1yr
	IMPACT EVALUATION OF THE MATERIALS																				
18	Was there any impact assessment or evaluation of the effect of the materials on target group?	Y	Y	Y	Y	Y	NO	Y	Y	Y	NO	Y	NO	Y	Y	Y	Y	Y	Y	Y	Y
19	How was the assessment or evaluation carried out?	QUE	M&E	QUE	QUE	M&E	NO	QUE	OBS	OBS	NO	QUE	NO	QUE	QUE	QUE OBS	QUE	FGD	FGD	QUE	SURV
20	What was the outcome of the evaluation?	PBC	PBC	PBC	PBC	PBC	PBC	PBC	PBC	PBC	NO	PBC	PBC	PBC	PBC	PBC	PBC	PBC	PBC	PBC	PBC
21	ANY BEST PRACTICE	ACT	T/ACT	INV	Coun	ADP	M/Dur	G/Org	QUAL MSG	QUA L	Profs	ACT	C/INV	CLB PROF	ID	Use L/Pct	INV	INV	INV	INC	FB Survy
22	BARRIERS OR CHALLENGES	FND	FND INAD MATR	FND	H toR	FND	M Syn	FND	FND	LOG S FND	INEX FND	INAD FAC	FND	FND	FND DST	M Syn	FND	FND	FND	INST	CULT

ANALYSIS BY THEMATIC AREAS		SWA	CERE HAD	CON	EHO	CHAN	WIPF	POF	JDPC	PriH E	True gold	TOR	EDU C	PLA	G/W Move	FAP	ACT	POW	ARFH	SHD	UMA
23	RECOMMENDATIONS	SUS M/Fd Profs	C/INV	CB M/Fd	M/Fd	C/INV	M/Fd	SUS INV	M/Fnd	H.ED SUP P	CB M/Fd	SUS	M/IE C	CB M/Fd	CB	SUS M/Fd CB	CB M/Fd	M/Fd	INV SUS PRT	PRT	SUS M/Fd

KEY:

CLB Collaboration
PROI Use of Professional
NO No
Y Yes
OBS Observation
PBC Positive Behavioural Change
QUA Quality Message
INEX Inexperience
FND Funding
LOG Logistics
TRG. Training Provided
H.ED Health Education Supported
APP Appropriate Message
CLR Clear Message
LIVE Live Pictures
ROU Routine
ACCI Acceptability
E&P English Language and Pidgin
STK Stickers
KH Keyholders
N.E Nearly Everything
ID Identification with target grp

Adaptation
Community Involvement
Monitoring & Evaluation
Inexperience
Transparency and Accountability
Distance
Inadequate materials
Evidence based
Relevance
Advocacy
Involvement of Target Audience
Pretest
Knowledge
Questionnaire
Integration
Incentive
Good Organization.
Instability
Capacity Building
Sustainability
Professionalism
More IEC

NAS Needs Assessment
INTN Internalization
U/Lag Use of Language
FB Survy Feedback Survey
M/Dur Material Durability
Couns Counseling
CULT Cultural Festival Oro
M Syn Money Syndrome
H toR Hard to reach
M/Fd More Funding
RTR Retreat
Use L/Pic Use of Live Pictures

PPENDIX VI

OYO STATE ACTION COMMITTEE ON AIDS (OYOSACA)

No 8, Government House Road, Agodi, Ibadan. Tel: 08055210769, 08034273516
Website: www.oysaca.org E-mail: oyospt@yahoo.com

Our Ref: OYSACA/RES/07/11 Your Ref:__________ Date: 17th June, 2008

Mr Bolarinwa K.Kolawole
Department of Health Promotion and Education
Faculty of Public Health,
University of Ibadan,
Ibadan.

Dear Sir,

Letter of Consent and Permission.

1. This is to inform you that this organization has reviewed your MPH thesis proposal on the proposed study on the Process of BCC material Development by Non Governmental Organizations (NGOs) funded for HIV prevention in Oyo State by our organization and having found it useful and relevant, we hereby give consent and permission for the study to be conducted in the State.
2. We equally pledge our support in any way you might deemed fit in the course of the study.
3. It is however anticipated that you would share your findings with this organization at the end of the study.
4. Aceept my assurance of best wishes.

M.A Ganiyu
Ag. Project Manager.