A Study of Health Communication Practice to Reduce HIV/AIDS In the Urban Areas of Addis Ababa Nifas Silek Lafeto Sub-City Woreda 11 in Focus

By

Abiot Kebede Haile

Thesis Submitted to the Graduate School of Journalism and Communication Presented in Partial Fulfillment of the Requirements for the Degree of Master of Arts in Journalism and Communication.

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This is to certify that the thesis prepared by Abiot Kbede entitled: A Study of Health Communication Practice to Reduce HIV/AIDS in the Urban Areas of Addis Ababa Nifas Silek Lafeto Sub-City Woreda 11 in Focus and submitted in partial fulfillment of the requirement for the Degree of Master of Arts Journalism and Communications complies with the regulations of the university and meets the accepted standards with respect to originality and quality.

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Advisor_____sig._____Date_____

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Chair of department or Graduate Coordinator

Abstract

A Study of Health Communication Practice to Reduce HIV/AIDS in the urban areas of the Addis Ababa Nifase Sik Lafto Sub-Ciy Woreda 11 in Focus

Abiot Kebede

Addis Ababa University, 2020

As a core component of the broader health system, Health Extension Program (HEP) focuses on the household and community that calls for coordinated action at all levels (FMOH, 2007).

This study focused on the health communication strategies used by health extension program workers to reduce HIV/AIDS in the urban areas, with an emphasis on whether these strategies were effective in promoting participation and creating awareness among the communities in the selected Woreda.

This was chosen purposively as case study area because it is one of the woredas with high HIV exposure rat.

This woreda was purposively selected for the study. Qualitative methods were used for data collection. Accordingly, from the selected woreda, in-depth interviews were conducted with four HEWs that work in four selected ketanas and two woreda health officers and supervisors, all of them are females. And the other interview was conducted from 2FSWs and 2 youths in the youth center and 2 in working area deliberately performed. The youths are 2 of them are male and the other two are females.

In the FGD sessions 4 (one-to-five) leaders and 4 one-to-five members in the woreda, four ketenas 2 in each ketanas were selected, and the recorded data were transcribed.

Based on the participatory communication model as a theoretical framework, the data was analyzed. The analysis indicated health extension program depended on interpersonal communication, team communication, and door to door communication and team communication strategies.

Among those methods of communications, interpersonal communication had a better acceptance by the community and the health extension practitioners.

In the case of community participation even through the Ministry of Health Bureau implemented a participatory development process as set out in the policy documents participation of the community horizontal communication. However, it was found out that in the study area, the two down communication was more predominantly used. Men were not included in the communication.

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List of Acronyms

AAHB	Addis Ababa Health Bureau
AAHAPCO	Addis Ababa HIV/AIDS Prevention and Control Office
AIDS	Acquired Immuno - Deficiency Syndrome
BCC	Behavioral Change Communication
CDC	Centers for Disease Control and prevention
CSA	Central Statistical Agency
FGD	Focus Group Discussion
FM	Frequency modulation
FMOH	Federal Ministry of Health
FAPCO	Federal HIV/AIDS Prevention and control office
FSW	Female Sex Worker
HEC	Heath Education Communication
HEP	Health Extension Program s 0911455982
HEW	Health Extension Workers
HIV	Human Immuno Virus
HSDP	Health Service Development Program
IEC	Information, Education and Communication
MCH	Mother and Child Healthcare
MOH	Ministry Of Health
MTCT	Mother to Children Transmissions

NAACS	National HIV and AIDS Advocacy and Communication Strategy
NGO	Non-Governmental Organization
PLHIV	People Live with HIV
PHC	Primary Health Care
UN	United Nation
UNDP	United Nation Development Project
USAID	United States' Agency for International Development
VCHWs	Voluntary Community Health Workers
WHO	World Health Organization

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CHAPTER ONE

1. Introduction

1.1 Background of the study

HIV, the virus that causes AIDS, is one of the world's most serious public health challenges. According to UNAIDS fact sheet 2019 there were approximately 32 million people lost their life and 37.9 million people across the globe live with HIV/AIDS. Of these, 36.2 million were adults and 1.7 million were children 0--14 years old. An estimated 1.7 million individuals worldwide became newly infected with HIV. (New HIV infections, or "HIV incidence," refers to the estimated number of people who newly acquired the HIV virus during a year, which is different from the number of people diagnosed with HIV during a year. Some people may have HIV but not know it.) Of these new infections: 1.6 million infections were among people ages 15 and older and 160,000 infections were among children ages 0-14 (UNAIDS 2019).

The problem is more serious in developing countries. An estimated one million people were newly infected with HIV in Eastern and southern Africa in 2019, bringing to 26 million the number of people living with HIV. Two third of the people of the world with HIV live in this region, and three quarters (75%) of all AIDS deaths in 2018 occurred there(UNAIDS 2019).

According to World Health Organization (WHO), the developing countries have the highest number of HIV/AIDS infections in the whole world. There are approximately 32 million people living with the virus in these countries.Sub-Saharan Africa, Caribbean, and South-East Asian countries with the highest HIV prevalence rates and the largest number of HIV-positive people in these regions (WHO, 2018).

HIV/AIDS, while continuing to be a main health issue, has evolved into a complex social and economic emergency. The virus primarily affects young adults, cutting a broad path through society's most productive layer and destroying a generation of parents, whose death leaves behind orphans, dissocialized youth and child-headed households. HIV/AIDS has a significant impact on the more educated and skilled segments of society because HIV primarily infects productive young adults rather than children or the elderly. The stigma attached to HIV and AIDS adds to the impediments encountered in mounting a response to AIDS, in addition to the

discrimination already faced by infected individuals. HIV also increases social and economic vulnerability among women (UNAIDS 2011).

According to the UNAIDS statics the growing evidence suggests that HIV/AIDS is having a devastating effect on economic growth and incomes. According to the World Bank, had average national HIV prevalence in sub-Saharan Africa not reached 8.6 per cent in 1999, per capita income on that continent would have grown 1.1 per cent, nearly three times the actual growth rate of 0.4 per cent achieved during 1990-1997. In the case of a typical sub-Saharan African country with a prevalence rate of 20 per cent, overall GDP growth would be 2.6 per cent lower each year. At the end of 20 years, the economy would be two thirds smaller than it would otherwise have been (UNAIDS 2011).

Governance suffers as a result of the epidemic: HIV/AIDS has a disastrous impact on the capacity of Governments, especially on the delivery of basic social services. Human resources are lost, public revenues reduced and budgets diverted towards coping with the epidemic's impact. Similarly, the organizational survival of civil society institutions is under threat, with a corresponding impact on democracy (UNAIDS 2011).

There are several factors that influence the spread of HIV/AIDS in Developing Countries,

Promiscuity is now the leading cause of the spread of HIV in the developing regions. Many people are having more than one sexual partner, and also prostitution is common in the regions. Promiscuity is being practiced by both young adults and married people. A big number of people in relationships are practicing infidelity without caring about its consequences. Surprising studies show that more than 60% of new infections are occurring in married people (Januaris , 2018 p.5).

Ignorance most people living in these regions are fully aware of the disease, but they continue to get involved in practices that fuel its transmission. This is ignorance, and it is adversely driving the HIV/AIDS epidemic in the whole world, not just the developing countries. Recently many Africans do not care about protecting themselves from the infection. HIV transmission can be prevented by condoms, but many people are reluctant to use them even when getting intimate with new partners (Januaris, et al 2018, p.6.).

Illiteracythe Third World countries have a large percentage of people who know very little about HIV/AIDS. Most people know the disease exists, but they lack information about its aspects. The illiterate people don't know anything about the HIV transmission ways and preventative measures, and they continue to engage in unsafe practices that spread the virus. These people are also easily influenced by the beliefs, myths, and misconceptions about the disease (Januaris, et al. 2018, p .9).

Poverty the developing world has a large population of people living in poverty. Most poor people are forced to do anything to earn a living, including engaging in sexual activities which are a high-risk factor for the disease. There have been many cases of young people getting involved in commercial sex in these countries. This activity has been studied to tremendously increase the disease prevalence. Poor people also have limited access to education which means that illiteracy is common among them (Scott, et al (.2018, p.11).

Drug and Alcohol UseDrug and alcohol use is quite common among the youth in the developing regions. According to studies, there have been consistent new HIV infections resulting from sharing of injectors among the drug users in these regions. There are also other ways in which alcoholism and drug use affects the spread of the disease in these countries. The alcohol users find themselves not being able to make wise decisions when getting involved in sexual activities. On the other hand, people who are addicted to drugs are turning to careless sexual behaviors to relieve the pain and stress caused by the addiction (Januaris, et al 2018,p.11).

HIV/AIDS Stigma: People living with the virus are still stigmatized in the developing world, and this is causing many people to avoid HIV testing. Most people who manage to get tested do not reveal their status if they have been found to have the virus. They also find it difficult to get antiretroviral (ARV) drugs or to use them in the presence of other people. Those who do not know their status continue to get involved in high-risk behaviors and activities. People who are infected with the disease and are not using ARVs are spreading the virus more easily compared to those who are using them (Januaris et al, 2018,p, 13).

Cultural Factors: The most common cultural factors fueling the spread of HIV/AIDS in the developing world include polygamy and wife inheritance. These cultural practices are specifically common in Africa. In the case of polygamy, if one partner gets infected, he or she is

highly likely to spread the virus to all the other partners. In these countries, most partners in a polygamous marriage are usually unfaithful which means that many of them introduce the virus to their marriages. In wife inheritance, HIV spreading occurs if the new husband or the widow has the virus the widows are usually HIV positive (Januaris, et al, 2018 .p 13.).

Lack of Access to Maternity Services: The developing countries lack enough maternity services for all their pregnant women. Most women, especially those in remote areas, bear children without the help of trained healthcare providers. Also, expectant mothers who are infected find it hard to get medical advice on how to keep their newborns free from the virus. So there are usually many cases of mother-to-child transmission in places with scarce maternity services in these countries (Januaris, et al 2018,p 5).

Tribal Conflicts and Civil Wars: The Third World has been experiencing tribal conflicts and civil wars for a long time. The areas hit by these conflicts and wars do not have enough healthcare services to cater for the HIV/AIDS victims. These areas also do not get enough disease awareness programs and VCT services. Most people affected by the conflicts and wars live in refugee camps. The camps are well known to be home to all sorts of evil, including drug abuse and prostitution which fuel the epidemic (Januaris, et al , 2018, p. 17).

Immigration and Movement of People: HIV/AIDS was introduced in most of these developing regionsby people from other countries (i.e., the developed ones). And even today, there are a big number of new infections that are caused by immigrants. The movement of people within these regions has been increasing the spread of the disease. Infected people spread the virus when they move to work or study in areas that are free from the disease. This is one of the reasons for the high prevalence rates in urban centers that are located along the major highways (Fores, et al , 2018 , p.17)

Data from Federal HIV/AIDS Prevention and Control Office (FHAPCO) indicates that in Ethiopia there are 649,264 people living with HIV, and 22,985 are new infection in 2018, the annual AIDS deaths in 2018 was 11,049 the prevalence rate is 0.91 percent of the population (FHAPCO 2019).

The numbers of Ethiopians who have died of HIV/AIDS in the last three decades are hard to come bay, but according to an estimate by FHAPCO, there were 19,743 deaths every year, which left behind about 247,250 children orphaned (EDHS 2016).

Following its official discovery in 1984, HIV/AIDS has seen a rapid spread all over Ethiopia, putting the lives of millions at risk directly or indirectly. Owing to lack of awareness, similar trend is seen in many countries in Africa (EDHS 2016).

Like many of other countries, Ethiopia's fight against HIV/AIDS is one of the few highly paid for projects by donors, which includes over US$2 billion contribution by the U.S. government through its program called 'President's Emergency Plan for AIDS Relief(PEPFAR)', making it the ever largest donation coming to the country for HIV/AIDS purpose. Owing to similar coordinated efforts, the spread of the virus has seen a decline over the last two decades especially in urban areas. The Ethiopian Demographic Health Survey (EDHS 2016) reveals that around 56% of the women and 55% of the men among the surveyed household have never been tested for HIV, an indication the current number of HIV positives in the country could be a lot more had all the population been tested. And, despite the existence of the large number of people living with HIV/AIDS, only 72% of them are thought to be aware that they are living with the virus; the remaining 28% think they are not infected (EDHS 2016).

Ethiopian Health Extension Program (EHEP) brings community participation through awareness creation, behavioral change communication, and planned and systematic community mobilization and community engagement for improved lifestyle (EHEP, 2004 p.2).

Addis Ababa is the second most infected region next to Gambila region. The per balance rate of the city is 3.4 percent and 107,917 people live with HIV .There are about 1408 people who newly acquired the HIV virus during a year 2018 among the estimated four million residents thought to live in Addis Ababa HIV prevalence stands at a staggering 3.4 percent according to the FHAPCO data, which places the city on second regions in the country followed by Gambela is the top of all region (4%), Harar and Dire Dawa (2.9% each) (EDHS 2016).

Ethiopian Health Extension Program (EHEP) brings community participation through awareness creation behavioral change communication planned and systematic community mobilization and engagement for improved life style (EHEP, 2004 p.2).

The Health Extension Program (HEP) was to serve as a primary vehicle for prevention, health promotion, behavioral change communication and basic curative care through effective implementation of sixteen health packages. Among these packages, reducing HIV and AIDS is given special emphasis (EHEP, 2004 p. 2).

A key factor contributing to high HIV and AIDS is the lack of awareness creation, behavioral change communication in the community. To tackle this problem, the Federal Ministry of Health initiated the Health Extension Program, one of the community-based Health programs in Ethiopia.It is based on the assumption that access to and quality of primary health care in communities can be improved through transfer of health knowledge and skills to households (EHEP, 2004 p. 2). .

Participatory health communication strategies are important for empowering women, men, families, and communities to recognize preventive health-related risks, and to take responsibility for developing and implementing appropriate responses. Increased knowledge and awareness is essential for reducing delays in seeking health care and in reaching a health facility. Communities and individuals must be empowered not only to recognize HIV-related risks, but they must also have the capacity to react quickly and effectively once such problems arise (Haimanot, 2013, p. 13).

1.2. Statement of the problem

The goal of health communication research is to identify and provide better and more effective communication strategies that will improve the overall health of society (Atkin & Silk, 2005p. 489).

According to Centre for Disease Prevention and Control (CDC 2016) successful communication programs require evidence-based planning, implementation and evaluation. To be effective, the messages will need to be adapted to the local context based on the knowledge of the target group and the social norms surrounding it (CDC 2016)

Health communication on HIV should be integrated into a holistic, comprehensive approach addressing the health and wellbeing of unsaved sex. An effective communication program does not limit itself to issues of sexual health, but embraces the overall health and social wellbeing

needs of the target group. Many multi sexual experiences a syndetic of infections, homo negativity, drug and alcohol use, social isolation and mental health, and these needs to be borne in mind when designing communication strategies (CDC 2016).

Health communication is the art and technique of informing, influencing, and motivating individuals, institutions, and large public audiences about important health issues based on sound scientific and ethical considerations (Haimanot 2013, p. 13).

Health communication has contributed significantly to the effective promotion of social mobilization at the grass roots-level social and community mobilization interventions have helped to promote positive behaviors towards HIV/AIDS, and ensure strong ownership of the response to HIV/AIDS at all levels (CDC 2016).

Community mobilization can positively influence social cohesion, sensitization, and through demand-creation, promote better health-seeking behaviors. Community counselors, HIV-positive peer educators and home-based care providers have been deployed in health facilities, linking formal health service provision to community interventions Health Extinction Workers(HEWs) are actively involved in community mobilization and HIV/AIDS education through ‘community conversation (CHEPE 2018).

An effective health communication strategy is indispensable, because it equips the public with the tools and knowledge to respond appropriately to health crises such as flu outbreaks, HIV/AID. Government agencies and technology corporations should collaborate together to bring healthy society and address as many households as possible. For the benefit of people with health literacy skills, pertinent health information should be provided at their level of understanding (CDC 2016).

In spite of the past efforts and gains registered HIV/AIDS prevention and control programs, it is realized that essential health services have not reached the grass-roots, as can observed in Addis Ababa HIV/AIDS indicators show a slight increase reports indicate it is still high at 3.4 percent prevalence rate and the second most infected region.

This is probably made worse by the prevalence against youths, use of harmful practices like drinking alcohols, chewing chat, smoking shisha and cigarette and these practice push them

unsaved sex and they are venerable to HIV /AIDS community attitudes towards such serious problems. There has been no research to comprehensively examine the communication strategies of the Health Extension Program used to reduce HIV/AIDS in the areas.

According to McQuail, (1997,P.102), although the concept of content and audience relationship fits well to fiction messages, "we can't assume that even basic 'factual' information will be understood as sent" This fact reminds us that while people's opposition or misunderstanding of the communication strategies, including HIV and AIDS, can be attributed to several factors, one that cannot be over looked is the role of community's potential interpretation or making sense of communication to addressing the public about the danger of HIV/AID.

In Ethiopia, over the last 30 years, a number of formal and informal AIDS education programs have been carried out by government and non-governmental organizations using different communication methods but theepidemic still presents unique challenges in terms of effecting Positive behavioral change on the part of the public. Consequently, it climbs Ethiopia's ladder of concern.

Even though the Federal Ministry of Health establishes sufficient infrastructure like health posts and the professional manpower called health extension workers, it is observed that health extension workers seem to lack skills to effectively communicate with the target community.

This study explores the health communication strategies used by health extension program workers to reduce HIV/AIDS in the selected areas, with an emphasis on whether these communication strategies are effective in promoting participation and creating awareness among the communities in Addis Ababa Nifas Silk Lafto Woreda 11.

1.3. Objective of the study

1.3.1. General Objective

The general objectives of this study is to assess the health communication strategies used by health extension program workers to reduce HIV/AIDS in urban areas, with an emphasis on whether these strategies are effective in promoting participation and creating awareness among the communities.

1.3.2. Specific Objectives

The study has the following specific objectives:

1. To assess the communications strategies' and campaign that used to reduce HIV/ADS in the health extension program.
2. To identify the factors that affect the practitioners and the target community to address health communication strategies in HIV/AIDS preventions package.
3. To assess the communication strategies influence the public to make free and open discussion, and debate about risky human sexuality behaviors and other sexuality related issues
4. To investigate the interests' of the community towards the communication strategies in terms of its educational as well as awareness creation values.

1.4. Research Questions

In order to understand the communicative nature of health extension program, this study will

Address the following questions:

1. What communications strategies' and campaign are used to reduce AIV/ADS in the health extension program?

2. What are the factors that affectthe practitioners and the target community to address health communication strategies in HIV/AIDS preventions package?

3. How is the communication strategies implemented to the community?

4. How are the interests' of the community towards the communication strategies in terms of its educational as well as awareness creation values?

1.5. Significance of the study

This study analyses the practice of health communication strategies with relation to reducing HIV and AIDS in urban community I believe that this study can have a significant role to play in shading light on how to mitigate the down beat impact of this rampant disease in the country in general and in the study area in particular.. It also may assist policy makers; college students, as well as other influential bodies like the mass media in indicating how the health extension program design the communication strategies to produce skilled community and confident individuals who work for sustainable development. Findings will help practitioners'stakeholders in the health extension program. It is also believed that it can potentially serve as a stepping stone for further research in the area.

1.6. Scope of the study

This study focuses on health communication strategies of health extension program to reduce HIV/AIDS used by the Health extension workers in urban areas. The research includes guidelines and recommendations for improvement in the process, objective, and implementation of programs. The study targeted in Addis Ababa Nifa Silk Lafto sub city woreda 11as study area.

1.7. Limitation of the study

The study is focus on the health communication strategies of health extension program and communities participation on it in reducing HIV and AIDS in Addis Ababa Nifas Silk Lafto sub city Woreda11. But given the time, budget and resources constraints, it was not possible to extend the scope. Therefore, the findings of the study might not be generalized to the whole sub city woredas. Therefore, the findings of the study are applicable to the selected area.

1.8. Organization of the thesis

This thesis has five chapters. The first chapter gives an introduction which incorporates the background of the research, statement of the problem objectives of the study, major research questions and scope of the study. Limitations encountered to conduct the study also incorporated in this chapter and the second chapter deals with the review of literature, which focuses on the theoretical frame work of health communication model, the health communication strategies briefly, HIV/AIDS in Ethiopia. This is followed by chapters three and four which deal with the research methodology and data presentation and analysis respectively.Conclusion and recommendations constitute the last part of the thesis.

CHAPTER TWO

1. Review of Related Literature

This chapter is expected to identify and review previous studies on the problems of HIV/AIDS epidemic and the prevention approaches. It focuses on the role of HIV/AIDS communication with special emphasis on behavioral change communication approaches on the health extension program.

1.1 Status of HIV and AIDS in a brief Overview

Historically, HIV/AIDS was first come in to exist on earth in 1981 in the United States. According to UNAIDS & WHO (2003), a new syndrome, the acquired immune deficiency syndrome (AIDS), was first recognized among homosexual men in the United States. By 1983, the etiological agent, the human immunodeficiency virus (HIV), had been identified. By the mid-1980‘s, it became clear that the virus had spread, largely unnoticed, throughout most of the world.

HIV was first detected in Ethiopia in 1984 and the first two AIDS cases were reported in 1986 (Tsega et al 1988 as cited in FMOH et al 2006). After a couple of years, high HIV prevalence rate was detected among long distance truck drivers (13%) and commercial sex workers (17%) frequenting and working in town along the main trading routes. Since then the epidemic is wreaking massive damage up on the productive population (EPHA, 2005).

Based on the recent reports of World Health Organization (WHO) and United Nations Program on HIV/AIDS (UNAIDS), the sub-Saharan Africa remains hardest-hit, and is home to 26 million people living with HIV. Two thirds of all people living with HIV are in sub-Saharan Africa, of which 75% are women. An estimated 2.4 million people died of HIV-related illnesses in this region in 2018, while a further 3.2 million became infected with HIV (UNAIDS 2019).

The HIV epidemic in Ethiopia is heterogeneous by sex, geographic areas and population groups. Among women and men combined, HIV prevalence is seven times higher in urban areas than in rural areas (2.9 percent versus 0.4 percent). HIV prevalence is 3.6 percent among women in urban areas compared with 0.6 percent among women in rural areas. Seven out of the nine regional states and two city administrations have HIV prevalence above 1 percent. it is highest

in Gambella (4.8 %), followed by Addis Ababa (3.4%), Dire Dawa (2.5%), and Harari (2.4%) CSA and ICF (2018).

According to Ethiopia National HIV Prevention Road Map (ENHPRM 2018) between 2000 and 2017 Ethiopia has witnessed a marked reduction in HIV/AIDS morbidity and mortality (new HIV infections reduced by 90 percent and AIDS-related mortality among adults reduced by more than 50 percent) through its leadership commitment and country ownership of the HIV programme response. Aware of the health, social, economic and demographic impact of the epidemic, an HIV/AIDS policy was issued in 1998, followed by the establishment of the National AIDS Council in 2000 and the Federal HIV/AIDS Prevention and Control Office in 2002, creating a platform for leadership and coordination of the multi sectorial response in the country (ENHPRM 2018).

The series of five-year strategic frameworks or plans to intensify the multi sectorial response to HIV/AIDS epidemic were Strategic Framework 2001-2005, SPM-I 2004-2008 and SPM-II 2010-2014. The current HIV/AIDS Strategic Plan 2015-2020, in an investment case approach, has four strategic objectives and four critical enablers.

Strategic Objectives of Investment Case 2015-2020

1. Implement high impact and targeted prevention programmes 2. Intensify targeted HIV testing and counseling services 3. Attain virtual elimination of Mother-To-Child-Transmission of HIV (MTCT) 4. Optimize and sustain quality care and treatment.

In the development of the current HIV National Strategic Plan, the government of Ethiopia has adopted the global goal to attain the 90-90-90 targets: 90 percent of people live with HIV (PLHIV) know their status, 90 percent of PLHIV who know their status are on treatment (ART) and 90 percent of PLHIV on treatment have attained viral suppression. In Ethiopia as of May 2018, 79 percent of PLHIV knew their status; 71 percent of eligible PLHIV are on ART and 87 percent of those ART have attained viral suppression. However, viral load service coverage is 51 percent (ENHPRM 2018).

As the 8th Roundtable's Report 2001 cited in Getachew Dinku 2005 Communication for Development Roundtable which focused on the HIV/AIDS pandemic and the communication

challenges examined the role of communication, its successes and failures and attempts made to deal with this pandemic Getachew(2005, P.16).

The HIV/AIDS communicators have been successful in: broadening awareness of HIV/AIDS; increasing knowledge of how HIV/AIDS is contracted; placing HIV/AIDS in the context of human rights; increasing knowledge and demand for effective services, and mobilizing political support for national HIV/AIDS plans (Getachew 2005, P.16).

It, however, underlined the spread of the pandemic citing inadequate communication strategies in containing and mitigating the effects of the epidemic despite the successes.

> *They have often: treated people as objects of change rather than the agents of their own change; focused exclusively on a few individual behaviors rather than also addressing social norms, policies, culture and supportive environments; conveyed information from technical experts rather than sensitively placing accurate information into dialogue and Debate; tried to persuade people to do something, rather than negotiate the best way forward in a partnership process, it said (ibid).*

1.2 What is health communication?

An understanding of health communication theory and practice requires reflection on the literal meaning of the word communication;

Communication is: 1). Exchange of information, between individuals, for example, by means of speaking, writing, or using a common system of signs and behaviors; 2.) Message a spoken or written message; 3.) Act of communicating; 4.) Rapport—a sense of mutual understanding and sympathy; 5.) Access—a means of access or communication, for example, a connecting door (Renata , 2007 , p.38).

One of the key objectives of health communication is to influence individuals and communities. The goal is admirable since health communication aims to improve health outcomes by sharing health related information. In fact, the Centers for Disease Control and Prevention define health communication as the study and use of communication strategies to inform and, influence individual and community decisions that enhance health, (U.S. Department of Health and Human

Services, 2005). The word influence is also included in the Healthy People 2010 definition of health communication as the art and technique of informing, influencing, and motivating individual, institutional, and public audiences about important health issues (U.S. Department of Health and Human Services, 2005: 11-12).

On the other hand Renata Schiavo (2007, p. 7)) emphasizes health communication with supporting individuals; Health communication is a multifaceted and multidisciplinary approach to reach different audiences and share health-related information with the goal of influencing, engaging, and supporting individuals, communities, health professionals, special groups, policymakers and the public to champion, introduce, adopt, or sustain a behavior, practice, or policy that will ultimately improve health outcomes.

Similarly Piotrow (1997) agreed that effective strategies in health communication identify and prioritize key behaviors, segment audiences, design messages based on scientific evidence and research, and reach audiences through key channels, while mobilizing communities to become involved in this processes. Health communication is generally conceived as a strategic process aimed at achieving a rational use of health services, and improving the efficiency and effectiveness of programs directed at disease prevention and health promotion.

Research has shown that health communication programs based on solid theory may bring health to the forefront of the public agenda, reinforce HIV messages, stimulate people to seek more and better information, and in some cases lead towards healthier lifestyles four key elements of the communication process are typically used in health communication: source, message, channel, and audience, increasingly coupled with social mobilization and participation components and with rigorous research Piotrow, 1997 cited in Haimanot , (2013 , p.39).

Another important role of communication is to create a receptive and favorable environment in which information can be shared, understood, absorbed, and discussed by the program's intended audiences. This requires an in-depth understanding of the needs, beliefs, taboos, attitudes, lifestyle, and social norms of all key communication audiences. It also demands that communication is based on messages that are easily understood Haimanot , 2013, p.39).

Health communication differs by context, like information flow through individual influence, disease prevention through behavior modification, is exchange, interchange information, two

way dialogue, scientific development, strategic dissemination, and critical evaluation of relevant, accurate, accessible, and understandable.

To inform and influence (individual and community) decisions. Moreover, health communication is a key strategy to inform the public about health concerns and to maintain important health issues on the public agenda (Department of Health, Australia, 2006).

The study or use of communication strategies is to inform and influence individual and community decisions that enhance health (CDC, 2001; U.S. Department of Health and Human Services, (2005).

Health communication is a means to disease prevention through behavior modification Freimuth, Linnan, and Potter, (2000, p. 337). It has been defined as the study and use of methods to inform and influence individual and community decisions that enhance health.

Health communication is a process for the development and diffusion of messages to specific audiences in order to influence their knowledge, attitudes and beliefs in favor of healthy behavioral choices Hansen, A., et al. (1998).

Health communication is the use of communication techniques and technologies to (positively) influence individuals, populations, and organizations for the purpose of promoting conditions conducive to human and environmental health Maibach and Holtgrave, (1995, p 219–220). It may include diverse activities such as clinician-patient interactions, classes, self-help groups, mailings, hot lines, mass media campaigns, and events, Health Communication Unit, (2006).

Ratzan and others (1994, p. 361). understood health communication as motivating individuals: The art and technique of informing, institutional and audiences about important health issues is scope includes disease prevention, health promotion, health care policy, and business, as well as enhancement of the quality of life and health of individuals within the community.

Effective health communication is the art and technique of informing, influencing, and motivating individuals, institutions, and large public audiences about important health issues based on sound scientific and ethical considerations (Tufts University Student Services, 2006).

Clift and Freimuth (1995, p.68) understand health communication is Change behaviors. Health communication, like health education, is an approach which attempts to change a set of behaviors in a large-scale target audience regarding a specific problem in a predefined period of time.

The goal of health communication is to increase knowledge and understanding of health related issues and to improve the health status of the intended audience Muturi (2005, p. 78). Communication means a process of creating understanding as the basis for development. It places emphasis on people interaction Agunga (1997, p. 225).

According to Renata (2007), health communication is exchange, interchange information, two-way dialogue. A process for partnership and participation of that is based on two-way dialogue, where there is an interactive interchange of information, ideas, techniques and knowledge between senders and receivers of information on an equal footing, leading to improved understanding, shared knowledge, greater consensus, and identification of possible effective action.

Health communication is the scientific development, strategic dissemination, and critical evaluation of relevant, accurate, accessible, and understandable health information communicated to and from intended audiences to advance the health of the public Bernhardt, 2004, p. 51 cited by Renata) .

Therefore, health communication, as an area of practice, uses various channels to reach the intended audience, share health related information and engage stakeholders.

2.3. Health Communication strategy

Therefore, program planners should not rely on any workshop, press release, brochure, video, or anything else to provide effective communication without making sure that their content and format reflect the selected approach (the strategy) and is a priority in reaching the audience's heart (Renata,2007).

Schiavo, Renata (2007) also states that an effective communication strategy is a critical component of the global endeavors in HIV/AIDS prevention and education. He added

Given the stress placed on HIV/AIDS prevention and care, mostly due to the absence of cure for or vaccination against the disease, employing effective communication strategies becomes pivotal in controlling the pandemic. Consequently, evaluating and redefining views to communicating proper messages to different populations and the public at large has become a critical aspect of HIV/AIDS prevention and care

2.4 What is Communication?

Even before we consider health communication and its application to HIV/AIDS, it may be helpful to briefly review how communication scientists tend to think about their own discipline. Communication is a fundamental human process without which most individual, group, organizational, and societal activities could not happen, including how people think about and respond to HIV/AIDS.

Through communication, people come to know what is happening around them, both nearby and far away and, by talking to others, make sense of it. Communication is the mechanism by which teachers teach and learners learn, by which marketers promote products and services, and consumers decide what to buy and to consume. It is the means by which communities build consensus and enforce norms, and the means by which conflicts arise, discrimination is expressed, and convergence can eventually emerge.

It is the process by which policies are negotiated and publicized to set political and institutional agendas. It is a critical aspect of how health professionals provide care and patients seek and use it and the process by which a person is persuaded to do something healthy or unhealthy (Lippincott 2014, p.1).

According to Williams et al 2014 communication science seeks to understand these diverse processes and effects, including how different channels and types of information can be mobilized instrumentally and strategically in domains such as public health. Communication scientists recognize that communication occurs at multiple levels of a social ecological system, namely, intrapersonal (the realm of emotion, cognition, and decision making), interpersonal (the realm of social relationships), networks and organizations (the realm of norms and social structures), and macro societal (the realm of large social systems and culture).

However, there is a tendency outside of the field to think of communication not as a social process but rather as the messages or materials that communication produce, such as a pamphlet in a doctor's office, a pharmaceutical advertisement on television, or a home visit by a front-line health worker. Such a view narrows down the range of possibilities we can imagine for communication in HIV/AIDS prevention, care, and treatment Lippincott Williams 2014, p. 2).

The Oxford English Dictionary provides these process definitions of communicates:

> *Communicate, v. (1) to impart (information, knowledge, or the like) to a person; (2) to convey one's thoughts, feelings; to gain understanding or sympathy; (3) to take part in an exchange of information, ideas; (4) to have dealings, relations; to enter into social interaction or contact. From the Latin: communicator, to make common.*

The mechanism through which these processes of information delivery, self-expression, exchange, and social connection and social regulation influence behavior are reflected in Cleland and Wilson's concept of ideation (as developed by Kincaid et al 13,14). Ideation research shows that behavior (e.g., going for an HIV test) is influenced by multiple factors, often simultaneously, including knowledge and attitudes about the behavior (e.g., whether or not testing is beneficial), one's self-image (e.g., as healthy or responsible), perceived risks (e.g., of HIV infection), self-efficacy or confidence (e.g., to protect oneself from HIV), emotional reactions to the health issue or situation (e.g., fear of AIDS or of transmitting it to an unborn child), perceived social norms (e.g., how common testing is), and the social influence of other people around you (e.g., whether or not friends or partners approve of getting tested) Williams (2014 ,p.3).

In the context of particular HIV/AIDS interventions, theory-based research about which of these factors are most strongly associated with desired behavioral outcomes informs the communication strategy, the design of messages, and the choice of communication channels. Strategically designed HIV/AIDS communication can influence all those factors in a positive direction, creating more positive attitudes toward HIV testing, shifting perceptions about HIV risk, increasing confidence to prevent infection, increasing the salience of social norms about testing, and encouraging friends to encourage each other to get tested. Kincaid et al cited in Williams p,13 have shown that these ideation factors have a kind of dose effect the more factors

that come into play at a moment of decision and the more that are favorable to the behavior, the greater the probability of the behavior.(Williams , 2014, p.13).

We can purposively use communication to achieve better health outcomes related to HIV/AIDS. Over the past 50 years or so, communication scientists in the "uses and gratifications" tradition, which studies how people use forms of communication to achieve personal goals and satisfy needs, have cataloged a wide variety of formal and informal communication functions, updating them as new technologies and modes of communication emerge, such as e-health, m-health, and social media Lippincott (Williams 2014, p.14).

Although there are many nuanced variations of uses and gratifications, most communication scientists would agree on 4 major functions of communication:

(1) To inform someone or to seek information about something, such as HIV risks,

(2) To motivate or persuade someone to think about something in a particular way and to act accordingly, such as to appreciate the benefits of male circumcision and be motivated to seek the procedure,

(3) To connect with others and to participate in interpersonal and small group relationships, such as peer support groups that provide social support for prevention among positives, and

(4) To express and maintain culture and the norms through which social identities and values are shared and the social–structural environment is sustained, such as voicing approval (or disapproval) of sexuality or sharing values related to support for people living with HIV.

Another widely recognized function of communication is diversion, through which we seek entertainment and/or escape. Communication relates to the use of entertainment– education strategies for persuasive purposes. For the purposes of this, we focus on the information, persuasion, social connection, and social structural/cultural functions Lippincott Williams (2014,p.14).

As health care instinctively think about communication directed at patients or clients for the purpose of health promotion. In the domain of HIV/AIDS, this means communicating with sexually active men and women, vulnerable women and girls, sex workers, and other high-risk groups to reduce risky behavior, encourage the uptake of gateway services, such as HIV testing, promoting uptake of services, such as voluntary male medical circumcision (VMMC), and encouraging treatment adherence. But what about communication with families, school teachers and officials, work groups in the office, and even whole communities? How can we encourage a positive group influence over their members? What about communication with and among doctors, nurses, midwives, and other service providers who have underdeveloped interpersonal communication skills or who are unaware or distrustful of the latest science?

How can we best communicate with them to increase their technical knowledge or improve their capacity for counseling? What about communication with community leaders or policy makers who do not understand or who ignore the feminization of HIV/AIDS or who support policies and laws that drive sexual behaviors underground and exacerbate HIV risks?

Communication can help to create and sustain a positive, supportive environment within which positive HIV-related behaviors can occur, and promote behavior change itself Lippincott Williams (2014).

2.5 Health communication channels

Channels and Tools, provides a guide for selecting the channels team will use to convey the message to the intended audience. The focus here is on identifying and assessing potential resources that can help audiences carry out a communication program. Health communicators define communication channels broadly as a delivery system for messages to reach intended audiences.

According to Piotrow & Kincaid (2001, p. 25). health communication channels are categorized as follows:

Interpersonal channels: Focus on either one-to-one or one-to-group communication. One to-one channels include peer to peer, spouse to spouse, and health clinic worker to client. An example of one-to-group communication may be a community-based outreach worker meeting with a

women's cooperative. Interpersonal channels use verbal and nonverbal communication (Piotrow & Kincaid, 2001, p. 26)

Community-oriented channels focus on spreading information through existing social networks, such as a family or a community group. This channel is effective when dealing with community norms and offers the opportunity for audience members to reinforce one another's behavior (Piotrow & Kincaid 2001, p. 26).

Mass-media channels reach large audiences. They are particularly effective at agenda setting and contributing to the establishment of new social norms. Formats range from educational to entertainment and advertising, and include television, radio, and print media, such as magazines, newspapers, outdoor and transit boards, the Internet, and direct mail (Piotrow & Kincaid 2001, p. 26).

However, selecting the appropriate channels and integrating them might be essential, but designing effective message is the underscoring issue.

2.6 Literature on HIV/AIDS Communication in Ethiopia

In general, Health Education in Ethiopia is characterized by poor planning and ineffective methods (UNAIDS/Pact Ethiopia 2002, MOH 2004). The government owned Health Education Center has been the major producer and distributor of health communication materials since its establishment in 1995.

Ministry of Health's assessment revealed that the learning materials produced at the central level are mostly not useful and applicable to the situations of regions for they fail to take the realities on the ground into account. The regions do not fully participate in the process of production of the materials and their role is limited to setting annual target beneficiaries, distribution of communication materials produced elsewhere. The report attaches these "deficiencies" to lack of skilled human resources in IEC/BCC at all levels, poor coordination and lack of due consideration in resource allocation for the activities (UNAIDS/Pact Ethiopia 2002, MoH 2004).

The assessment also uncovered that projects implemented by some NGOs have established research-based locally relevant and highly effective health communication programmes (UNAIDS/Pact Ethiopia 2002, MOH 2004).

Another evaluative study the Health Education Center (HEC) carried says that regions demanded print materials which reflect their socio cultural characteristics and dismisses "groundless rumors that consider the print materials if HEC as totally unacceptable," (MOH, HEC 2005). This report suggests, among others, that HEC has to work hard to meet high demand of health communication materials that are research-based, audience focused, culture sensitive, timely, understandable in a manner that considers stakeholders' demand and involvement MoH, HEC (2005).

All the health communication situations hold true for HIV and AIDS communication. In fact, the larger proportion of printed and audiovisual materials HEC and others produced are on HIV and AIDS. Specific to HIV and AIDS communication, the National HIV/AIDS policy takes up IEC as the first strategies to adopt in the effort to combat the pandemic. The policy states IEC materials shall be provided to all government and nongovernmental organizations, mass organizations, religious groups, professional associations and the community at large to make all give adequate attention to HIV/AIDS and fully participate in the prevention. Further indicating the process, the policy stipulates, "intensive, extensive and sustainable IEC activities through all possible media, materials and methods taking such culture and belief into account, languages shall be planned, tested, implemented and evaluated for continued success in educational efforts" (AIDS Policy of Ethiopia 1998).

It is, however, difficult to say the practices were in line with the policy provisions. This is to be seen in light of the changes in the prevalence rate. Many of the behavioral change interventions carried out in response to the massively growing epidemic have not yielded the intended outcome as well as the impact in reduction of HIV incidence and prevalence in the regions (UNAIDS/Pact Ethiopia 2002).

In 2002, Ethiopia adopted UNAIDS/PENN State's HIV/AIDS Communication Framework with the goal of reducing the prevalence of HIV/AIDS and providing appropriate care and support to the infected and affected through comprehensive communication programmes. As opposed to previous efforts of targeting individual behavior, the framework advocates the need for taking into account the political, socioeconomic, gender, spiritual and cultural contexts that prevail in the various countries and their impact on efforts to mitigate HIV/AIDS (UNAIDS/Pact Ethiopia 2002).

The framework argues that the continued use of "individual based intervention methods" is not allowing organizations and institutions to make head way in the combat of HIV/AIDS. Health communication encompasses the study and use of communication strategies to inform and influence individual and community decisions that enhance health (ODPHP, 2010). Most communication strategies aim at changing peoples' behavior.

According to Renata communication strategies are the overall approach that is used to accomplish the communication objectives. Communication strategies need to be research based, and all activities should serve such strategies (Renata,2007).

According to Piotrow et al. (1997) there are certain elements that guide the design and implementation of strategic communication. We need to follow a systematic approach which means a sequential ordering of actions in the design, implementation, and evaluation of the program.

In addition, health communication strategies need to respond to an actual need that has been identified by preliminary research and confirmed by the intended audience. (Renata , 2007).

HIV/AIDS communication "refers to programs or activities where the primary output is communication rather than the provision of services, treatments or commodities such as condoms" (Eldis, n.d.). HIV/AIDS communication does not refer to the communication aspect of all programs, but rather to a number of specific approaches, methods and a rapidly evolving body of knowledge applied to major steps and processes taken in containing the epidemic (Renata,2007).

Currently communication is understood as a process that tends to employ several complex variables especially in the context of health communication in general and HIV/AIDS communication in particular. The reason is that health communication especially aims at more demanding outputs such as behavior change and modification of some social and political factors that influence behaviors in some way (Hubley , 1993:cited in Gulilat 2006,p .11).

At times this process may require a major change in an individual's or a community's socio-cultural norms that have been valued for generations. Such attempt of challenging deep-rooted

social or cultural behaviors is not a simple task for communicators and cannot be achieved overnight even if its effect is constructive to a given society (Gulilat , 2006,p.11).

If we take HIV/AIDS communication, for instance, awareness creation or information transmission alone could not guarantee success to tackling the epidemic. The fight against HIV/AIDS is as complex as its causes and hence requires a range of communicative approaches that must take specific account of various social, economic, cultural and political backgrounds of the given community. Change in behavior is at the heart of HIV/AIDS communication. And such a change requires both individual and social commitment. There is not any prescribed universal model of communication, which can be employed to effectively reduce risk of HIV and AIDS. Hence any communication approach that best fits to various socio-cultural aspects of a given society could be individually or jointly employed (Gulilat , 2006, p .11).

2.6. Theories and models underlying HIV/AIDS prevention communication

Like many other development intervention programs, HIV/AIDS prevention is also informed by theories. Most theories underlying the modes and framework used in HIV/AIDS prevention were derived from social psychology and communications. Furthermore, many of these formulations have been borrowed from family planning and population programs, which have successfully advanced the understanding and use of information, Education and Communication (IEC).

However, in-depth evaluation of the applicability of the borrowed theories, models and framework to the special circumstances of HIV/AIDS prevention and care rarely, if ever, one of the principal made uncertainties, for instance, is whether communication can be credited a determining factors in observing behavior changes. This is particularly true when mass media from parts of the mix (UNAIDS/PENNS, 1999).

The models of behavioral change most often used to guide health communication programs are the same one used to inform health promotion programs. Some of these theories and models listed by UNAIDS include the Health Beliefs Model, the Theory of Reasoned Action, Social Learning and Cognitive Theories, the AIDS Risk Redaction models, Stage of Change, Hierarchy of Effects , Diffusion of Innovation, and Social Marketing (UNAIDS/PENN 1999). However, the theories and models have been effectively used is questionable given the fast spreading of HIV in developing countries over the years.

2.6.1 Health belief model (HBM)

The Health Belief Model (HBM) is a psychological model that attempts to explicate and predict health behaviors by focusing on the attitudes and beliefs of individuals. The HBM was developed in the 1950s as part of an effort by social psychologists in the United States Public Health Service to explain the lack of public participation in health screening and prevention programs (e.g., a free and conveniently located tuberculosis screening project using x-ray). Since then, the HBM has been adapted to explore a variety of long- and short-term health behaviors, including sexual risk behaviors and the transmission of HIV/AIDS (The Communication Initiative, 2003 and FHI, 2004).

According to this model, change in behavior is a factor of variables such as perceived threat, perceived benefits of the change, perceived barriers, cues to action and self-efficacy. This model considers people as rational beings who can observe their environment and develop the right behavior, which is likely to avoid health threats.

Communication is, therefore, considered as a tool which is meant to make people aware of things like the degree of susceptibility to health risks, how severe the risk is likely to be if not tackled, how much benefit they may receive if they adopt a certain behavior, the potential negative consequences that may result from taking a particular health related action and the degree of confidence an individual develops in executing a certain behavior required to produce desired outcome.

Neglecting issues like environmental or economic factors that may influence health behaviors and failure to incorporate the influence of social norms and peer on people's decisions regarding their health behaviors have been mentioned as drawback of this model that are worth considering especially when working with adolescents on HIV/AIDS issues (FHI, 2003).

2.6.2 AIDS Risk Reduction Model (ARRM)

Introduced in 1990, the AIDS Risk Reduction Model (ARRM) provides a framework for explaining and predicting the behavior change efforts of individuals specifically in relationship to the sexual transmission of HIV/AIDS. It is a three-stage model, which incorporates several variables from other behavior change theories, including the Health Belief Model, "efficacy"

theory, emotional influences, and interpersonal processes. AIDS Risk Reduction Model (ARRM) identified three major stages an individual faces in the course of change in behavior (FHI, 2004). These are: Stage 1: Recognition and labeling of one's behavior as high risk; Stage 2: Making a commitment to reduce high-risk sexual contacts and to increase low-risk activities; and Stage 3: Taking action. This model assumes that people will measure the pros and cons of developing a certain behavior based on the information, knowledge and skills they have had about risks of HIV and AIDS. People are assumed to rationally analyze the cost and benefit of sustaining or reducing risky sexual activities based on various factors (mainly psychological and to some extent socio-cultural and environmental).

Like what is the case in the Health Belief Model (HBM), communication in ARRM is viewed as transmission of information and experiences either from health professionals or peers to individuals so as to help them take calculated actions regarding whether to change their behavior in a way that health risk could be reduced. Unlike the Communication for Social Change Model (CFSC), ARRM focuses on output of communication but not much on the process.

A general limitation of the ARRM is its focus on individual while focusing on individual may bring about the required change in behavior, it is not a full proof for change in behavior is likely to be affected by the different socio-cultural and environmental factors, which are ignored by this model (FHI, 2004) .

2.6.3 Diffusion of Innovations Theory

Diffusion, according to Rogers - the father of diffusion theory, is “a particular type of communication in which the information that is exchanged is concerned with new idea. The essence of the diffusion process is the information exchange by which one individual communicates a new idea to one or several others” (Rogers, 1983:17).

The communication process in this model involves at least four important elements: an innovation, an individual or other unit of adoption that has knowledge of or experience with using the innovation, another individual or unit that does not have knowledge of the innovation and a communication channel connecting the two units (Rogers, 198,p:17).

While various channels of communication ranging from interpersonal to mass media can be used for diffusing the innovation, the choice differs with the nature of innovation and the nature of information exchange between the communicators. However, interpersonal communication seems effective in facilitating the innovation whereas; mass media can help rapidly disseminating the innovation to many.

In favor of this Nwosu et al., 1995, P.23 cited in Gulilat (2006 , 26)

> *"[Diffusion] focuses on interpersonal interaction among adopters of an innovation with in a specific social system, and the role communication plays in this process. The end result of the process is either structural or functional changes in the system itself).*

By innovation, in this context, Rogers mean that certain degree of uncertainty is involved in the diffusion process, not necessarily because the innovation is completely alien but may be due to the fact that people did not try it before. Rogers, 1983, P. 6)

Though the communication process in this model assumes a change agent to play basic role in creating curiosity and in convincing them to adopt the innovations, there should not be hetero-philous relationship between the change agent and the potential adopters so that effective communication be maintained (p. 18-19). The more similar attributes communicators do have the more likely that the change agent influences the adopter.

Diffusion is, therefore, a special process by which an innovation (obviously new idea, material or any creativity) is communicated through certain channels overtime among the members of a social system so as to convince people adopt it. Communication, in this sense, is a social process by which participants create and share information with one another so as to reach on mutual understanding. It is not at all a one way process of information transmit ion (Rogers, 1983 p.5-6).

Generally, communication is taken as a tool that facilitates a range of steps in the diffusion process such as providing knowledge, persuading adopters, helping decision making of adopters so as to implement the innovation and confirm its benefits to others. Communication is not considered a panacea. Diffusion, as well, is not an activity to be accomplished overnight.

2.6.4 Communication for Social Change Model (CFSC)

Communication for Social Change (CFSC) has been defined as "a process of public and private dialogue through which people define who they are, what they want and how they can get it" (Figueroa, et al., 2002: II; cited in Gulilat 2006,p.26). It is a participatory process that allows communities to articulate their values, reconcile disparate interests and act upon shared concerns Reardon, C. (2003, P.1). Hence, it just puts people at the center of an intervention. It has been difficult to make distinction between CFSC as an approach and as a model as both are defined similarly in some of the existing literatures.

Based on the philosophies of Paulo Freire (1983p. 26) , the Brazilian educator who contends that everyone must be agent for one's own change, CFSC argues that sustainability of social change is more likely if the individuals and communities most affected own the process and content of communication. "…when communities articulate their own agendas, they are more likely to achieve positive changes in attitudes, behaviors and access to opportunities. What is more, because they are highly invested in the process, they are more apt to sustain these gains".

While a certain outcome such as adopting a healthy sexual behavior or social norm is emphasized in case of CFSC, the process of participation, dialogue and debate is equally focused. Communication, in this case, is not considered as a product to measure its extent; it is rather considered as a means to an end. Here, the aim is to bring all individuals or "rights holders" into the process of decision-making about HIV and AIDS.

Communicators, as well, are not considered as persuaders, as mere information senders or as outsider technical experts who give "valuable" information to the community in a "top-down" manner. They are rather considered as active and interactive agents who catalyze and guide the debate, dialogue and negotiation of the community so as to see them reach at a consensus (Freire , 1983, p.26).

The "emphasis on outcomes should go beyond individual behavior to social norm, policies, culture and supporting environment", unlike what has been the case in individual-oriented models such as health belief model, social learning theory and AIDS risk reduction model Gulilat (2006,p.27).

Since communication for social change involves both horizontal and top-down interaction among participants, it is more likely to give voice to previously unheard members of the community. In this sense it considers the role of empowering participants who are otherwise incapacitated. Communication, in case of CFSC, is not a "magic bullet" for social change. It only constitutes part of the real solution. It can help enable people to shape their own agenda, articulate their own priorities and aspirations of how to address the epidemic, and ensure that concerned stakeholders such as donors are responding to public and policy debates as well as shaping such debates (Rockefeller Foundation 2001, cited in Capobianco).

Because it engages people in dialogue about difficult issues, it can be slow and unpredictable. It can also be difficult to evaluate. Communicators use the communication for social change methods to spark public and private dialogue, set an agenda, frame public debates and create an environment that is conducive to change (Reardon, 2003:1).

2.6.5 The role of behavior change communication (BCC) for HIV/AIDS prevention

Behaviour change communication promotes tailored messages, personal risk assessment, greater dialogue, and an increased sense of ownership. Behavior change communication is developed through an interactive process, with its messages and approaches using a mix of communication channels in order to encourage and sustain positive, healthy behaviors. See also 'social change communication' (UNAIDS, 2011).

According to Wilson Boulevard et al (2002) BCC is an integral component of a comprehensive HIV/AIDS prevention, care and support program. It has a number of different but interrelated roles. Effective BCC can:

Increase knowledge. BCC can ensure that people are given the basic facts about HIV and AIDS in a language or visual medium (or any other medium that they can understand and relate to).

Stimulate community dialogue. BCC can encourage community and national discussions on the basic facts of HIV/AIDS and the underlying factors that contribute to the epidemic, such as risk behaviors and risk settings, environments and cultural practices related to sex and sexuality, and marginalized practices (such as drug use) that create these conditions. It can also stimulate discussion of health care seeking behaviors for prevention, care and support

Promote essential attitude change. BCC can lead to appropriate attitudinal changes about, for example, perceived personal risk of HIV infection, belief in the right to and responsibility for safe practices and health supporting services, compassionate and non-judgmental provision of services, greater open-mindedness concerning gender roles and increasing the basic rights of those vulnerable to and affected by HIV and AIDS (Wilson Boulevard et al 2002).

Reduce stigma and discrimination. Communication about HIV prevention and AIDS mitigation should address stigma and discrimination and attempt to influence social responses to them.

Create a demand for information and services. BCC can spur individuals and communities to demand information on HIV/AIDS and appropriate services.

Advocate. BCC can lead policymakers and opinion leaders toward effective approaches to the epidemic.

Promote services for prevention, care and support. BCC can promote services for STIs, intravenous drug users (IDUs), orphans and vulnerable children (OVCs); voluntary counseling and testing (VCT) for mother-to-child transmission (MTCT); support groups for PLHA; clinical care for opportunistic infections; and social and economic support. BCC is also an integral component of these services Wilson Boulevard et al (2002, p.6).

Improve skills and sense of self-efficacy. BCC programs can focus on teaching or reinforcing new skills and behaviors, such as condom use, negotiating safer sex and safe injecting practices. It can contribute to development of a sense of confidence in making and acting on decisions Wilson Boulevard et al (2002, p.6).

2.6.6 Social Change Communication

Social change communication is the strategic use of advocacy, communication and social mobilization to systematically facilitate and accelerate change in the underlying determinants of HIV risk, vulnerability, and impact. It enables communities and national AIDS programmes to tackle structural barriers to effective AIDS responses, such as gender inequality, violation of human rights, and HIV-related stigma. Social change communication programmes act as a catalysts for action at the individual, community, and policy levels (UNAIDS2011).

CHAPTER THREE

3. Research Methodology

3.1. Introduction

This study attempted to explore the health communication strategies employed in the urban heath extension programme in Addis Ababa Nifas Silek Lafeto Sub-City woreda 11 to reduce HIV/AIDS.

The research site was deliberately chosen from the 12 Woredas inhabited in Nefas Silek Lafeto Sub City Woreda11 was selected in the basic of accessibility, representativeness, and some characteristics related to the researcher hypostasis (e.g. the level of HIV vulnerability and intervention) woreda 11 is selected for it is believed that this woreda to be more hot spot area among the other woredas because of current investment initiatives that are result in permanent and seasonal labor flow. There are different working environments like condominium, privet house, hotels contraction and garment factories, around this woreda.

There are many daily laborers, permanent workers, and some local women come from different rural areas of the country and sale home-made alcohols these women also believed that they remain sex worker and have contact with daily laborers at night. According to National HIV and AIDS Advocacy and Communication Strategy (NAAACS 2013) alcohol abuse is a major social and cultural problem and there are increasing occurrences of violence, rape and high-risk sexual behavior that have been directly linked to drunkenness. This eventually increases the risk of new HIV infections among high-risk, non-infected populations (NAAACS 2013)

In many areas of the country, alcohol is socially accepted. alcohol abuse is also known to be influenced by peer pressure; gender roles that support men spending a considerable number of hours at pubs; idleness and lack of alternative recreational activities; poverty and frustrations about life; lack of counseling in family conflicts; and failure to value life when under the influence of alcohol. (Ibd2013)

The places with the highest number of incidents of drinking are in most cases associated with high-risk sex. Locations for high-risk sexual behavior fall into three settings. First, it is most prevalent in entertainment locales such as bars, clubs, brothels, local video theatres and others.

Second, it occurs at transit locations such as highways stop overs, public transport areas and weigh bridges. Third, high risk sexual behavior occurs in employment settings such as construction sites, mining areas, plantations and markets (NAAACS 2013).

This woreda is selected purposely as mentioned earlier it has variety of community live and very exposed to HIV/AIDS related to their working environment.

According theworeda administration data indicated that, woreda 11 is one of densely populated in the sub-city with a totalpopulation 80,000 people live in. Among these male 31,300 and 32,100 females totally 63,400 live with permanent ID card and the other 16,600 people are mobile and daily laborers. As the large portion of the Woreda is taken by public institutions like Schools, Woreda Administration buildings, and other private organizations, due to the cheapness of therent house different governmental and privet worker, mobile and daily laborers are also live in this woreda. So, the space left for residence has become very limited that makes the Woreda highly crowded. This is believed that to represent all kinds of venerability for HIV/ADS in the city.

3.2. Population of the Study

This paper was targeting people of age groups ranging from 15−49 who are living in Addis Ababa Nifas Silek Lafeto Sub-City woreda 11 as a subject of the study.These age groups are sexually active and are of the most vulnerable age brackets to HIV/AIDS (MOH, 2009). And the motive behind selecting the study site is because of the fact that this woreda to be more hot spot area among the other woredas since current investment initiatives that are result in permanent and seasonal labor flow.

3.3 Sample Size and Sample Technique

The case study area, woreda 11, has eight townships or they locally call *ketana* which specific number of communities lived. Among these eight *Ketanas*, the researcher purposively selected four *ketanas* tha*t ketna* 1, *ketena 3*, *ketene*7 and *ketna* 8 are selected to consider the balance between the highest venerability of HIV /AIDS. According to Van Mere(1978, p. 8), the areas that will bring differences venerability to the community behaviors. This helped the research to obtain data from different communities with diverse settings. The research believed that it would

have been better to include more sample, however, due to time, finance and manageability of data, the research limited itself among eight *ketana* four venerable had selected only.

Moreover, to elicit adequate data, FGDs were formed by taking participants from the group formally called one-to-five. Every one-to-five group that assigned by the woreda highest leader in order to transmit different political and socio economical messages. The members expanded the messages to the other communities.

There are 24 one –to- five group leaders these leaders' lead 30 women each and a total number of 720 members in four *ketana* communities. From this 24 group leader of one-to-five 4 group leaders and 5 members in each *ketana* totally 24 FGD participant in four FGD groups from each *ketanas* one FGD groups selected for their relative engagement in health extension program. These all are female and the education back gerund was from reading and writing up to high school complete.

3.4. Study Design

The study used the qualitative research designs to clearly observe and understand social phenomena from the perspective of the subject of the study (Silverman, 2004; Bryman, 2004). Meaning, it attempts to view the world through the eyes of the subjects of the study.

According to Henn et al. (2006:p, 150), the objective of qualitative research design "…is to take detailed descriptions of people's behavior and thoughts to illuminate their social meanings." According to Holland and Campbell qualitative research is all for its explanatory power and for the richness and depth of information it generates rather than standardizing to describe the norm,qualitative research seeks to explain differences. This approach is, thus, believed to be so suitable to this particular study to explore a detailed account of the role how the HEP in HIV prevention program that playing on the part of the public.

3.5. Justification for Employing Qualitative Method

Any research method falls into either of the categories: quantitative or qualitative. These, especially in social studies have their own merits and demerits Bryman, (2004, p. 1). Though it has been changed in times, one of the differences between the research methods is their method of data gathering. Describing this Bryman (2004) states that 'qualitative research' came to

signify much more than ways of gathering data; they came to denote divergent assumptions about the nature and purposes of research in the social sciences"

In qualitative research, one interviews people to understand their perspectives on a scene, to retrieve experiences from the past, to gain expert insight or information, to obtain descriptions of events or scenes that are normally unavailable for observation, to foster trust, to understand a sensitive or intimate relationship, to analyze certain kinds of discourse Lindlof, 1995, p. 5).

Since this study focuses on evaluating the behavioral change that the health communication brought to the study groups, it will be very suitable to employ the qualitative research method for it.

Moreover, Bryman (2004, p. 266) describes qualitative research method as a method that "usually emphasizes words rather than quantification in the collection and analysis of data" and is inductivity as a research strategy.

The nature of this study justifies highest the need to use qualitative research approach than quantitative. In order to support this point, Natifu (2006) states that research is a means of investigation in which appropriate methodology should be utilized to answer specific questions, drawing on the strengths and weaknesses of a range of approaches. Similarly, an exploratory study like this one is most likely to be effective if employed qualitative approach for data collection and analysis than the quantitative.

Other natures of the qualitative research method that justify the rightness of it to this study are mentioned in Denzinet al (1998,p. 270). to distinguish it from the quantitative with qualitative research…

- Research is conducted in the natural setting of social actors.
- The actor's perspective (the "insider" or "emic" view) is emphasized.
- The primary aim is in-depth ("thick") descriptions and understanding of actions and events.
- The main concern is to understand social actions in terms of its specific context (idiographic motive) rather than attempting to generalize to some theoretical population

These natures of the qualitative study are much relevant to this particular research as it used the natural setting to observe the problem from the point-of-view of the participants by employing data collection methods that enabled to gather thick information in order to understand the situation in the specific social context. So the study used data collected from primary and secondary sources through scrutinizing the materials produced to address the target audience of the health extension program with HIV/AIDS prevention and control programs, observing the process and way of training the communities, and by conducting in-depth interviews, observation and focus group discussions to see the awareness of the communities that the communication strategy in the course of the implementation of the Urban Health Extension Program (UHEP) in Addis Ababa Nifase Selik Lafto Sub –City woreda 11 .

3.6. Data Collection Techniques

In this research, attempts are made to vary the techniques of data collection. Therefore, the researcher has tried to closely study the materials, like brochures, posters and methods like practical demonstrations that the HEWs and the Woreda Health Bureau use to transmit messages aimed at changing the behavior of their target audience to reduce HIV/AIDS and its risks.

In addition to this, in-depth individual interviews were carried out with experts like HEWs, and officials who participate in the health communication program to see the strategies they have been using in the program. Moreover, the researcher has attempted to visit and make a participant observation on some indicators of the prevention strategies of HIV/AIDS with the help of a check-list developed beforehand.

Denzin (1989), as quoted in Frey (1994, p.373). States that many researchers tend to use multi-method approaches to achieve broader and often better results a method referred to as "triangulation"

Discussing the necessity of triangulation, Jankowski and Jansen (1991) say that the "weaknesses in each single method will be compensated by counter-balancing strengths of another". This can definitely show how the use of multiple methods helps this research to make a credible conclusion.

3.6.1. Document Analysis

As one of the objectives of this study to finding out the communication strategies employed by the UHEP, the researcher has tried to closely study the materials that the HEWs use to train the communities to reduce HIV/AIDS.

In this attempt, documents of the Health Policy, different HEP manuals, handouts, brochures, posters, and banners developed by the Woreda administration were analyzed. Since the handouts and brochures are mostly derived from the HEP Manuals published by the FMOH, it was necessary to evaluate the same manuals to check whether they were in compliance to the eight characteristics of health communication. The collection of data from secondary sources has also been used to measure the magnitude to which the messages could build the target audience's self-efficacy and thereby change their behavior.

3.6.2. In-depth individual interview

The qualitative technique (both semi-structured and unstructured interviewing) involved in this research gathered in-depth, detailed information from individuals who understand the phenomenon and can express from their filings. Lincoln and Guba (1994, p. 245) Saied that qualitative research involves the production of knowledge, not its discovery.

The qualitative research interview seeks to describe and the meanings of central themes in the life world of the subjects. The main task in in-depth interviewing is to understand the meaning of what the interviewees say Kvale, (1997). Thus, the interviews with participants help to obtain this knowledge in combination with interviewees to produce knowledge about their communication situations in order to help gain understanding from both of our viewpoints.

Therefore, the researcher used unstructured and semi-structured interviews so as to gather the data from the purposively selected population. It is proper to employ this interviewing technique to explore communication strategies' and interpersonal relationships through the awareness of AHIV/AIDS from health extension program.

In-depth interviews use the same principle as a focus group, but subjects are interviewed individually, ideally in the patient's own home and health post. The researcher encouraged subjects to express their views. This method is particularly a useful technique for the critical

incident study, in which subjects were asked to comment on real events rather than giving generalizations. This can reveal more of the beliefs, attitudes, and behavior of informants.

The researcher may be able to obtain more detailed information for each subject, but loses the richness that can arise in a group in which people debate issues and exchange views. So, for this in-depth interview, the researcher included the Head of Woreda Health Office and two health Officers by taking their relevancy, four health extension workers that works in the selected ketanas and one supervisor, 2 FSWs pier leaders that leads other ten each and 2FSWs pier two yothes from the youth center and the other two from daily workers were selected for in depth individual interview.

The Woreda health officers and head are selected because they are the higher official working with the Woreda Health program and the researcher believed they would provide a more in-depth explanation about the area. The four particular health extension workers are selected because they are the professionals implementing the program in that specific area of four more HIV venerable *ketanas*. The FSWs and youths were selected due to the reason that they were active participants that the researcher believed they would express their feelings in an outgoing manner.

3.6.3. Participant Observation

Deacon and others (1999, p. 248 & 249) suggest that observation is a very important technique in a qualitative research, especially for studying inters personal -communication. Since the term 'observation' is ambiguous and misused in different researches the same writers have loosely classified it into "three broad types: simple observation, participant observation and ethnography".

As quoted in Temesgen (2007), Gray (2004, p. 34). Statesthat participant observation "is not simply a question of looking at something and then noting down the 'facts". However, it is "a complex combination of sensation (sight, sound, touch, smell and even taste) and perception".

Deacon and others (1999, p. 250) also support this idea by explaining that participant observation is not just "being a 'fly on the wall'", in which the participant has no relationship with the process or people being observed, who remain unaware of the researcher's activities.

These indicate that a careful and systematic viewing of people's acts and behaviors either overtly or covertly can help to keep record of the observed elements and analyze them.

In this research also, apart from the intentional observation to be made during the interviews and the dissemination and collection of questionnaires, a deliberate and overtly conducted visit was made to observe the techniques and strategies of communication, and the awareness of the communities, behavior towards the risk of HIV/AIDS. Notes about the observation were taken with the help of a check-list prepared for the same purpose and some are recorded. This is believed to create a favorable condition for subjective understanding, seeing the unseen by being there at the spot and making the data deep and full of texture.

3.6.4. Focus Groups Discussion (FGD)

Focus group discussion is one of the data collection tools chosen to be used in this study. As many researchers argue, it is the most commonly used types of data generating tools in qualitative research design. involved small groups selected from a wider population and sampled through open discussion. In line with this idea, Henn et al. (2006: 164-165) also describe the significance of focus group discussion as:

> *"… the intent is to stimulate discussion among people and bring to the surface responses that otherwise might lay dominant. Such discussion may enable participants to clarify their views and opinion positions or, on the basis of engaging with others, to articulate more clearly than they otherwise might. The interactive dynamic is therefore considered to be a crucial element of the focus group approach."*

These are employed to collect data from the health 'army' groupwhose leader of women that assigned by the woreda leaders to lead women's for every activity like health ,security ,and other political and socio economic issues in the wereda. This health army group structures, which are called One-to-Five groups.Mentions earlier there are 24 group leaders of one-to-five from four *ketnas* that 4 group leaders and 5 members in one-to-five participant from four *ketana* totally 24 FGD participates and 4 FGD groups from four *ketanas* one FGD group in each *ketana* for their relative engagement in health extension program.

These all are female and the education back ground from reading and writing up to high school complete and the aim here is to gather information about the perception on the structure and to see its functionality.

The researcher took with the discussion guides that contained already prepared open-ended questions. In the discussions, the researcher worked as a facilitator to help participants of the group (One to Five) when they were expressing their ideas.

For this method the researcher brought together the small number of subjects who were previously formed the highest woreda leaders which is commonly called 'one- to- five'.

The group size is kept deliberately as it is, so that its members do not feel intimidated but can express opinions freely. A topic guide to aid discussion is prepared beforehand and the researcher usually 'chaired' the group, to ensure that a range of aspects of the topic are explored. The discussion happen with using tape-recorder then transcribed and analyzed. The researcher also used group workshops to generate data. Brainstorming techniques were used to explore the 'ideal' care giving situation.

The places where the focus group discussions were conducted include the community meeting areas, health posts and the open areas near the homes of the leaders of the 'one to-five'.

3.7. Data Presentation and Analyses

All the data that were collected from the study units in any form of qualitative data collection techniques employed were first transcribed since the majority of data were audio tape recorded. Then, the relevant data were categorized so as to make them convenient for analysis.

The categorization was normally made based on their relevance to the central ideas of the research questions raised in this study.

The data collected with the help of the filled out by the models and the checklist used during the participant observation had to be tallied and arranged so as to use them in a very handy way while writing the analysis. However, some of the data, which had no any contribution to this study, were simply discarded. Finally, the transcribed materials were translated into English. In

doing so, the data were thoroughly presented in the way that they could be used for careful data analysis.

3.8. Summary

In this chapter, the research design chosen for this particular research and the justification of the choice is discussed. Moreover, the data collection techniques that were used in an appropriate way to the research design are presented. The use of these techniques has made it possible to collect quality data that significantly contributed to finding responses to the central questions raised in this study.

The chapter also indicated that use of multi methods or triangulation is an imperative in qualitative research like this one. This is because it helps to eliminate biases that could arise from a single methodology and to ensure reliable research findings.

Finally, this described how the data collected were processed and presented. The proceeding chapter makes use of qualitative data presentation and analysis to come up with specific findings.

CHAPTRE FOUR

4. Data Presentation and Analysis

This chapter basically deals with the presentation and analysis of data from the perspective of health communication theories and practice at grass roots level.

Qualitative methodology is used in the study to analyze documents, participant observation, focus group discussions and in-depth interviews.

This chapter incorporates communication strategies occupied the HEP in woreda 11of Nifas Selk Lafto sub city to create awareness in the community about HIV/AIDS including interpersonal communication, group communication, door to door communication and health army communication with the group one-to-five and mediated communication. It also assesses the communication between HEWs and other stakeholders, the role of the community in the communication process and cultural factors within the community that could constrain the health extension program.

4.1. Communication strategies employed to create awareness about HIV/AIDS

Communication plays a vital role in providing knowledge and changing people's attitude and also it initiates and accelerates changes that are already underway as well as in reinforcing and supporting the change that has occurred.

Effective communication offers guidelines in supporting policies, positive legislation and increased resource allocation. While the focus of this research is the role of health communication program to reduce HIV/AIDS and the overall aim of HEP is to bring change in the community. This brings the fact that community based communication for the purpose of health service deliveries tends to take place in the wider community setting i.e. in a group basis.

According to FMOH (2007), health providers, HEWs communicate with community in many ways and at various levels of intensity by taking individual households as the basic area of involvement. In the documents, interviews, focus group discussions and participant observations understood that most common communication strategies that are used by health extension workers are interpersonal, team education method and media communication.

4.1.1 Interpersonal Communication

The FGD respondents have responded that, access to the existing mass media like television and radio; but they not give attention to listen the program therefore, they prefer interpersonal communication and optional kind of strategies.

Running series of trainings and administering health related consultations, the health extension workers are trained to become health facilitators in community where they are assigned. The weekly training conducted in the form of learning circles helps to raising awareness and the health army group become community-based change agents. As a result, health extension workers are health promoters and communicators. With this process chain, HEWs trained selective health army group as pier educators that easily understand and teach other share of the community. Such methods are done using interpersonal communication as a major tool.

In relation to interpersonal communication, the health extension workers stated that;

> *Teaching women's are considered as teaching the community, so to change each individual women's community I was indebted to communicate them separately with face to face interaction and trying to create awareness them for long life of their family, even most of the time.*

> *I was not effectively communicating the community while they are coming as group since they want to keep their problems secret in their cultural context. Because of this, I was trying to talk too separately in my office and also at their home. I followed this approach hoping to keep their interest so as to get detail and extra information about their problems.*

Those from the Focus group discussion is agree; one Participant pointed out that,

> *Communicating interpersonally had helped them to privilege the occasion to forward the questions that when something wrong in their family discussion.*

This dispense the idea of Rubin, (1988) when we are designing health messages, we need to focus on effective interpersonal message strategies that will prove effective with the unique complexities and barriers patients and their family members often face.

Even though there is no appropriate respect for the HEWs from the community on the beginning the health extension program, interpersonal communication appeared crystal clear that all the interviewed key informants of both community and from the health extension category were satisfied by the interpersonal type of communication channel. In the same way, the majority of FGD respondents were absorbed in interpersonal communication with health extension workers and it has been employed to promote the program about HIV/AIDS.

4.1.2 Door to door communication

According to the head of woreda11 health office and also the (FMOH, 2007) argued that, the basic philosophy of the HEP is to transfer ownership and responsibility for maintaining their own health to individual households by providing health knowledge and skills. Health extension workers spend percent of their time visiting families in their homes and performing outreach activities in the community. The house-to-house activity starts by identifying households that can be used as role models.

These households have earned the respect and credibility of the community because of their extraordinary performance in other social and economic aspects. They are also willing to teach other communities upon completion of the training and have the capability to persuade and convince other households to adopt new and innovative health practices. The pier educators are considered as fast adopters of health communication in line with heath extension packages. They play a key role in diffusing health messages which in turn leads to the adoption of the desired practices and behaviors by the rest of the community.

On the other hand, health extension workers pointed out that people these days look for health services during door to door orientation and they actively participate in village health promotions. If they do not manage to see them in the outreach door to door program, the observation confirms this as one health extension worker formed some of them are go to their homes asking for demanding health related training and orientation. I witness a real willingness in the people to get consulted about their health.

Another HEWs argued that, their door to door movement constraint them to some problems at a time of health education program. Visiting the door to door takes a lot of time and the problem is that**,**

As health extension workers, we do what we can because to visit the houses, we need a lot of time and that is something we do not have. Even if we were paid as a community health worker for what we do, then we couldn't cover everything, but we don't have choice to omit any Visiting (HEW, ketene 3).

Even though the motivation to serve the needs of the community exists, all health extension workers are often too limited by time in what they are able to realistically accomplish. Since the job is huge and demanding responsibility, it is also often difficult to be accomplished by one person. In this regard, they indicated that there is burden of health extension workers to cover all the communities.

On the other hand from the community point of view, one of the FGD who was a member of the health 'army' group traces the importance of door to door communication as follows;

I like door to door movement of health extension workers. They explain and tell us about HEP in relation to what we have to do during pregnancy and health 'army' group for my families especially for my husband. When health education and community conversation sessions are organized, the message is passed through me and my friends. We are representatives of people in the village. Prior communication occurs between us before any health service reaches my family, but finally those health extension workers persuade our family while they are visiting us.

Similarly other woman from focus group pointed out the same idea;

Before the health extension workers moved door to door I was doing hard work in time of my pregnancy and I was tired , but now through door to door, HEWs aware my husband how hard working during the pregnancy is harmful. As a result I am not forced to work hard as I used to.

This shows that door to door communication, getting communities' confidence by those members of health 'army' groups a result of strong social capital owed to persuade their husbands and also their families. In addition to what has been said so far, the preference to and appreciation of health extension workers may also be related to the fact that most women prefer to give birth at home since they can't access health education and that can't get medical

treatment. But behind this the health extension workers has pessimistic attitude that they can't cover everyhome within the given period of time. But on the contrary the researcher observes that there could be indicative of unfavorable relation of women with their husband opposing what they do with HEWs. Due to this, women need HEWs to persuade their family by moving to door to door.

4.1.3 The team education method

This communication strategy once structured the community in a group which called one-to-five and one- to -ten having a total five women in number in a single group. The communities provide their input and the health extension workers make the final decision.

Most of the time illiteracy and reading interest is the main problems of community which in turn constrain to teach and make them to understand within a short period of time, causes a huge problem to communicate by using print media and leaflets especially within the immigrant sex workers those come from rural era. It has an influence on women's awareness creation and to bring societal attitude change.

According to the woreda health extension supervisor in the interview, stated that

> *This structure was formed, as she replied, where the minimum requirements were met such as five and thirty in number. In other words once the minimum requirements are met, the group would have one representative for each one-to-five group that are short-listed and presented to the entire community and then they vote on that. With an attempt to know how team communication and HEWs work together,*

Interviews with HEWssessions revealed that there is co-working between the community and the structures. A health extension worker from the woreda describes the group work this way;

> *work with one-to-five group in counseling pregnant mothers.We provide them different materials that can be used for teaching- learning; we teach them if any wrong happens to discuss. We co-educate pregnant women. They are helpful in encouraging women to seek them in health posts or health centers. We do all this because there is constructive and rewarding interaction between us.*

On the contrary to HEWs, from the community's perspective of FGD participants show that there is some level of cooperation and good interaction between HEWs and both the developmental health army and one to five group. Most of the participants of FGDs rejected that team communication is waste of time in attending group meeting.

According to Servaes (1995) and Veneklassen (1990), in participatory communication, there should be a process of raising consciousness and deep understanding about social reality, problems and solutions; rather than persuasion for short-term behavioral changes those are only sustainable with continuous campaigns. However, in the case of in Nifase Selk Lafto woreda 11 the health extension workers perused the community with exclusion of their interest and agreement.

All these are solid proofs that the health extension workers are providing different information using different methods and styles which will be instrumental in getting people aware about the HIV/AIDS prevention mechanisms and on how to be treated while they are caught by diseases. In addition to creating awareness, this type of stage will play an important role in creating competition among people so as to take care of them.

4.1.4 The Mass media and BCC

Mass media channels are labeled to be limited to creating awareness among the target audience, despite this fact, many health communication programs tend to make use of mass media to convey health related and behavioral change issues. The UHEP also plans to benefit from the advantages of mass media (FMOH, 2009, p.31). Therefore, FHAPCO, AAHB and AAHAPCO and some NGOs sponsors and facilitates the airing and publication of HIV/AIDS and other related messages on local and national media in addition to the news, talk shows, program , advertisements and other ways transmitted by the initiatives of the media houses themselves.

Moreover, the HIVposters and banners posted around public organizations and health centers and brochures and fliers published and disseminated by the city administrative of HIV/AIDS prevention and control office , AAHB, FHAPCO, NGOs and sectors are conveying messages.

According to woreda health office head that who were interviewed banners and posters carrying the UHEP messages are posted for the public's consumption in the woreda while brochures and

summarized handouts on the packages of the program are printed and used in the training and refreshment programs given to the pier educators' and model families.

The HEWs have also showed a very high commitment to circulate the printed materials to their audiences, as they said during the interviews and seen in the participant observation.

Nonetheless, the Woreda Heath Office Head claims that they have budget constraints to make the brochures and handouts self-explanatory and attractive. She says, "The woreda has limited budget. The cost of publication, on the contrary, is continuously getting high. That is why our brochures and handouts remained dull, filled with text, and short of explanatory pictures." This indicates that cost was denied due attention even if it is one among the criteria to choose a channel.

In line with this, models that accepted and fully completed the HEPs and graduated a model performer they help the HEWs to train other community. This model being complains that the brochures and hand outs are difficult to comprehend as they are too brief and unattractive.

This model, who is only a junior school graduate says, "I prefer to keep these publications aside and depend on the interpersonal communication I do with my trainer". Also they use social media like telegram, Facebook and transmit information related to HIV/AIDS to create awareness special to address youths and other communities.

A supervisor at the Woreda also suggests that much has to be done in exploiting the capabilities of the broadcast media, radio and television, by the AAHB. She keeps on by saying, "our limited resources need to be complimented with video clips that aim to encourage behavioral change in HIV/AID such materials are easily consumable by both the literates and illiterates".

According to the document written by the sub city, there is awareness creation brochures are published in Amharic language. The brochure features HIV privations and voluntarily counseling testing (VCT). The objective of the brochure is intended to raise awareness about problems of HIV that the community is facing and about the advantage of knowing it self-statues by testing in the society.

One of the interviewed woreda supervisor says;

> *We distribute the brochure for woreda offices, sector offices, different youth associations and gender clubs, youth center libraries and different construction and garment factory areas. The main goal is to raise awareness and showing the advantages is creating awareness by presenting what these communities should do to protect themselves from HIV/AIDS.*

The target group for the brochures r is mostly create awareness; however since some of are illiterate community cannot read in turn only focus on the given pictures. The message not sported by picture.

Therefore, issues like illiteracy and limited accessibility adversely affect its distribution. The health extension workers use the brochures to inform the one –to-five leaders and to motivate them to further communicate and channel the information in the brusher to other. This means that the information in this case reaches the public indirectly via the leaders that led the group members that make a brief brochures both illiterate and literate community .This shows how communication messages can travel in two ways and it is an indication of how the health extension workers are giving attention to the leaders who in turn plays inevitable role in spreading information to the rest of the community.

In this contemporary world especially in developing country where the mass of the people resides in common areas, leaders are more acceptable and heard than other community.

Focus group discussion women'smentioned that;

> *The brochure is making women to discuss about what they see in the society and encourages them to take a look at the importance of attending health extension program through women's eyes. The brochure is considered as an empowering and eye-opening medium. Mostly, this is done through picture presenting. The females are called for social change and preaching new perspectives about women's issues in the HIV/AIDS were testing and awareness creation to the women before born the children.*

As the woreda health office manual (2011) indicated, in addition to this, health extension program distribute different types of publications similar to brochures that are provided by different NGOs. Those NGOs are involved in HIV/AIDS program of Addis Ababa. The brochures have picture expressions which are represented to be easily understood by the illiterate community. But according to the HEWs supervisors, the communication strategies are not really understood by the mass public because there are some people illiterate and cannot consume print media output in the woreda.

Additionally, one interviewee respondent added that radio is more important than other media outlets. She says that she always listens to the Sheger FM Betgna HIV/AIDS program and Ethiopian radio health program and shares the ideas related to HIV/AIDS issues with her parents and community.

4.2. The communication between and among other to HIV/AIDS prevention and control

4.2.1The role of stake holders to prevent HIV/AIDS

According to the woreda officer in the interview tell that stack holders that works in the issue of HIV/AIDS prevention and control and those help the government to address HIV/AIDS program to the target community was decreased through time to time but there is one NGOs and other governmental organization sport the HIV package. This NGO works in awareness creation of FSW how to protect from HIV/AIDS by use condoms, because most of the time young girls come from different rural areas and directly entered to in hotels and bears without information about HIV.

As the woreda health head said in the interview female sex workers are different in their activities, home based FSWs, mobile sex worker and straight based FSW.

Home based FSW: - are sex worker in which girls do sex in a small and narrow rent house,

Mobile females' sex worker: - in which the name indicates they move from places to places which different mega projects and factories are performed, to do their own business.

Straight based FSW: this is performed in the area that more pensions, bares, hotels and night clubs area the girls stand and get customers to do their sex business.

The NGOs can help this FSW specially those home less to get rest and take shower, to cook foods, and after that they give training about HIV /AIDS how to use condoms. Also make them a group free discussion and change their experience each other about the problem they faced and how to solve in their working areas.

From interview respondents said that

> *"Peer to peer discussion with my friends make me very free even what happen during sex with my customers and the other will learned from each other, so I like this methods of free learning to more understanding about the problem of HIV/AIDS.*

These indicate peer to peer education and training is more effective to address the information about how FSW protect themselves from HIV/AIDS.

The HEW in the woreda added that most of the time FSW are neutral from the community social life owing to this we formed them peer to peer education and give ten selected out of them and these ten FSW are reaches and lead other ten FSWs. It is effective because since they work the same job they can communicant each other freely with sharing experiences about how to protect themselves by using condoms and also how to solve the challenges during some customers when drinking more alcohols and like.

4.2.2 Communications between health extension workers and other stakeholders

Although the health post is the place which is considered as the center for most of the health activities, it is believed that effective service under HEP is delivered through the participation of different organizations.

Accordingly, one of the points this study initially aspired to explore is to find out the nature of communication between HEWs and stakeholders of the various hierarchies (particularly with health centers, woreda, supervisors coordinator. Some results were obtained from the interviews with HEWs and key informants which indicated that the overall interaction among these stakeholders is strong.

When the researcher asks how they describe their interaction and coordination among themselves, HEWs from Woreda11 replied that they have strong link with health centers and woreda health officer's through their responsibility on them. Although the Woreda health officers, the leaders at large and the health system are the major stakeholders, the strategies for the success calls for coordinated action at all levels failed in supporting the HEWs.

As the community based program, HEP needs good coordination with various sectors. Most importantly, the document FMOH (2007) also emphasizes that the program needs strong partnership with local administration. The HEP brings the health sector to woreda level, whereby the HEW represents health sector in the local administration.

In spite of all the descriptions, HEWs said that these are not applicable in the health extension program of interaction between HEWs and AAHB at the various hierarchies.

This was also confirmed by the woreda coordinator and supervisor when they said that their interaction with HEWs is not strong and interactive as it could be. In particular, HEWs were asked to describe their relation with woreda leaders and replied that woreda officials dictate them. But there are no sporting HEWs by training and other facilities to do their job more effectively.

HEWs complained that they are perceived not as health workers but as political cadres by some woreda officials. And this leads to the community opinion on us a political representative. HEWs reported that the absence of strong bond has resulted for weak information exchange in time of reporting and health management.

Further, HEWs have disclosed that visits by woreda coordinators and even regional level supervisors are untimely, sudden, irregular and not periodical. They said that they have no information about who comes to visit and when that visit takes place. All of them understood that this is negatively affecting their work by creating a feeling of frustration.

In general, the study shows the absence of training and coordinated interaction between HEWs and AAHB at different levels on one hand; and the enforcement of extension workers to act in the interest of local administrators on the other hand. This recalls us that well-coordinated

interaction and communication among them is inevitable and significant if community health has to be addressed effectively and successfully.

But from the perspective of the Ministry of Health documents on FMOH (2007) reproductive health officers, one to five and health army is the structure that a participatory health communication strategy would greatly improve the approach towards reducing HIV in the community and greatly improve the community share to achieve. And this is the result of the stakeholders (the Woreda health officers and the leaders) assisted the health extension worker.

The HEW says that, health extension program should lead to the greater participation by the community in the process formed by the woreda health officer on health extension program to ensure the community at grassroots level needs are truly encompassed in the HIV/AIDS prevention package initiatives behind them.

The health extension workers argued that horizontal communication should be assured between the Woreda health officers and the grassroots community. If people actively participate directly to the woreda health officer about any issues pertaining to them, they will be benefited and their awareness standard will be improved. Accordingly, any communication strategy, therefore, has to be designed and implemented having in mind lateral and participatory communication.

4.2.3. The community attitudes towards health 'Army' groups

The point of reference that community have put their attitude on the health army program is based on the tradition and culture of the society especially the place the women occupy in the community and women's attitude in the context of what they are thinking.

A respondent who is from FGD health army groups says;

In our family, men are obvious and, every activity is not done without their consent.

If I try to hide something from him, he feels as if I am not real wife. But if you see the health extension program doesn't include men's participation in this one-to-five group. Because of this always quarrel with him when we want to share ideas that we discussed in the group.

On the other hand, in the focus group discussion from group respondent expresses her attitude on health army group as follows;

> *To me it is not important participate in this health army group; it is only wasting time and energy because everything at home I am not dissuaded without my husband. Even I can't use contraceptive method without his consent; I can't say anything without his approval.*

Such attitude constraints the arguments of the participatory model, it stresses the importance of cultural identity of local communities and of democratization and participation at all levels international, national, local and individual. It points to a strategy, not merely inclusive of, but largely emanating from, the traditional receivers Servaes, (1995).

Almost half of the respondent in focus group discussions and those who are members of the group showed a negative attitude and no appreciation of one to five health army groups as a result of only women are in the group.

Another participant argues that,

> *It is not necessary to form one to five health army groups, most of the time they waste their time without any thing. They all are the same, no one knows anything that different from one another and it might be important to share ideas that someone else has different idea in relation HIV/AIDS. She also added that the health extension workers also have no interest in the group structure. But since the Woreda officers forced to write them a report simply formed them. Finally when she pointed that she gets from FGD "The advantage that I got from the health extension program family plan is the number one."*

Both the Focus group discussion and the interviewee respondents particularly stressed that they waste their time them of thinking and behaving as what the health extension workers said watch what is being exhibited on the discussion and interpret it according to what happens in their communities.

When one respondent in FGD expresses her attitudes of one to five army groups;

Of course I am attending the meeting once starting from the time we established the group, I don't know who formed the group, but the woreda leader tell me as

I am representative of the group and if I am absent from that group discussion, will pay ten birr. So, in order not to be punished with that amount of money, I am obliged to attend the group meetings.

This practices opposes the idea of participatory model incorporates the concepts in the emerging framework of multiplicity. It stresses the importance of cultural identity of local communities and of democratization and participation at all levels international, national, local and individual.

On the other hand, Participants of the FGD revealed- that

Those health army groups are acting as a bridge between HEWs and the community which could shed light on the effectiveness of the program.

One of the interviewees who were also peer groups said:

At the beginning on our meeting HIV/AIDS was our issue; the people were introduced and told about HEWs by pier s' leader of the woreda and officials. At the end of the meeting they were told us to organized health education and community conversation sessions, the message is passed over through me and others having the same work division. We are representatives of people in the village. Prior communication occurs between us before any health service reaches the people.

Generally these gender based group structure raises negative attitude from the communities' knowledge, beliefs and attitudes. And the communication messages and interventions that are used by health extension program is reinforce existing beliefs and social norms or ultimately establish new beliefs, attitudes and social norms that women cannot do anything without the participation of their husband. Because of this health extension workers are not effectively communicating the person which in turn adversely affects the understanding and acceptance of new behaviors as well as revised gender perspectives. Including gender concerns in this communication program makes the messages not to be effectively communicated. Additionally,

when the structure is formed the concerned body does not communicate the group members and the group members are not introduced and oriented about the aim of creating such group.

What the researcher understood in this Woreda community has no sense of ownership over its group structure of army group; it also has perception of the agenda on them that simply imposed from the outside of the health extension workers.

This community awareness can be constructed to the ideas of (Clarke, 2009)who pointed that, the participatory approach is to establish active citizenship, a sense of empowerment, partnership, accountability and ownership. All of these concepts and attributes are linked and are complimentary. Without active citizenship and community participation, a sense of ownership over the development process cannot be achieved.

Additionally, the researcher observed that health extension program does not make gender analysis in the context of participatory development before the program functionalize; gender analysis helps to understand how gender differences affect access to resources and the participation of women in development activities. Such an analysis would help them to take appropriate measures to ensure that men's are not excluded. Ideally, gender analysis should not be a separate participatory method but should be integral to all participatory methods.

4.2.4. The community expectations from HEWs:

HEWs are primarily required to give primary health services by focusing on the individual family. In the document of FMOH (2007), the following definition was given. The definition shows that the primary goal of the program is to focus on health promotion and prevention. It was defined as:

A package of basic and essential preventive and selected high impact health services targeting households. HEP is similar to PHC in concept and principle, except HEP focuses on households at the community level, and it involves fewer facilities (p.6).

From the above definition we can understand that, the program should focus on preventive and promoting packages. In addition, have no curative service on the most widespread diseases like HIV/AIDS was also incorporated. Participants of this particular study indicated that clients are

not getting access to health services as expected; even services on high impact were reported as inefficient.

Interviews and FGD sessions uncovered that there is a gap between what people expect from HEWs and what is being provided. The community expects services like what is given in the health centers and hospitals. Participants reported that extension workers' role is limited and are considered deficient in the delivery of health services like the treatment of the sick. It was said that the beneficiaries are dissatisfied because of the gap in expectation which in turn brought for the gradual decline in acceptance.

One of the key informants from woreda FGD HEW said that;

> *It is obvious that people do expect a lot. As these urban communities live the nearest health facility, they need the treatment for most prevalent diseases like diarrhea. HEWs are also expected to render services like TB treatment.*

Theoretically HEWs are responsible to address such issues through prevention. But people need the medical service gives in hospital and health center. Additional trainings were given to selected extension workers. Currently, however, HEWs provide treatment, but only of febrile diseases (mostly family plan) which itself is inefficient. They could address other diseases if continuous trainings had been given. There have been such efforts though it is not enough. I hope the people will benefit from additional services after some time.

The Woreda reproductive health officer argues that, people actually need extension workers to attend the sick. She feels that sufficient work is not done as the main goal was to focus on the preventive aspect. Accordingly, she revealed that

> *Some necessary conditions are being done to enhance the capacity of HEWs to make them ready to respond for the HIV counseling and testing service clients expect.*

The FGD participants also identified that

> *Some people need from HEWs not only health education but also direct medical assistance to the sick in terms of drugs and injections. Inefficient training might be*

difficult for HEWs to provide what a junior nurse performs, let alone what a medical doctor does.

Generally, what the interviews and FGD sessions revealed is that the gap between people's expectation and what the HEWs are providing, created a greater dissatisfaction which contributed for the gradual loss of acceptance in the community.

4.2.5. Communities attitude about health extension workers

The effectiveness of interpersonal communication often relies on the communicator's perceived attitudes towards each other. This opinion determines the power balance and communicative behavior. Therefore, when opinion is affected negatively, it apparently affects the effectiveness of the communication.

The community in this group has both positive and negative attitudes on the health extension workers. From village the interview respondents stated that,

"Health extension workers have not social mobilization and communication skills simply they wear clothes as a junior nursebut nothing is added on their skills. From all these we can understand that the educational quality of the health extension practitioners is under question mark which adversely affects their quality of work.

In this regard also shares from his participant observation, all the concerned bodies including the government, society, stakeholders and the health extension workers themselves has to contribute their share for the improvement of this sector by producing qualified health extension workers. The improvement updating of health extension efficiency by training is probably the most important question that all HEWs have to be addressed as quickly as possible. But it found that this is negatively affecting the motivation, commitment and accountability of the community not given respect. They ascertained that this is creating a feeling of reluctance among them which seems threat to continue of HEP program.

But in case of the Head of Woreda Health Office attitude towards health extension program, being a female is an important attribute. As women in service, they understand the challenge that women have to go through in woreda, so there is strong desire to support their fellow citizens.

She pointed out that HIV/AIDS is strongly linked with having a strong health system and if the health extension workers are part of that system, as women themselves, and it is sure that they would be able to support the women in the community.

On the contrary to the community's perception the health officer pointed out that the health extension worker has to be selected from the community where they are assigned to serve. Being a member of that community is also a strong motivator to support their relatives, their family members, and their neighborhood. She also added that language and cultural understanding is very important. If you bring in someone else from another ethnic group cultural difference and deploy them in those areas, it won't work. Being able to effectively communicate using the communities attitude is important and this has to be given due attention.

What the researcher understand, there is two divergent thoughts between the communities perception and the woreda health officers on HEWs. The officers' argument is the Guide line documents (FMOH, 2007) that everything they did is the same to the documents.

4.2.6. The role of the community in the communication process

Health extension workers are placed to play an important role in enhancing the program' effectiveness with special contributions they have rendered to communities to HIV preventions activities have been critical to increase workers' performance since they address everybody within a given period of time (FMOH, 2007).

One of the interviewed woreda health extension workers stated that, one contribution made by the community members was support the orphan child where the health extension workers are persuaded them. The way the collection money was done is that the HEW have provided persuasion that are not easily performed at the community level, these types of things that need to be bought elsewhere are provided by the government to the community. However, the community contributes their money to support those orphans. So, that they have played a very important role.

Another woman's from FGDs stated that;

> *In our area there are a structure formed that the community have what they call health committees in every ketana and these health committees have*

representatives from the elderly, respected individuals within the same village, youth, women, religious leaders and so on. So, they provide the oversight to the health extension workers on what to be done and how it should be done, but this as in orally that we cannot see it in practical.

The health extension workers involve these village health committees throughout the planning process as well. So when she sets her targets on how many and what type of services she is going to provide over the years and what targets she needs to achieve, she will consult with the health committees and she will definitely use them to mobilize the community as well.

But the interviewed women when they came at health post in collaboration with participant observation revealed that the major function the communities in the structured group is like sponge only absorbing what health extension workers are said.

This line up with the idea of Pretty et.al, (1995) Participation for material incentives that People participates by providing resources, for example labor, in return for food, cash or other material incentives. Much on-farm research falls into this category, as farmers provide the fields but are not involved in the experimentation of the process of learning. It is very common to see this called participation; people have no stake in prolonging activities when the incentives end.

But in relation to their communication in the issue of HIV/AIDS prevention FGD argues that, they have no role, they are doing what the HEWs orders. Primarily the communities participate by being informed about what is going to happen or has already happened.

Community's feedback is non- existent, and their participation is assessed through methods like hand counting and contribution to the discussion. This participation is similar to Mefalopulos and Tufte (2009) referred to as participation by information or passive participation.

4.2.7. Communication strategies in assembling participation and changing behavior

Still awareness of communities is not changed about the importance of health extension program on changing their attitude towards the disease. From the interview participants one pointed out that,

Most of the time the health extension workers teach us to use condoms in order to effectively cultivate our life healthfully. But there is absence of the condoms distribution, there are two major problems, those are either we uses unsaved sex or lose the business.

The respondents from Health extension workers said, and the FMOH (2007) stated that in order to make this package effective and successful, it is very important to involve communities starting from the planning stage and during implementation, monitoring and evaluation of the package.

Nevertheless, before going into implementation, there is a need to promote the programs and mobilize communities. Sensitization and orientation activities should be undertaken at public places, among every, women and youth associations, at religious places, market places, schools, civil society organizations such as Idirs. (local association for helping someone who has lost his loved one) to raise their awareness about the package. But most of the respondents interviewed are looking these ideas in different way.

Additionally, health extension workers stated that,

Of course the woreda health officers trained us there should be community participation although the reverse is true in practical. Since our focus is preventions there should be active community participation at all stage of Planning, implementation, monitoring and evaluation, even if the truth is that no more community at large is participating except at the implementation stage doing ordered them from us.

Yoon (2000) argues that allowing people to participate in the implementation, evaluation and decision making processes concerning the health communication strategy, will empower them to benefit and will enable sustainable outcomes.

4.3. Uses of harmful substances and other practices to HIV venerability

A healthy society is created from healthy community. The youths of today are the leaders and productive forces of tomorrow. The major causes of youths and HIV in woreda 11 are lack of education on the part of parents about youth health care, and means of preventing diseases.

Harmful substance using like drinking alcohols, chewing chat, smoking cigarette and shisha are existed for a long period of time in the society are and still applied on youths and some women Iam eye wetness that when I do personal observation .

The woreda heath office head in the interview also noted that this woreda is more hot spot area among the other woreda in the sub city. There is verity of HIV venerability practices performed such as underage girls starting sexual practices could increase. She added that having more than one sex partners are common in the woreda even they know about the awareness of the HIV but they not fire of it.

One youth from the interview stated that,

> *In this woreda early sex practice is come in the young girls that come across the rural area to search work. She added the brokers are lead this immigrant young girls to start sex because they live with the broker more than two and three days at this time forced to sex with the broker .*

Although most people acknowledged the complications associated with un planned child bearing due to early sexual practices, most practices are common it did not act to control such threat because there are large number of local daily workers come in the woreda day to day.

4.4. What expected from the city health Bureau

Behind the above communication problems in the interviews with HEWs and the Woreda health officer as well as from FGD pointed out the following.

Facilities: In this regard, HEWs informants put poor sportive supervision system among higher health administration is most important barrier. They ascertained that capacity building training problems have resulted in irregular stakeholder interaction, particularly among the providers.

Social mobilization skill: The focus group informants have admitted that HEWs lack the initiation and have no well-developed knowhow on how to mobilize the venerable community of the woreda. As a result, they have a gap of mobilizing the community for health activities. It is said that this limited their ability to establish active communication and relationship with their clients is the most important precondition for social interaction.

Social impacts and linkages: HEWs explained that there are no positive social environments that encourage their work. People's awareness, attitude and value to their activities are declining through time.

Generally, HEWs reported that the absence of capacity building training from them and working situation is becoming boring for the reason which they did not satisfied.

Limited support from the leadership: According to HEWs, the AAHB administrators, higher officials in the woreda and community leaders are reluctant to work and coordination with them. However, they indicated that local government bodies possess significant authority that enables them to promote the recognition of HEWs.

4.5. Summery

The Centers for Disease Control and Prevention define health communication as the study and use of communication strategies to inform and, influence individual and community decisions that enhance health.One of the key objectives of health communication is to influence individuals and communities. The goal is admirable since health communication aims to improve health outcomes by sharing health related information.

According to FMOH (2007) Ethiopia introduced ahealth policy and health development program that targets disease prevention.in the implementation of the health extension packages. Female Health Extension Workers (HEWs) are assigned at each health post and each village. They are regular employees and salaried.

The government, society, stakeholders and the health extension workers themselves has to contribute their share for the improvement of this sector by producing qualified health extension workers.

The improvement updating of health extension workers efficiency by training is probably the most important question that all HEWs have to be addressed as quickly as possible. But it found that this is negatively affecting the motivation, commitment and accountability of the community not given respect.

They ascertained that this is creating a feeling of reluctance among them which seems threat to continue of HEP program.

Most of the time the HEWs use home to home communication this is difficult to adders each home and when they go to individual home they get women this also make gender difference women cannotdo every things without the interests of husband . The gender based group structure raises negative attitude from the communities' knowledge, beliefs and norms.

The leaders of one-to-five group that assigned by the woreda highest leader the aim is not only health message transmitter but it used different political and socio economical messages. These not make the communities comfort to discuss freely.

CHAPTER FIVE

5. Conclusions and Recommendations

This research has explored communication strategies, and particularly community participation, in the Health Extension Program to reduce HIV/AIDS in the urban areas of Addis Ababa Nifase Silk Lafto sub city as a case study.

It has specified particular attention to explore strategies of health communication program and whether there is community participation or not. This chapter pressing up by presenting the general idea of the findings and, based on them, listing down what has to be carried out in the future for the sake of rectification of the health extension program on the issue of HIV/AIDS

5.1. Conclusions

With regard to communication strategies used by the health extension workers mainly depends on interpersonal communication, door to door communication and team communication. Among those methods of communication, interpersonal communication has a better acceptance by the community and the health extension works. In relation to door to door communication, the people are mainly informed that it is not that communications direct advantage but it will give the opportunity for the health extension workers to get the husbands directly. Contrary to this, in this door to door communication, it is difficult for the health extension practitioners to reach each individual's home.

The health related structures which are created for women are not effective; they do not match with the community's culture and belief. Rather than solving the communities health related problems, these structural organizations create misunderstanding and dispute among the family members. As per the structure, the wife does not perform any actions without her husband's good will and permission. Even if such structures mainly consist of women, these women who get such skills and knowledge from the health extension practitioners are not able to employ the information without the consent of their husbands.

The communities' attitude towards the health extension workers is more or less not positive. This is because the communities' original opinion about the health extension workers greatly differs from those who assigned to work with the community. Accordingly, the extension workers are

usually engaged in writing reports to their higher leaders. The reason why they are not successful in their practical performance is that almost all of them are not updated by training. This situation seems to have pushed the community to believe that they do not have the appropriate knowledge and skills for the job. This adversely affects the success of the health extension program.

There is no clear understanding between the health extension structure and the communities.This means the communities see the one –to-five structures as something that stand for political purposes rather than for health related issues.

Confrontation with traditional healers in the HEP; expectation of clients for more health service and the effect of 'time' were considered the major factors. The combination of these factors has certainly affected the credit and relevance to health services of HEWs.

According to the policy documents and others, the Ministry of Health recommends the implementation of a participative development process. However, the concerned health workers are not able to employ this method and they usually resort to the top-down style of communication.

5.2. Recommendation

- When the government approved the health extension program, 75% is based on prevention mechanisms. Accordingly, to achieve this mission, assigning skillful and knowledgeable health extension workers in the sector is of paramount importance.
- Especially those professionals who satisfy the needs of the community and those who have the ability of social mobilization and interpersonal communication are likely to be effective; so, attention has to be given to this issue of the selection of health workers who are qualified and who are familiar and have good understanding the culture and beliefs of the community.
- With regard to the structure, there should be a clear idea and procedure on how to work with it. The community always perceives the structure of one-to-five as a political tool other than its formal purpose that is serving the community as a preventive health set up. It is important for development community to know why the time and efforts would be spent on programs that are not compatible with bringing about development.

- Health army group based on gender should be restructured to include both sexes because this is likely to help develop men's awareness that might help communities find culturally appropriate ways to change existing beliefs, attitudes and social norms that restrict gender equity and equality.
- The planning on the health extension program should be based on identifiable purposes by the community members in order for them to be accepted and implemented as recommended.
- To prevent the spread of HIV/AIDS in the city as well as the country in general the regional and the federal government must be reduce the youth immigrants which came across to searches work and must create jobs opportunity to the youths in their regions that caused more HIV venerability in the city.
- The government as well as the community must week up in the deep sleep of to protect from HIV since the disease prevalence is still increasing.
- The media houses must take due attention the issue of HIV/AIDS prevention and controlling role for social response.
- The higher government administrative bodies must give attention to incorporate the issues of HIV/AIDS prevention and controlling role as a basic agenda.
- Brokers who work to connect the worker and agents must be awarded and decided to work legally while they pushes the young girls to do sex worker even they are fresh for practices this with the broker .
- Harmful substances like chewing chat , smoking cigarette and shisha are factors that affect to the youths more venerable to HIV/AIDS and other sexual transmitted disease, it be need legal solve the problems .
- This research encourages further research on the area; especially the wide fluctuation of the youth from rural to urban increases the venerability of HIV/AIDS.

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Appendixes

Appendix 1

Data Gathering Instrument Guide The purpose of this instrument is to gather data for a master thesis as a partial fulfillment of master's degree in Journalism and Communication. I am very grateful to thank you for your kind cooperation in advance!

Interview questions for Woreda Health officers and the Health Extension Workers

1. What is the role of Health Exertions program to reduce HIV?
2. What kinds of communication strategies have you been used to reduce HIV/AIDS in the Health Extension program?
3. Are there active stakeholders of audiences to address the program?
4. What is their individual role in the communication process?
5. What kind of Persuasive communication techniques are used in the health extension program for addressing the issue of HIV for urban community?
6. Have you used a media for this program? If you have been used what kind of media?
7. What can the community do to address the issue of HIV/AIDS?
8. What can the health Professionals do to address the issues of HIV/AID?
9. Are the Health Extension Workers capable in communication strategy?
10. What are the cultural factors within the community were deterrents to effectively addressing HIV/AIDS?
11. How can solve those Cultural problems?
12. Is there community participating in the designing, implementation, evaluation process of Health communication?
13. Is there know the community change knowledge, attitudes, or behavior on the HIV/AIDS issues? Did it occur as a result of the group discussion programs?

14. Does the HEP that used to reduce HIV/AIDS achieve the intended goal?

15. Can the changes in outcomes be explained by the program, or are they the result of some other factors occurring simultaneously?

16. Are successful Communication activities in the program being expanded to apply to other audiences or situations?

17. What were the major challenging problems in communicating the community about the issue of HIV/AIDS?

18. What kind of relation do you have between the community and you?

19. Who developed communication strategy (individual, the community or involvement of communication specialist)?

20. Was there any research done to ascertain what would work in such a strategy?

21. Can you please describe your view of the current communication process between the Health Extension program and the community with regard to the HIV/AIDS?

22. What would you say that the Health Extension program had any successes (if any) with the current communication strategy used?

Appendix 2

Points for focus group discussion

1. How do you see the current HIV/AIDS spreading condition?
2. What are the basic causes for the revival of HIV/AIDS?
3. How do you know that cause for HIV/AIDS?
4. Is there in your Keble venerability factors for HIV/AIDS? How can solve it?
5. What is the important of, community conversation/BCC to reduce HIV/AIDS?
6. Did you get vocational training by Health officer trainers of this program?
7. How did you learn or come to know about the community conversation to reduce HIV/AIDS in the health Extension program?
8. What Motivate you to join in the community conversation groups?
9. As a community conversation member, in what kind of activities do you participate?
10. In what ways do you participate in changing the conditions in your village related to HIV/AIDS?
11. Does your tradition allow such kind for solution to avoid HIV/AIDS venerability?
12. What recommendations can you present to improve this Health Extension Program?
13. How does your group member usually exchange information about HIV/AIDS?
14. How far your communication approaches were culturally appropriate?

Appendix 1

የአዲስ አበባ ዩኒቨርስቲ የጋዜኝነትና ኮሙኒኬሽን ድኅረ ምረቃ ት/ቤት "ሁለተኛ ዲግሪ (MA) ማሟያነት የሚደረግ ጥናታዊ " የሚሞላ መጠይቅ

መግቢያ፡

ይህ መጠይቅ በአዲስ አበባ ዩኒቨርስቲ የጋዜኝነትና ኮሙኒኬሽን ድኅረ ምረቃ ት/ቤት "ሁለተኛ ዲግሪ ማሟያነት የሚደረግ ጥናት የሚሞላ ነው፡፡ በመሆኑም ዓላማውም ሆነ አገልግሎቱ ለጥናቱ ብቻ የሚሆን መረጃ መሰብሰብ ነው፡፡

ጥናቱ በከተማችን በአዲስ አበባ እየተካሄደ ባለው የከተማ ጤና ኤክስቴንሽን መርሐ ግብር ውስጥ ከተካተቱት ፓኬጆች አንዱ የሆነውን ኤች አይ ቪ/ ኤድስ ፕሮግራም በመውሰድ በዚ" ዙሪያ የነዋሪዎችን አስተሳሰብ ለመለወጥ የአዲስ አበባ ከተማ አስተዳደር ጤና ቢሮ የተጠቀመባቸውን የመልዕክት ማስተላላለፊያ ዘዴዎች ብቃት በመገምገም ላይ ያተኩራል፡፡ ጥናቱ በንፋስ ስልክ ላፍቶ ክፍለ ከተማ የሚገኘውን አንድ ወረዳ (ወረዳ 11 እንደ ማጣያ ስለሚወስድ ይህንን መጠይቅ የሚሞሉት ከወረዳው ነዋሪዎች ውስጥ የተመረጡ ሰዎች ብቻ ናቸው፡፡

የቃል ጥያቄዎች ለወረዳ የጤና ባለሙያዎች እና ለጤና ኤክስቴንሽን ሠራተኞች፡-

1. **ኤች አይ ቪ/ኤድስን ከመከላከል አኳያር የጤና ኤክቴንሽን ፕሮግራም ሚና ምንድን ነው**

2. **በጤና የኤክስቴሽን ፕሮግራም የኤች አይ ቪ/ ኤድስን ስርጭትን ለመቀነስ ምን አይነት የኮሙዩኒኬሽን እስትራቴጂዎችን ትጠቀማላችሁ?**

3. **የኤች አይ ቪ/ ኤድስን ፕሮግራም ለማከናወን ንቁ ባለድርሻ አካላት አሉ?**

4. **በኤች አይ ቪ/ ኤድስ ኮሙኒኬሽን ሂደት የእያንዳንዳቸው ባለድርሻ አካላት ሚና ምንድን ነው?**

5. **በከተማ አካባቢ ለሚኖሩ የማህበረሰብ ክፍሎች ኤች አይ ቪ/ ኤድስን ስርጭት ለመቀነስ ምን አይነት የኮሙኒኬሽን ስልቶችን ትጠቀማላችሁ?**

6. ለዚሁ ፕሮግራም ሚዲያ ተጠቅማችሁ ታውቃላችሁ ተጠቅማችሁ የምታውቁ ከሆነ ምን አይነት ሚዲያ?

7. የኤች አይ ቪ ስርጭትን ለመቀነስ በሚከናወኑ ተግባራት ህብረተሠቡ ምን ማድረግ ይጠበቅበታል?

8. የኤች አይ ቪ/ ኤድስን ስርጭት በተመለከተ ሚዲያው ምን ማድረግ አለበት ብለው ያስቡ ?

9. የጤና ኤክስቴንሽን ባለሙያዎች የኮሙዩኒኬሽን ክህሎታቸውን እንዴት ያዩታል ?

10. የኤች አይ ቪ/ ኤድስን ስርጭት ለመቀነስ በህብረተሠቡ ውስጥ ያሉ የባህል ተግዳሮቶች አሉ? ካሉ የትኞቹናቸው?

11. እነዚህን የባህል ተግዳሮቶች እንዴት ማስወገድ ይቻላል?

12. የጤና ኮሙኒኬሽን በማዘጋጀት፣ በመተግበሩ እና በመፈፀሙ በኩል የህብረተሠቡ ተሣትፎ ምን ይመስላል እንዴትስ ይገልጹታል?

13. ስለ ኤች አይ ቪ/ ኤድስ ህብረተሠቡ የባህሪ፤ የአመለካከት እና የእውቀት ለውጥ አለው ብለው ያስባሉ? አለ ካሉ በምን ምክንያት የመጣ ነው?

14. የጤና ኮሙኒኬሽን ፕሮግራሙ የታቀደለትን ግብ አሣክቷል ብለው ያስባሉ ?

15. ውጤታማ የኮሙዩኒኬሽን ክንውኖች እየተስፋፉ ከሆነ በምን ያረጋግጣሉ ?

16. ስለ ኤች አይ ቪ/ ኤድስን ስርጭት ህብረተሠቡን ኮሙዩኒኬት ለማድረግ የገጠሟችሁ ዋና ዋና ችግሮች የትኞቹ ናቸው?

17. በእናንተ እና በህብረተሠቡ መካከል ያለው ግንኙነት ምን አይነት ነው?

18. በኮሙዩኒኬሽን ስትራቴጂው ትግበራ ወቅት የሕብረተሰቡ ሚና ምንድን ነው?

19. በዚህ ስትራቴጅ ምን መሠራት እንዳለበት የተሠራ ጥናት ነበረ?

20. ኤች አይ ቪ/ ኤድስን ስርጭት በሚመለከት በአሁኑ ወቅት በህብረተሠቡ እና በጤና ኤክስቴንሽኑ መካከል ያለውን ኮሙዩኒኬሽን በእርስዎ አስተያየት እንዴት ይገልፁልኛል?

21. አሁን ከምትጠቀሙበት የኮሙዩኒኬሽን እስትራቴጅ (ስልት) አንፃር የጤና ኤክስቴንሽን ፕሮግራም ውጤታማ ነው ማለት ይቻላል

22. አሁን ስለሚሰጠው የጤና ኤክስቴንሽን ኮሙኒኬሽን ፕሮግራም ኤች አይ ቪ/ኤድስን ከመከላከል አንፃር ያለውን ውጤታማነትና ድክመት እንዴት ይገልጹታል?

Appendix 2

ጥያቄ ሁለት የቡድን ውይይት ጥያቄዎች

1. አሁን ያለውን የኤች አይ ቪ/ ኤድስን የስርጭት ሁኔታ እነዴት ያዩታል?

2. ለኤች አይ ቪ/ኤድስን ስርጭት ዋና ዋና ምክንያቶች የትኞቹ ናቸው?

3. በአካባቢያችሁ ለኤች አይ ቪ/ ኤድስ ስርጭት ምክንት የሆኑ ነገሮች ምንድን ናቸው?

4. ለኤች አይ ቪ/ ኤድስ ስርጭት ምክንያቶች መሆናቸውን እንዴት ማወቅ ይቻላል?

5. እነዚህን አጋላጭ ነገሮች እንዴት ማስወገድ ይቻላል?

6. የማህበረሰብ ውይይት ማድረግ የኤች አይ ቪ/ ኤድስን ስርጭት ለመቀነስ ያለው ጥቅም ምንድን ነው ብለው ያሰባሉ?

7. ስለፕሮግራሙ ለጤና ባለሙያዎች ትምህርታዊ ሥልጠና ተሠጥቷችኃል?

8. በጤና ኤክስቴንሽን ፕሮግራም ስለ ኤች አይ ቪ/ኤድስ እንዴት ነው የምታውቁት ወይም የምትማሩት?

9. የማህበረሰብ ውይይት ማድረግ ኤች አይ ቪን ለመቀነስ ያለው ሚና ምንድን ነው ?

10. የማህበረሰብ ውይይት አባል እንደ መሆንህ/ሺ በምን አይነት ተግባራት ትሣተፋለህ/ሽ?

11. በአካባቢያችሁ ያለውን የኤች አይ ቪ/ኤድስ ስርጭት ለመቀነስ የናንተ ድርሻ ምንድን ነው ?

12. ይሄንን የኤች አይ ቪ/ኤድስ የጤና ኤክስቴንሽን ፕሮግራም ለማሻሻል ምን መደረግ አለበት ትላለህ/ሽ?

13. **የእናንተ የቡድን አባላት ብዙውን ጊዜ ስለኤች አይ ቪ/ኤድስ መረጃ የመለዋወጡ ሂድት ምን ይመስላል?**

14. **የምታደርጉት ኮሙኒኬሽን ከባህል አንፃር ምን ያክል ግልፅና ተገቢ ነው ብለው ያስባሉ?**

Appendix3 List of Informants In-depth personal interview

No	Position	Sample HIV venerable ketana	Educational back ground	Gender
1	Peer Leader of FSWs	Ketana 1	Grad 7	F
2	Peer Leader of FSWs	ketana 3	Grad 10 complete	F
3	Peer member of FSW	ketana 7	Grad 4	F
4	Peer member of FSW	ketana 8	Illiterate (no read and write)	F
5	Leader of Youth center	Ketana 1	BA degree	M
6	Participant of Youth center	ketana 3	Grad 8	F
7	daily laborer 1	ketana 7	Grad 7	F
8	daily laborer 2	ketana 8	Grad 6	M

Appendix 4 List of Respondent in FGD

No	Sample HIV venerable *ketana*	Number of FGD participant	Place of FGD
1	Ketana 1	6	In the health post
2	ketana3	6	Around the group leader home
3	ketana7	6	Center their home
4	ketana8	6	In the health post
total	4	24	

Appendix 5. List of Key Informants In-depth interview

No	Position	Name of the place they worek	Educational back ground	Gender
1	woreda Health Office Head	Woreda 11	BSC in HO	F
2	Woreda Supervisor	Woreda 11	BSC in HO	F
3	Woreda Heath Extension Worker	Ketana 1	BSC Nurse	F
4	Woreda Heath Extension Worker	Ketana3	BSC Nurse	F
5	Woreda Heath Extension Worker	Ketana7	BSC Nurse	F
6	Woreda Heath Extension Worker	Ketana8	BSC Nurse	F
7	Woreda Health Office 1	Woreda 11	BSC in HO	F
8	Woreda Health office 2	Woreda 11	BSC in HO	F