

**Investigating the Impact of Media Advocacy in Framing
Accessibility of Antiretroviral Treatment in Ethiopia:
A Social Work Perspective**

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Abbreviations and Acronyms

| | |
|---------|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| ANC | Antenatal Clinic |
| ARC | AIDS Resource Center |
| ART | Antiretroviral |
| ARVD | Antiretroviral Drugs |
| BCC | Behavior Change Communication |
| CBOs | Community Based Organizations |
| CDC | Center for Disease Control and Prevention |
| FBOs | Faith Based Organizations |
| GO | Governmental Organizations |
| HAPCO | HIV/AIDS Prevention and Control Office |
| HBC | Home Based Care |
| HCs | Health Centers |
| HEC | Health Education Center |
| HIV | Human Immuno-deficiency Virus |
| IEC | Information Education Communication |
| JHU | Johns Hopkins University |
| MOH | Ministry of Health |
| NGO | Non-Governmental Organization |
| OIs | Opportunistic Infections |
| PEPFAR | President's Emergency Program for AIDS Relief |
| PLWHA | People Living With HIV/AIDS |
| PMC | Population Media Center |
| PMTCT | Prevention of Mother To Child Transmission |
| RHAPCOs | Regional HIV/AIDS Prevention and Control Office |
| RHBs | Regional Health Bureaus |
| UN | United Nations |
| UNAIDS | Joint United Nations Program on HIV/AIDS |
| VCT | Voluntary HIV Counseling and Testing |
| WHO | World Health Organization |

Abstract

In Ethiopia poor health care infrastructure, stigma, low collaboration and coordination among agencies, and sustainability issues have endangered accessibility of Antiretroviral Treatment (ART) by PLWHA. Paramount among the stakeholders strategy to address these problems is advocacy using media as a significant tool. This research is a quantitative and qualitative research based on survey and key-informants interview with ART stakeholders of governmental organizations, non-governmental organizations, hospitals, US based universities, PLWHA associations and media agencies to investigate challenges, barriers and best practices of media advocacy to address accessibility of ART synergistically.

According to the study, all stakeholders responded that there is a huge information gap of ART among the public. More than 82% of the stakeholders are engaged on advocacy and over 81% of them responded radio and/or TV is the best channel of advocacy tool. Even though 36% of the stakeholders responded that they have produced ART related broadcast messages, none of them are aimed to influence policies and decision makers to advance services of ART. Over 58% of the stakeholders responded that collaboration among themselves and with the media agencies to undertake vigorous media advocacy activities is not satisfactory. This study contrary to the fear appeal approach relies upon person-in-environment concept of social work and systems theory to improve accessibility of ART at various systems level. The study concluded that media advocacy practices by the stakeholders are limited and suggests media advocacy tool and recommendations for future directions.

CHAPTER ONE: Introduction

1.1 HIV/AIDS in Ethiopia

1.1.1 History and Epidemiology of HIV

HIV/AIDS is the greatest health crisis the world faces today. In two and a half decades, the pandemic has claimed nearly 30 million lives and 14, 000 new infections occur daily. Today some 37.8 million people (range 34.6-42.3 million) are living with the virus, 95% of them are found in developing countries (UNAIDS & WHO, 2004). Sub Saharan Africa, with only 10% of the total world population, is carrying the burden of 80% of the world HIV infection and AIDS cases.

Ethiopia is among the most heavily affected countries in the world by the HIV/AIDS epidemic. With an estimated 1.5 million people living with HIV/AIDS and a national prevalence rate of 4.4% (12.6% urban and 2.6 rural), Ethiopia is one of the hardest hit countries by HIV/AIDS epidemic (MoH, 2004; UNAIDS, 2005).

HIV infections were first reported in Ethiopia in 1984. HIV prevalence remained low in the 1980s but sharply accelerated through the 1990s, rising from an estimated 3.2 % in the 15-49 age groups in 1993 to 10.63 % by the end of 1999 with similar increases in various population subgroups (MoH, 2004). Since the first reporting and detecting the first case in 1986, the HIV epidemic has evolved into a generalized epidemic and AIDS is now the leading cause of morbidity and mortality among adults in Ethiopia (Health Education Center, 2004). It was also found that 7.8% of Antenatal Clinic attendees in the age group of 15-24 years were HIV positive. This age group, most likely being the sexual debut period, can be a proxy for new infections thus indicates high incidence of HIV with

12.9% prevalence in urban, 4.2% prevalence in rural and 9.0% national prevalence among the same group (MoH, 2005).

Ethiopia's population is characterized by the younger generation, with 45% of the total population under 15 years of age. Young people are especially vulnerable to HIV/AIDS. Other vulnerable population groups include female sex workers, unemployed people, long-distance truck drivers, migrant workers and internally displaced populations (WHO, 2005). HIV in Ethiopia is predominantly spread through unprotected heterosexual intercourse, which accounts for approximately 88% of all HIV infections. Mother or parent to child transmission (MTCT) accounts for 8-10%, and 2-5% of HIV infections can be attributed to blood and blood-contaminated products (MoH, 2005).

Among the largest countries in Africa, few published data are available that describe the Ethiopia epidemic on a national scale. In Ethiopia, although surveys and case reporting are taken as sources, the main source for HIV surveillance trend data is the antenatal clinic (ANC) based HIV sentinel surveillance system (UNAIDS & WHO, 2003). The HIV epidemiology presented in this study is acquired through modeled surveillance data (using Epidemic Projection Package and Spectrum software) and from antenatal clinics (ANCs).

According to these sources of data, an estimated number of 1.5 million people living with HIV (PLWHA) are found in Ethiopia, out of which 817,000 are women and 96,000 are children under 15 years. Deaths due to AIDS brought down life expectancy gains from a projected 53 years in 2001 to 46 with the impact of HIV. If the current death trend continues the projected life expectancy gain to 59 years in 2014 will be reduced to 50 years (MoH, 2004).

Hladik, Shabbir, Jelaludin, Woldu, Sehaynesh, Tadesse (2006) show, modeled data suggested a rise in prevalence of HIV in Ethiopia. In 2003 in rural areas the prevalence rate was 6% and 4.4% in all of Ethiopia, but a stable prevalence of 14.6% was observed in Addis Ababa and 11.8% in other urban areas. Other sources also projected the urban epidemic has peaked and it is expected that prevalence in urban areas is going to remain steady up to 2008, whereas in rural areas it will increase steadily and may reach 3.4 % from current level of 2.6% (MoH, 2005).

The number of new AIDS cases in 2003 is estimated as 98,000 and 25,000 for adults and children respectively. In the same year there were approximately 90,000 adult and 24,000 pediatric AIDS deaths. Since 2004, there are an estimated 105,453 and 27,226 new AIDS cases in the adult and children population respectively, and some 90,000 adults and 25,000 children have died of AIDS (MoH, 2005).

In the years 2003 and 2004, there were 128,000 and 138,000 HIV-positive pregnant women and 35,000 and 34,000 HIV positive births, respectively. Among children, it is estimated that there were a total of 96,000 and 104,000 children living with HIV; 4,900 and 37,500 new HIV infections; 25,000 and 27,000 new AIDS cases and 25,000 and 27,000 deaths in 2003 and 2004 respectively (CDC, 2004).

According to published information on history and epidemiology of the virus, HIV/AIDS has affected all segments of the country since the first infection report in 1984. Now the HIV epidemic has become a generalized epidemic with impacts on all sections of the larger community especially on the vulnerable groups of youth, children and women. With its high prevalence rate, decreasing life expectancy and increasing mortality and morbidity rate in various population subgroups especially on the young

generation in rural areas, HIV/AIDS has inevitably evolved as the main development threat of the country.

1.1.2 Impacts of HIV/AIDS in Ethiopia

In Ethiopia HIV/AIDS is one of the key challenges for overall national development. It has led to a seven years loss in life expectancy, close to a million orphans and a loss of productivity and income at the workplace with severe effects at the household and community levels. The high rate of morbidity and mortality associated with HIV/AIDS has strongly affected all sectors and communities and by now it is perceived not as a health challenge but as a development challenge of the nation.

In macro level as World Bank (2000) stated, AIDS is already causing a one percent annual reduction in economic growth in Ethiopia, which together with declining life expectancy and labor force reduction, is undermining the country's efforts to reduce poverty through improvements in health, education, agricultural production and household food security. Therefore, HIV/AIDS now poses the foremost threat to Ethiopia's development, and its future depends on responding to the epidemic fast and forcefully.

On a micro level the impacts of HIV/AIDS on individuals and communities is evident and large population groups are carrying the burden of the disease. While the relative burden of AIDS is increasing and despite the relatively lower prevalence and incidence rates, the biggest share (number of HIV infections, AIDS cases and AIDS deaths) is increasingly borne by rural Ethiopia. The rural women are increasingly bearing the brunt of the disease and its impact because of the significant gender inequalities,

lower socio economic standings which resulting in higher stigma, discrimination and poorer access to public health services (MoH, 2004).

HIV patients are the most affected by the disease. As a result of the infection, they endure extended period of pain and suffering. High cost of treatment and medication erodes their financial savings and makes them become dependent on family and friends. With 31% of the population earning under \$1 dollar a day the marginal existence of HIV patients becomes critically overstretched (MoH, 2005). Illness, absenteeism and eventual loss of employment undermine their ability to support themselves. In addition, stigma associated with the disease fosters society's alienation of HIV patients in the household, community and workplace (MoH, CDC, I-Tech, JHU, USAIDS & Walta, 2005).

1.2 Background to the Problem

1.2.1 Antiretroviral Treatment (ART)

Anti-Retroviral Treatment (ART) is the administration of at least three different medications known as Anti-Retroviral drugs (ARV) in order to suppress the replication of the human immunodeficiency virus (HIV). Treatment with these combinations of drugs is also known as Highly Active Antiretroviral Therapy (HAART). As Linsk & Bonk (2000) indicate:

Combination therapy consist of three or more agents, at least one of which is a protease inhibitor. The various types of antiretroviral drugs act on different stages in the process of viral replication to try to stop the virus from reproducing. This strategy is to try to intervene using combinations of drugs to attempt to intervene and block viral replication at least two different points in the replication process in order to arrest further copies of the virus (p. 213).

Antiretroviral Treatment has a fundamental impact on our thinking about HIV/AIDS and with its advent most of HIV intervention programs are changing their

essence; for instance home care would shift from carrying for a dying patient to ensuring adherence to treatment (Birhanu, 2005). The treatment and care, therefore, has the promising potential to make HIV/AIDS more of a manageable chronic illness with restored economic productivity and social functioning. This in the end has an important implication for prevention because it lessens the cost of HIV in the society by reducing the number of deaths and AIDS orphans. But these effects have been seen only in settings where resources were available to make the drugs accessible and where health services are capacitated to optimize the sustained, safe and effective use of ART (Gant, 2000). In sub Saharan countries like Ethiopia where these resource settings are not in place the advent of ART can't change the situation of PLWHA. The clear AIDS treatment gap and its effect between Sub-saran countries and developed countries is overwhelming (see Figure 1).

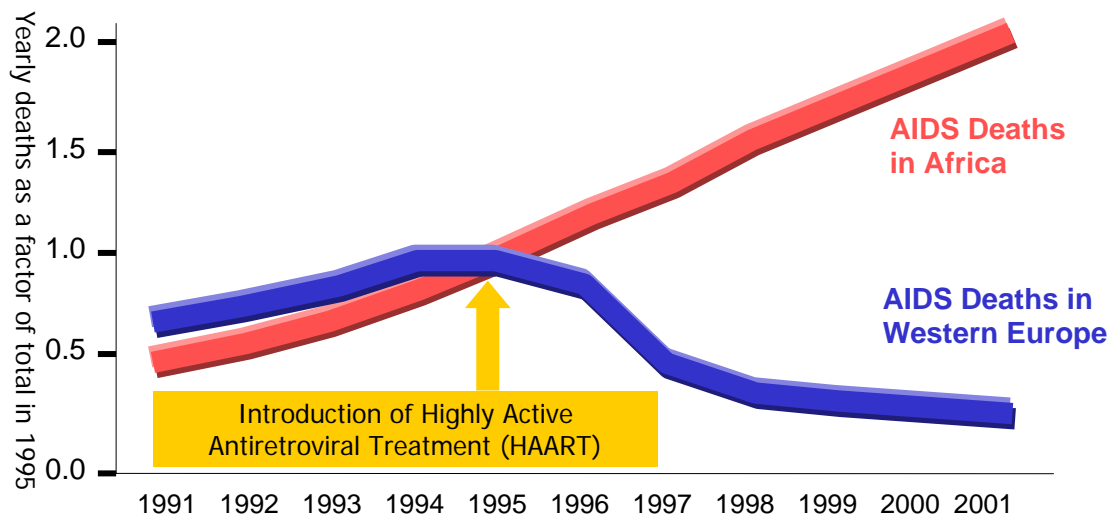


Figure 1 Widening Gap of AIDS Treatment

Source: WHO/UNAIDS Statistics & HIV/AIDS Surveillance in Europe, End-year report 2001, No 66, CESES

In the industrialized countries, where access to regular care and treatment systems is possible given the prior educational and employment skill, lack of structural inequality and with the existence of good federal legal and policy support the right of PLWHA for access and human rights respected, they are reaching a level know as ‘Lazarus Effect’. Lazarus effect is a concept of Christian belief where Jesus Christ resurrected a man from the dead and it was one of the miracles recorded in the gospel of John (John 11:43-44).

In the origination of this term Larry (2000) states:

In 1996, the term Lazarus Effect applied only to the rapid response to protease inhibitors and later combination treatment. ...far from simply eliciting a positive response to medication, the Lazarus Effect now conflates notions of medical care response, quality of life, and return to work (p. 206).

This “miraculous” recovery to normal life through combination therapy seems not a good news for third world countries like Ethiopia, where the preconditions to effect this level of life are not in place. Larry (2000) is right in saying the Lazarus Effect is not necessarily a good news for people in locations in which HIV/AIDS cases are increasing and for whom access to care, adherence, and educational and occupational skills pose significant challenges.

1. 2.2 Barriers to Scale up ART in Ethiopia

1.2.2.1 Governance and Coordination

The government of Ethiopia has demonstrated increasing efforts of combating the epidemic since the late 1980s (MoH, 2004). A National Task Force on HIV was established in 1985, and two medium-term prevention and control plans were designed and implemented between 1987 and 1996. A comprehensive HIV/AIDS policy was adopted in 1998 outlining strategies for HIV prevention, care and support and targeting

vulnerable groups. The National AIDS Prevention and Control Council was established in 2000 under the leadership of the President and oversees the implementation of the federal and regional HIV/AIDS plans, examines and approves annual plans and budgets and monitors planning, performance and impact (WHO, 2005). But in light of the changes observed there are also comments that the Ethiopian government does not appear focused on AIDS, despite occasional statements on the issue. Healthcare workers privately have criticized efforts in recent years as half hearted; and UN officials have publicly warned Ethiopian leaders to take more measures to stem the epidemic (Gordon, 2002).

In 2003, WHO/UNAIDS estimated Ethiopia's total treatment need to be 200 000 people, and the WHO "3 by 5" treatment target was calculated at 100 000 people by the end of 2005 (based on 50% of estimated need). In 2004, WHO/UNAIDS estimated that Ethiopia's total treatment need had risen to 211,000 people. The government-declared a national treatment target of 100,000 people by the end of 2006. In January 2006, the government launched a program to provide universal access to antiretroviral therapy free of charge and made a commitment to roll out the program across the country (WHO, 2005). But so far only 26,000 individuals were receiving antiretroviral therapy in Ethiopia.

The national response to scale up ART needs multi-sector cooperation and coordination and should engage the public sector, private sector, nongovernmental organizations, faith-based organizations and community-based organizations. All African countries including Ethiopia with medium to high prevalence rates has a national treatment plan in place. Many of the countries have some money from the Global Fund,

or the World Bank, or the Clinton Foundation, or the Gates Foundation or the United Nations family or bilateral donors or President's Emergency Program for AIDS Relief (PEPFAR). What they need now exactly is the capacity to give overall co-ordination and direction so that the treatment regimens succeed (Lewis, 2004).

1.2.2.2 Health Infrastructure

HIV/AIDS is one of the key challenges to overall national development in Ethiopia. It has led to a seven-year loss in life expectancy, close to a million orphans and a loss of productivity and income at the workplace with severe effects at the household and community levels (MoH, 2005). The high rates of morbidity and mortality associated with HIV/AIDS have strongly affected the health sector and are among the major impediments to delivering quality care to its full capacity.

In January 2005, the government of Ethiopia launched a program to provide universal access to antiretroviral therapy free of charge and made a commitment to roll out the program across the country. The national road map for scaling up access to antiretroviral therapy plans to provide treatment to 100 000 people by the end of 2006. A total of 88 health facilities have been identified for providing antiretroviral therapy for all parts of the country (WHO, 2005). But with the present figure of only 26,000 individuals who are receiving ART the plan seems unattainable.

With 119 hospitals and 412 health centers, Ethiopia's health infrastructure has the potential to scale up access to antiretroviral therapy, but there is a substantial shortage of health workers to serve the needs of a rapidly expanding population. This shortage is aggravated by high turnover among health workers, especially physicians and counselors, throughout Ethiopia (WHO, 2005). Antiretroviral therapy is provided only at referral and

provincial hospitals. Scaling up antiretroviral therapy services would require an extension within the health system to include more peripheral facilities. Systems to procure and distribute drugs and surveillance, monitoring and evaluation systems also need to be strengthened. Moreover, both the availability and demand for testing and counseling will have to be increased substantially. Gordon (2002) competently states Ethiopia's health infrastructure capacity as follow:

Ethiopia has never had a viable national healthcare system because of overwhelming poverty and years of war. The government is soliciting international assistance to build its capabilities, but progress on this front is likely to take years (p. 63).

1.2.2.3 Stigma and Misconceptions

As a guiding principle, the 3 Million By 2005 plan clearly places the needs and involvement of people living with HIV/AIDS at the centre of all of its program (WHO, 2003). Stigma, denial and fear of disclosure due to discrimination among HIV/AIDS-affected persons continue to fuel the epidemic and remain a serious impediment to any treatment efforts in Ethiopia. In Beneshangul-Gumuz, the stigma attached to the diagnosis of HIV/AIDS was found to be so strong that health workers were afraid to pronounce the diagnosis of AIDS; thus no clinical or serological diagnosis was attempted (UNAIDS, 1997; Kloos, 2000). There are enormous areas in Ethiopia where due to stigma and discrimination access to ART is unthinkable.

Stigma and discrimination are among the biggest challenges for HIV patients as they would be reluctant to get treatment, care and support for fear of alienation. Preventing and reducing stigma is vital so that people are not discouraged from using and helping others on ART. Because of stigma, patients are forced to take their medications

in secrecy increasing the likelihood of non-adherence (MoH, CDC, I-Tech, JHU, USAIDS & Walta, 2005).

1.2.2.4 Sustainability

A major concern of the National ART Program is how to sustain a life long supply of free ART for all those on treatment. Since the ART program is supported by donors such as the Global Fund for HIV/AIDS, Tuberculosis and Malaria and the US government's Ethiopian AIDS Emergency Plan, a complete dependence on donors' commitment might be vexing (MoH, 2005). In order to address this issue, national leaders and policy makers have recommended various approaches to assure sustainability. These resource mobilization and cost saving strategies include establishing cost sharing with income sliding scale, encouraging workplace ART initiatives, approaching local groups and persons in the Diaspora for support, promoting public-private partnerships and most importantly promoting local production of ART (MoH, 2005).

1.2.3 The Need for ART Communication

Ministry of Health of the Ethiopian government has developed a document on accelerating access to HIV/AIDS treatment in Ethiopia which is a road map from 2004-2006. On the road map the communication component for ART is mentioned as the main element of the document.

Of the mentioned activities, two of them remarkably call for the need of effective communication to ensure the achievement of the plan. They are:

- Developing a training package for media practitioners', gatekeepers and policy makers and
- Conduct a public drug literacy campaign, import public and private media outlets. Establish a comprehensive communication/education strategy, and establish an assessment tool commensurate with the strategy to ensure that the strategy is meeting its objective at all levels.

The tremendous impact of media in addressing and dispelling all the above mentioned obstacles for a better access and utilization of ART through advocacy work seems disregarded. Journalists shy away from adopting an overtly proactive response to HIV advocacy on the grounds that they must remain neutral and objective commentators (Falobi & Babingbetan, 2000). It has been argued that this results in the failure of the media to use its influence in AIDS policy-making and agenda-setting (Backstrom & Robins, 1998).

1.2.3.1 Service information of ART

The Survey conducted by Population Media Center showed that there seems to be a shift in source of information on HIV/AIDS and related issues from the traditional social gathering to electronic media. The proportion of women and men who relied on social gatherings for HIV/AIDS information has decreased by 70 percent and 54 percent, respectively, since the baseline survey. For instance, women who get HIV/AIDS- related information from radio and TV increased by 12 percentage and 36 percentage, respectively (Population Media Center, 2005).

The need for information in relation to HIV/AIDS in general and on ART in particular is very great, which can be depicted from the hotline service being given by the National AIDS Resource center in the country. Accordingly 85.18% of the 280,000 hotline calls were in need of HIV related information and 87.72% of inquirers were not tested (see Figure 2 & 3). This gives glance information that people who do not know their status are in need of information on issues related to HIV/AIDS and proper information delivery might leads them to VCT centers and through VCT centers to ART service delivery.

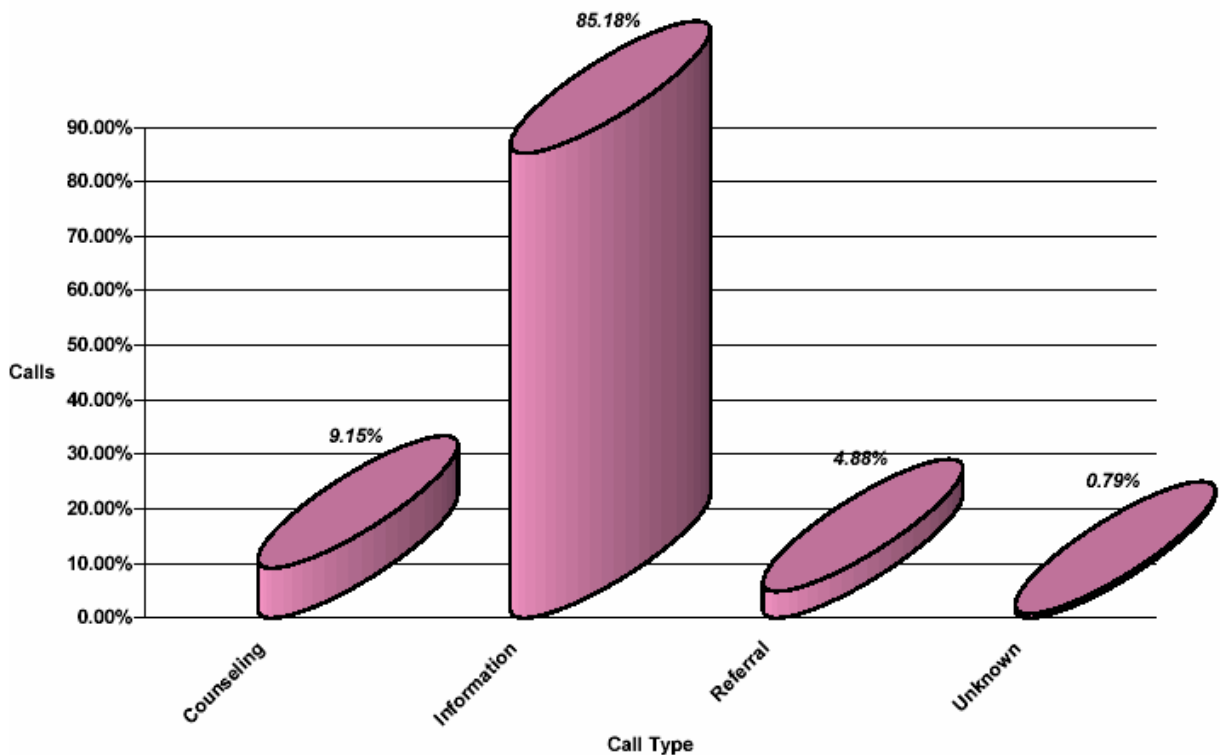


Figure 2 Calls of AIDS Talkline by Type

Source: AIDS Resource Center.(2005).Wegen AIDS Talkline in Figures, p. 48

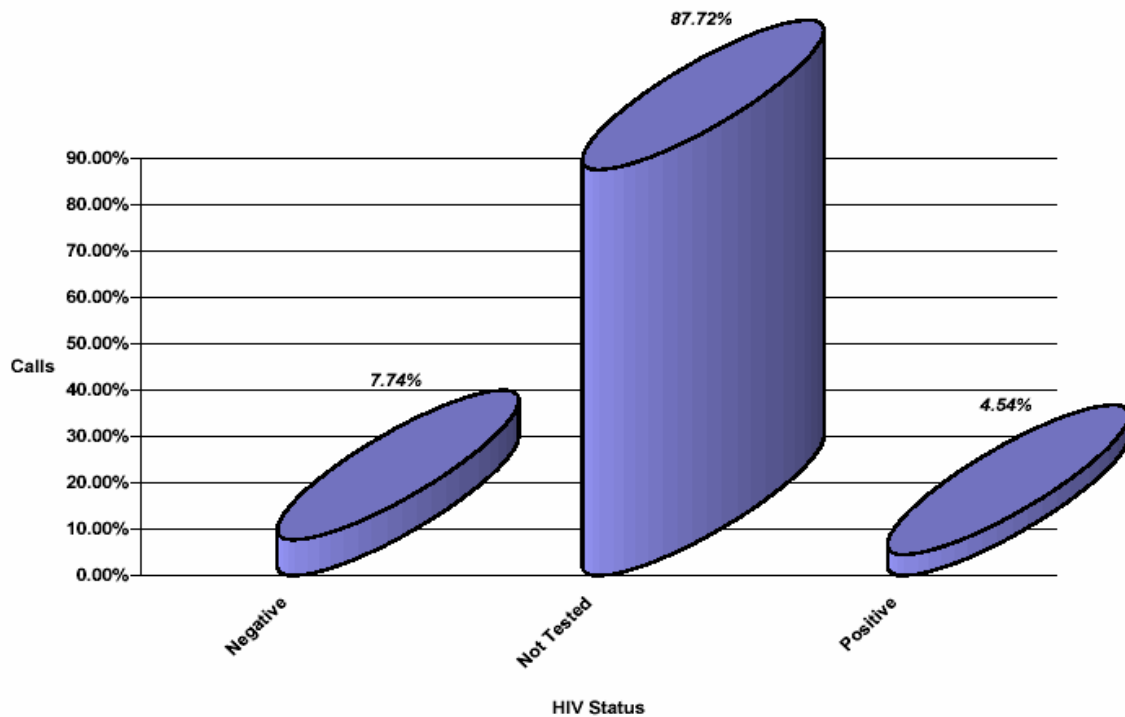


Figure 3 Calls of AIDS Talkline by HIV Status

Source: AIDS Resource Center.(2005).Wegen AIDS Talkline in Figures, p. 8

In Africa as the other regions of the world, the media are an essential part of the solution by conveying the right information for the target beneficiaries (Soul City, 2001). Therefore the media as a tool of information injection can be a tremendous force in scale up ART.

1.2.3.2 Media Advocacy Practice Related to ART

Kofi Annan, United Nations Secretary-General once said:

Media have tremendous reach....We must seek to engage these powerful organizations as full partners in the fight to halt HIV/AIDS through awareness, prevention, and education (UNAIDS, 2004; p. 2)

Most broadcast media agencies in Ethiopia are government owned and non-profit makers, but they have a tendency to focus on news that contributes to highest sales volumes. This results in lower coverage of socially pertinent issues such as HIV and ART. The media also lack accurate, up-to-date information on HIV and ART which can lead to dissemination of misinformation that fosters misconceptions and stigma (HAPCO, Pact-Ethiopia & UNAIDS, 2002).

The understanding of the role of media in the promotion of public health is especially useful when applied to the media's advocacy role in relation to HIV/AIDS. This role involves more than educating the public regarding appropriate individual behavior and includes the promotion of social change and collective action. More specifically, it includes agenda setting, promotion of government policy designed to facilitate a socio-economic environment conducive to behavior change and to managing the impact of HIV/AIDS over the long term (Soul City, 2001).

Despite its crucial role in bridging the gap of information raised around ART, proper attention is not being given to the communication component of ART interventions. This creates difficulty to identify and dispel the obstacles that hinder active ART program in the country. This and other factors make the need of focusing on media advocacy a vital strategy to contribute to the national effort of scaling up ART programs.

1.3 The Study

The government launched an Antiretroviral Therapy (ART) initiative in 2003, and though several policies and strategies are in place to support the implementation and scaling up of the national response, the number of individuals who get access to ART is very minimal.

In light of the above mentioned problems, the broadcast media is uncharted terrain that should be explored to score dramatic change by all ART stakeholders who are involved in national ART program. World wide, media coverage is one of the best ways to gain the attention of decision makers from local elected officials to members of parliament. Continuous and methodical media advocacy that addresses ART will play a significant role in educating the public, swaying public opinion and influence policy-makers to increase access and proper utilization of the drugs.

1.3.1 General Objective

Investigate challenges, barriers and best practices of media advocacy as performed by ART stakeholders and observe opportunities that the state broadcast media can contribute to the national effort to scale up ART.

1.3.2 Specific Objectives

- To assess the extent of media advocacy involvement of ART stakeholders to address problems that cause hindrance to accessibility of ART.
- To assess whether ART is getting due attention by the broadcast media to set it as the public agenda
- To explore the strengths and weaknesses of the collaboration between agencies working in ART and broadcast media agencies.
- To assess skills, approaches and best practices of agencies working to address ART using broadcast media.
- To identify areas where social work and social media best fit to contribute in the scale up process of ART.

1.3.3 Research Questions

- Do ART stakeholders and media agents report there is a problem of ART accessibility?
- Do ART stakeholders engaged on advocacy work use media to address problems that hinder accessibility of ART and do they believe broadcast media is the best channel for media advocacy?
- Is there collaboration between stakeholders to perform media advocacy?
- Do they design messages to accelerate behavior change?
- Are there gaps that social work practice and social media can fit for a better result to ensure accessibility of ART?

1.3.4 Significance of the study

As antiretroviral treatment is a recent agenda in the country, it has to be adequately promoted and advertised. Mass communication is therefore, essential to sensitize and introduce the drugs and ART service providers to AIDS patients in particular and the public in general. Information and communication can also be a useful tool for resource mobilization.

This study *Investigating the Impact of Media Advocacy in Framing Accessibility and Use of Antiretroviral Treatment in Ethiopia* will contribute to the national plan to scale up ART to 100,000 individuals in the end of 2006. As a state property the broadcast media should give priority and should be in the forefront on the on going outbreak war against HIV/AIDS. In relation to ART, Media plays a great role as agenda setter,

information conveyor and behavior inducer. In this regard the great power of media is being wasted.

This study, therefore, will probe for conditions that the media's role can be leveraged to address the current complications of ART. Also the study has implications for the HIV/AIDS policy makers, social workers and media practitioners to fill the communication gap to reduce the overwhelming number of death wrought due to HIV/AIDS. The study directly targets ART stakeholders, who are working recently to ensure accessibility of ART to PLWHA. Findings can be used by these audiences to design advocacy policy and intervention programs aimed at sustaining accessibility to treatment of HIV/AIDS. Study results also can enable a newly emerging social work academia to focus areas of concern in relation to Care and Support for PLWHA.

CHAPTER TWO: Literature Review

2.1 Political Environment and HIV/AIDS Mass Communication

Mass communication and its wider impact in macro level through persuasion with outlets like broadcast media is the underlying question to be raised with the trend of political will and culture of mass communication found in a given country. One of the most difficult problems for media freedom and the growth of the independent media is the political culture of intolerance and disrespect for popular participation in public affairs discourse (International Media Support, 2003). In reality the health communication strategies are influenced by government policies, development programs, reforms and philosophy (Soul City, 2001). Hence, health communication strategies need to consider the country's situations and directions.

The authoritarian theory, the liberation theory, the social responsibility theory and the soviet communist theory are four theories of mass communication stated by Siebert (1984). The Ethiopian mass communication practice seems to confirm to the authoritarian theory of mass communication. In the authoritarian approach of mass communication, authoritarians turn to the functions of the mass media and determine the basic purposes of government. As Siebert (1984) informed:

Government's purposes inevitably control the attitude toward both the cultural and political aspect of the communication.... The units of communication should support and advance the policies of the government in power so that the government can achieve its objectives (p. 34).

In democratic situations, media are responsible for accessing citizens with disseminate health messages among community members. Thus the government and private presses as well as radio and television programs are vitally important and relevant

to the health communication strategy (Health Education Center, 2005). In countries where no social groups make the question of broadcast media freedom may give an indication of how deeply entrenched such political culture must have grown even within the political elite (International Media Support, 2003).

As the democratic process grows the county may reach at liberationist stage where as Siebert (1984) stated:

Government in a democracy is the servant of the people. As such it occupies a much different relationship to its adherents than does the authoritarian government. Yet even though the government is subservient to and responsible to the public at large, it is not thoroughly trusted to identify its ends with the ends of its citizens. Innumerable devices have been invented in democratic countries to keep governments from reverting to authoritarian practices as well as from subverting the “unalienable rights” of its individual citizens (p. 53).

Given the existing political will of the government mass communicating on HIV/AIDS and motivating relevant stakeholders to support interventions through the media was recognized from early times. In recent times the use of the media for advocacy interventions is a key feature of advocacy manuals and guidelines. The use of media or media advocacy is critical to achieve results (Yisa, 2004). The mass media can be used as a method of bringing an issue into the public arena and the political discourse. Stakeholders need to consider media work as a very important strategy and explore ways and means of using media to promote their advocacy issues.

2.2 Media Advocacy and Framing Accessibility: Making ART Public Agenda

Advocacy can be defined as a communication strategies focusing on policy makers, community leaders & opinion leaders to gain commitment and support or an appeal for a

higher-level commitment, involvement and participation in fulfilling a set program agenda (HAPCO, Pact-Ethiopia, & UNAIDS, 2002).

Wallack, Dorfman, Jernigan & Themba (1993) in their book *Media Advocacy and Public Health* define advocacy as publicity or popularization of important issues; mobilization of support in the defense of a cause, more succinctly advocacy is a strategy for blending science and politics with a social justice value orientation to make the system work better, particularly for those with the least resources. From a social work perspective advocacy, whether individual or systemic, case or class, means championing or speaking for the interest of clients or citizens (NASW, 1969 cited by Hardcastl, 1997).

Media advocacy is an integral part of advocacy and can be defined as a force for influencing public debate and putting pressure on policy makers by increasing the volume a given social problem and in turn, by increasing the visibility of values, people and issues behind the voice (Wallack, Dorfman, Jernigan, & Themba, 1993). .

From a policy and prevention perspective, agenda setting is one of the most important aspects of the mass media. The primary task of media advocacy is to focus the spotlight on a particular issue and hold it there (Maibach & Parott, 1995). In other words the media advocates want to extend the attention span of the media to increase the saliency of the topic for a given audience. As Cook et al (1983) stated:

Agenda setting has been one of the principle themes of mass communication research, the process by which problems become salient as political issues merging the attention of the polity (p. 61).

The mass media plays a role of agenda setter by selecting certain people or events for attention and then frame the issue by telling the audience what is important to know

about it. Based on America's response to fight drug abuse Wallack, Dorfman, Jernigan, & Themba (1993) nicely described the power of media in setting public agenda:

In 1989 president Bush announced he would give a major speech announcing the war on drugs. This announcement was followed by a 2-week spurt of intensive news coverage and a prime-time speech announcing the war on drugs. Subsequently, 64% of the population volunteered the response that "drug is the most important problem facing this country today" as part of a national survey (p. 65).

Here is a clear example of the media setting the public agenda. In the case of AIDS, however, President Reagan did not talk about AIDS until the epidemic was already 6 years old (Wallack, Dorfman, Jernigan, & Themba, 1993). Hence AIDS was not a public agenda during those times.

Artist Seleshi (Gash Abera Molla) was a well know celebrity in Ethiopia. When he presents his concern on environmental sanitation through mass media the agenda of environmental sanitation was set as a public concern. Everybody has been involved in cleaning the city and a tremendous result was scored. This movement goes to the extent that the municipality, the concerned governmental body to clean the city, was blamed by the activist for not performing its mandated responsibility.

Wallack, Dorfman, Jernigan, & Themba (1993) have summarized the three concrete, fundamental steps of media advocacy as follows:

- Setting the agenda (framing for access), Shaping the story to get the attention of journalist to gain access to the media. Often it means being able to create an event that will be interpreted as news.
- Shaping the debate (framing for content), and

- Advancing the policy. Telling the story the way you want it told, emphasizing root causes. The story should be framed so that its conclusion is the policy you seek to advance.

During framing content, for example supporters of condom use in HIV prevention might craft messages touting condom success rates, whereas critics of condom usage might tout failure rates. Simply speaking “whether the cup is half empty or half full” is persuasive equivalent to a 95% success rate versus a 5% failure rate of condom use during HIV prevention. The messages that use only one or the other of these statistics are likely to lead to different behavioral responses (Maibach & Parrott, 1995). The same rule works in ART communication approach 3% success is equal to 93% failure to attend the treatment but with different framing. Epstein (1987) combines several writers thinking on this issue, nicely putting the difference between the two frames as follow:

This difference in preferences between frames is startling because the only thing that changed between the two scenarios was the wording—the underlying information conveyed was the same. Even using somewhat different stimuli, researchers have found this “framing effect” to be quite robust (p. 31).

2.3 Individualistic Framing: Person with Problem

The other factor noteworthy to be considered in relation to framing is the underpinning concept adopted by journalists in addressing a given issue. Most of the times social problems presented in broadcast media are in an individualistic manner. As a result, the audience sees problems as individual in nature and disassociated them from broader social and political factors; Iyengar (1991) explains that the primarily individual frame used by television news has the effect of obscuring the connection between social problems and the actions of political leaders. Social and political change becomes

secondary to personal and behavioral change (Wallack, Dorfman, Jernigan, & Themba, 1993). This individualistic portrayal of social and health problems pervades the society and is reinforced through framing in the mass media. For example Ethiopian Television youth delinquency frequently portrays as strictly individualistic problem, society and institutions are not seen as causal agent in producing delinquency. The same thought pervade with HIV/AIDS infection as it understood primarily as a result of individual life-style.

The method and approach of our messages also depicts there is a problem with the frame we chose. In his regard episodic and thematic frames are worthy of mentioning. Episodic framing results in an emphasis on individual responsibility for social problems such as poverty. As a result, politicians and public institutions are insulated from responsibility to address the problem. Thematic framing, on the other, leads to attribution of societal responsibility for problems such as poverty. Consequently, in stories with thematic frames, audiences hold politicians and public institutions responsible for addressing the problem. However, episodic rather than those thematic frames dominate television news, the overall effect of news story is to reinforce an exceptionalist, individualistic frame for social problems (Wallack, Dorfman, Jernigan, & Themba, 1993)

Through our haphazard communication for social and health problems, which naturally tend to be individualistic, we form a big depression between the individual from its environment which create difficulty for advocacy work because advocacy primarily addresses the environment of an individual.

In the concept of “blaming the victim”, Rayn (1991) explains that victim blaming involves analyzing problems in terms of the deficiencies in the victim-the person with

problem. Although the system may have gaps, remedies for those gaps are believed to be at the individuals not the structural, level; hence, advocacy is not necessary. Because the problems we face as a society are characterized by flaws in the individual rather than the social fabric, education and rehabilitation

2.4 Universalistic Framing: Person in Environment

The ecosystems or person-in-situation perspective is a social work construct that attempts to appreciate and understand people in their environment context which involved the special and temporal interrelationships between humans and their economic, social and political organization (Compton, Galaway, & Cournoyer, 2005). The central task of behavioral science is to develop taxonomies of environments, behaviors and behavior-environments linkages and to determine their distribution in the natural world (Compton, Galaway, & Cournoyer, 2005).

Contrary to individualistic view, the universalistic view is peculiar for its environmental perspective which has direct attachment to the role of policy and community-level factors during treatment promotion. The environment perspective includes both physical and social elements. For example policies and practices that support active use of ART accessibility and availability, both of which help cultivate positive social perceptions about these products, are primary; targets for change.

There are two important reasons for emphasizing the environment. First as actions based and focused on social conditions is more effective than efforts aimed primarily at threatening individuals. Second, universalistic analysis points to the importance of quality and social justice as the foundation for action. Universalistic-or environment- oriented

solution tend to confront the underlying conditions that give rise to and sustain disease and thus promise long-term change (Wallack, Dorfman, Jernigan, & Themba, 1993).

2.5 Communication Theories of Behavior Change

In response to the massively growing epidemic various behavioral interventions have been implemented. Many of such interventions carried out have not yielded the intended outcome as well as the impact in reduction of HIV incidence and prevalence. In many literatures the use of behavior change models for such interventions is widely cited, and moreover, their usefulness as well as drawbacks are largely reported. Most of these theories and models are targeting individual behaviors. I strongly agree with Asres, Fahmi, Shabir, & Yene (2002) in their saying:

Most of the theories and models are based on individual theory, which is basically foreign to non-western societies which tend to view the self as a product of the family and the community. In non-Western contexts the family and the community play a great role in decision-making. The continued use of “individual based intervention methods” is not allowing organizations and institutions to make head way in the combat of HIV/AIDS (p. 53).

How does behavior change occur through social and public health communication? This question probably has as many answers as there are diverse populations and cultures. Every HIV/AIDS behavioral change program, however, is based on answers for this question. This calls for theories as to why and how people change their behaviors.

2.5.1 Non-Stage Models of Communication

Non-stage theories and models of behavior change (e.g., the health belief model, theory of reasoned action, and protection motivation theory) view behavior change or adoption as movement along a single continuum of action. They assume that the relative probability of a person taking action is a mathematical function of that individual's attitude and belief (Weinstein, 1999). Which factors are included in this function, how they are weighted, and their interactions are assumed to contain from the time one learns of a threat to the time action is taken. Two of the most commonly cited non-staged models of communication for behavior change theories are The Health Belief Model and the AIDS Risk Reduction Model.

2.5.1.1 Health Belief Model (HBM)

The Health Belief Model (HBM) is a psychological model that attempts to explain 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. 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. These models are being applied in research outside of the United States, and they may not capture the elements necessary for behavior change in every culture or population. The key variables of the HBM are as follows (Rosenstock, Strecher & Becker, 1994):

- Perceived Threat. Consists of two parts: perceived susceptibility and perceived severity of a health condition.

- Perceived Benefits. The believed effectiveness of strategies designed to reduce the threat of illness.
- Perceived Barriers: The potential negative consequences that may result from taking particular health actions, including physical, psychological, and financial demands.
- Cues to Action: Events, either bodily (e.g., physical symptoms of a health condition) or environmental (e.g., media publicity) that motivate people to take action

General limitations of the HBM include a) as a psychological model it does not take into consideration other factors, such as environmental or economic factors, that may influence health behaviors; and b) the model does not incorporate the influence of social norms and peer influences on people's decisions regarding their health care decision (Maibach & Parott, 1995)

2.5.1.2 Theory of Reasoned Action (TRA)

Research using the Theory of Reasoned Action (TRA) has explained and predicted a variety of human behaviors since 1967. Based on the premise that humans are rational and that the behaviors being explored are under volitional control, the theory provides a construct that links individual beliefs, attitudes, intentions, and behaviors (Fishbein, Middlestadt & Hitchcock, 1994).

Some limitations of the TRA as indicted by Kippax & Crawford (1993) are the inability of the theory, due to its individualistic approach, to consider the role of environmental and structural issues and the linearity of the theory components. Individuals may first change their behavior and then their beliefs/attitudes about it.

2.5.2 Stage Model of Communication

Stage models view behavior change as a series of actions or events. These models allow researchers to detect movement towards a behavior change among people who have not yet attained the behavior change. In addition, investigators or communicators can see the influence of factors at the beginning and through out the change process, rather than expecting all factors to impact the end product of actual behavior change (Prochaska, DiClemente, & Norcross, 1992; Weinstein & Sandman, 1992). Two of widely known stage models are the AIDS Risk Reduction Model and the Stages of Change Model.

2.5.2.1 AIDS Risk Reduction Model (ARRM)

The AIDS Risk Reduction Model (ARRM), introduced in 1990, provides a framework for explaining and predicting the behavior change efforts of individuals specifically in relationship to the sexual transmission of HIV/ AIDS. A three-stage model, the ARRM incorporates several variables from other behavior change theories, including the Health Belief Model. According to Catania, Kegeles, & Coates (1990) the three stages of this model are: recognition and labeling of one's behavior as high risk; making a commitment to reduce high-risk sexual contacts and to increase low-risk activities; taking action through information seeking; obtaining remedies; enacting solutions. Depending on the individual, phases may occur concurrently or phases may be skipped.

A general limitation of the ARRM model is also its focus on the individual. For instance, many women in an ARRM-based study in Kampala, Uganda, felt at risk for HIV, not due to their own behavior but because of the behaviors of their sexual partners -

an issue the women reported was outside of their control (McGrath et al., 1993). As a result, the researchers suggested that the ARRM do not take into greater consideration the socio-cultural issues that influence that may limit an individual's behavior choices and ability to make health care decision.

2.5.2.2 Stages of Change (SC)

The rationale behind "staging" people, as such, was to tailor therapy to a person's needs at his/her particular point in the change process. As a result, Prochaska, DiClemente & Norcross (1992), are listed the four original components of the Stages of Change Theory (precontemplation, contemplation, action, and maintenance) were identified and presented as a linear process of change. Since then, a fifth stage (preparation for action) has been incorporated into the theory, as well as ten processes that help predict and motivate individual movement across stages. In addition, the stages are no longer considered to be linear; rather, they are components of a cyclical process that varies for each individual.

As a psychological theory, the stages of change focuses on the individual without assessing the role of structural and environmental issues may have no tangible impact on a person's ability to enact behavior change. In addition, since the stages of change presents a descriptive rather than a causative explanation of behavior, the relationship between stages is not always clear. Finally, each of the stages may not be suitable for characterizing every population. For instance, a study of sex workers in Bolivia discovered that few study participants were in the pre-contemplative, contemplative stages in regard to using condoms with their clients (Posner & Higuera, 1995).

2.5.3 Behavioral Change through Staged Social Cognitive Approach

2.5.3.1 Transtheoretical Model (TM)

Transtheoretical theory describes behavior change as a process in which individuals' progress through a series of discrete phases or stages of change. The stages of change have been documented with individuals undergoing behavior change in the areas of condom use (Galvotti, Cabral, Grimley, Riley, & Prochaska, 1993). The five stages of this theory have been labeled by Maibach & Parott (1995) as precontemplation, contemplation, preparation, Action and Maintenance.

The Transtheoretical Model (TM) has a number of important implications for health message design. First and most obviously, it can serve as the basis for an effective audience segmentation analysis. An analysis of this type is conducted by assessing a representative sample of the target audience to establish their current stage of change and other relevant psychosocial and behavioral variables (Maibach & Parott, 1995).

2. 5.3.2 Social Cognitive Theory (SCT)

Of all the theories mentioned above Social Cognitive Theory (SCT) describes human behavior as being reciprocally determined by internal personal factors and the environment in which a person lives (Bandura, 1986). Reciprocation among behavior, person, and environment is common in this model. SCT presents a balanced and optimistic view of the human condition: People and their behaviors are shaped by their environments, yet people also shape their environments through their behavior and expectations. In relation to ART Maibach & Parott (1995) state that SCT on individual behavior change can be facilitated by modifying people's personal factors and by altering environmental factors to encourage healthful behavior. These behaviors includes

contraception and STD/HIV prevention; pain and disability reduction; stress reduction; and adherence to prescriptive and rehabilitative regimens of ART

Before behavior change is likely to occur, people must have knowledge both about their risk factors (the behaviors or conditions that place one at risk e.g. HIV/AIDS as life threatening disease and the way risk factors can be reduced e.g. attending ART. Such kind of knowledge, skills, self efficacy (people believe in their capability) and outcome expectations and personal goals are personal factor. These personal factors are reciprocally interact with social, institutional and physical environmental factors and depending with frequency, consistency and other relevant aspects of behavior and reciprocal interaction between the three domains, determination of behavior will be rectified with person in Environment approach (see Figure 2)

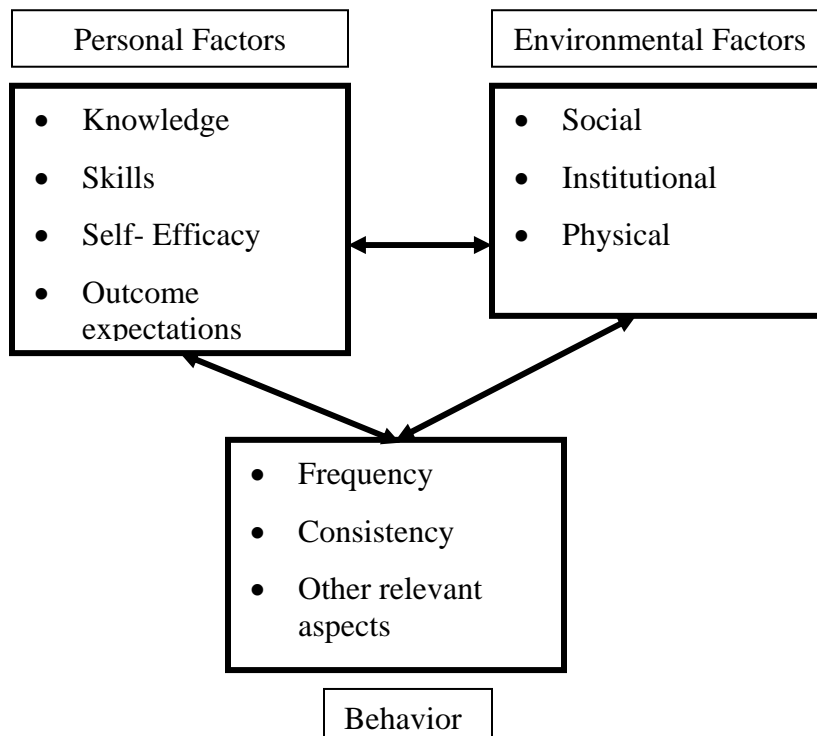


Figure 4 The Reciprocal Determination of Behavior, Person and Environment

Source: Maibach & Parott, (1995), *Designing Health Message*, p. 17)

2.5.4 Staged Social cognitive approach in a Transtheoretical Model

The integration of Social Cognitive theory with the transtheoretical model for the purpose of health message design seems workable for effective health communication. SCT offers a parsimonious set of internal personal factors that influence the production of behavior (i. e., a compelling explanation of how people change what they do). TM offers an equally parsimonious temporal framework and model of behavior change dynamics (i.e., a compelling explanation of how people change what they do). As such, TM offers a clear framework for addressing the internal personal factors suggested by; SCT as causal determinants of behavior (Maibach & Parott, 1995).

Maibach & Parott (1995) also explain the benefit of adapting this model in designing tailored messages for different group in different stages as follow:

The transtheoretical model suggests several important message design considerations. First, messages must be tailored to the specific cognitive and behavioral conditions of people at each given stage. For example, a message designed for people in precontemplation (to help them move to Contemplation) will be different than a message designed for people in the Action stage (to help them move to Maintenance). This strategy is a distinct advancement over the all-too-common approach in health campaigns where it is assumed that all message recipients are ready and willing to change their behavior immediately upon being persuaded (p. 42).

Combined the two to produce tailored messages designed to facilitate behavior change will be much easier. Seeing all the shortcoming of the above mentioned theories of behavior change I agreed and with Maibach & Parott's (1995) adoption of SCT model for effective behavior change. He succinctly summarizes the advantage of SCT in a transtheoretical way as follow:

SCT delineates the triadic nature of behavior expression, that is, the reciprocal interaction among person, environment, and behavior. Furthermore, SCT identified the internal personal factors, such as self-efficacy and outcome expectations, that influence the development and maintenance of health behaviors. The transtheoretical model provides a framework for conceptualizing the temporal sequence in which people modify their intentions and health behaviors. Efficient movement through the stages can be promoted by addressing specific internal personal factors when they are most likely to facilitate change in the behavior change progression. Health message designers can utilize this combined perspective to develop focused messages for a variety of healthy-related behavior change programs (p. 44).

As the previous description and model illustrate, social cognitive theory and the transtheoretical model can be effectively combined to produce tailored messages designed to address a given social problem from a systems approach. Social Cognitive Theory also delineates the triple nature of behavior expression, that is, the reciprocal interaction among person, environment, and behavior at all levels. With this approach, a person will be treated in their environment and the objective of advocacy will be met when the person perceives their environment.

Advocacy, whether individual or systemic, case or class, means championing or speaking for the interest of clients or citizens (NASW, 1969). Media advocacy is an integral part of advocacy and can be defined as a force for influencing public debate and putting pressure on policy makers by increasing the volume of a given social problem and, in turn, by increasing the visibility of values, people, and issues behind the voice using media as a means. Using media, a given social problem can be set as public agenda and once the agenda is set, the debate can be framed to influence policy makers and executives to be able to address the problem at the crux.

CHAPTER THREE: Design and Methodology

3.1 Study Sample

The study design included survey, and key informants interview. Based on the information obtained from AIDS Resource Center (ARC) and Christian Relief and Development Association (CRDA), agencies who are ART stakeholders are identified. 'ART stakeholders' in this study refers to collaborators in the service of ART who are working to ensure accessibility of ART for PLWHA at all levels. This collaboration among the stakeholders is to avoid duplication of efforts and maximize outputs in resource limited settings. These stakeholders include governmental organizations/non governmental organizations, media agencies, hospitals, PLWHA associations and higher institutions.

Probability samples using random sampling was taken from the population of non-governmental organizations as the list of them was obtained from CRDA. The same sampling method was applied to PLWHA associations. The number of governmental agencies working on ART are few and limited but for analysis purpose stratification between GOs/NGOs and PLWHA associations was made to take proportional samples of agencies from each category of agencies. Since the population of the rest ART stakeholders (media agencies, hospitals and higher institutions) is minimal sampling was not conducted, rather the whole population was approached to collect data. As the population size of all ART stakeholders are known and stratification was made before sampling the elements of interest have equal chance of being included in the samples hence the sample is representative.

Overall 62 agencies approached which comprised 36 governmental and non-governmental organizations, ten PLWHA associations, four hospitals, eight media agencies, four U.S. based universities working on ART were approached and 53 of them have give response to the questionnaire.

Stratified random sampling was also conducted for the key informant's interviews from each category of agencies. Accordingly, based on the information obtained from the filled questionnaire four key informants from governmental and non governmental organizations, two key informants from PLWHA associations, one key informant from referral hospitals, two key informants from Radio and TV media agencies and one key informant from US based universities identified and approached to collect data.

3.2 Instrumentation

A standardized Semi-Structured questionnaire consisting of three main sections; the first part is designed to assess the extent of the agencies involvement on ART. The second part of the questionnaire is intended to assess the extent to which the agencies involved in advocacy in general and media advocacy in particularly to Address ART issues. The final part of the questionnaire is to assess the manner they prepare media messages (if there is any), (See Appendix.).

To complement the quantitative study and obtain additional information to augment the findings of the study, key informants interviews were conducted. Three kinds of specifically tailored interview questions with the above mentioned three main sections prepared and conducted with sampled agencies. The interview was tape-recorded, while the researcher took notes which finally transcribed and analyzed to augment to outcome of the survey.

3.3 Pre-testing

The questionnaires were specifically tailored for each category of agencies and it was prepared based on observational assessment conducted in some of the agencies. Pretest was done with some of AIDS Resource Center and Dawn of Ethiopia Association core staff and with the comments and feedback the questionnaires were revised.

3.4. Data Collection

For the questionnaire, all agencies contacted through a directory on Agencies working on HIV/AIDS prepared by Christian Relief and Development Association (CRDA) and AIDS Resource Center (ARC). With a personal visit the questionnaire was then distributed to all selected agencies. More than 50 percent of the questionnaires were not replied to by the due time so they were reminded to send it with the second deadline. Nearly 50 % of all replied and finally with a second round phone call and e-mailing the electronic version of the questionnaire to the agencies which finally help to get 53 questionnaires filled with a return value of 85.4%

3.5 Analysis Plan

Completed questionnaires were examined to see whether the items were answered appropriately and whether there were any items left unanswered. The first step in quantitative data analysis involved screening the data to identify and correct inappropriate codes and coding the open ended questions of the questionnaire. The raw data were entered into the computer using SPSS version 10. Then using descriptive statistics the variables were cross tabulated to observe the relationship in terms of frequency and percentage.

Key informants interviews are conducted to collect qualitative data. The interview was done by extensive probing using open-ended questions and conducted on a one-on-one basis between a respondent and the researcher. The interviews were conducted to a number of informants of sample size from each category of stakeholders. During analysis comparisons were made to distinguish forms of relationships between issues of ART accessibility and media role to address the issues as it reflected by all agencies. By identifying themes that emerge from the interviews, categories of issues were identified. Then, for each theme comparison was made using spreadsheets as each theme was treated by each individual interviewee. By understanding these comparisons, interpretation made using inductive analysis where efforts made to understand the details and specifics of the data using categories, dimensions, and interrelationships.

3.6 Ethical Considerations

Consent for the study was obtained for the representatives of the approached agencies. Each respondent gave informed verbal consent, after being told the purpose and procedures of the study. All responses were kept confidential and anonymous. Although the study was not expected to cause physical or psychological harm to the respondents, the names of interviewees have been kept confidential and the privacy of participants was respected.

This study also involved personnel involved in the organizations with HIV/AIDS information section as subjects or contributor of data and other personnel as producers and as reviewers of the preliminary findings. This type of research is often described as participatory or collaborative because of the active role participants play in the process;

this kind of partnership research will strengthen the validity and the utility of the findings (Mason, 2002).

3.7 Limitations of the Study Sample

The study samples are selected from the city of Addis Ababa. As a result the reality of ART issues at grassroots can't be included on the study. These issues are integrated as the approached organizations presented the issues; hence, it is not inferential.

Analyzing broadcast media messages might be helpful to enrich the findings of the study but due to time constraints and a very limited number of ART related messages this component of the study was not possible.

CHAPTER FOUR: Findings

The findings of the study are discussed in this chapter. Starting with a presentation of background characteristics of the study participants, description of participants' barriers to ensure accessibility of ART will be presented. Following this a result of univariate analysis of the study variables are discussed. This study is a descriptive study which confines to the task of describing and summarizing the study samples. By assigning participants in group bias due to confounding variables are minimized.

4.1 Description of the Study Sample

Sample Characteristics

The research sample was comprised of 53 agencies or stakeholders of ART as a whole. Table 1 shows their distribution in terms of the kinds of services they render to address ART. 29 of the total population (55%) are governmental and non-governmental organizations, eight of the total population (15%) are PLWHA associations, four of the total population (7.5%) are hospitals giving ART services in Addis Ababa. There are four universities (7.5%) who are giving ART services in different regions of the country. There are also eight broadcast media agencies (15%) directly or indirectly working on HIV/AIDS.

Table 1 Percent Distribution of Study Samples

| Stakeholders | N | % |
|---|----------|----------|
| ▪ Governmental and Non governmental Organizations | 29 | 55% |
| ▪ PLWHA associations | 8 | 15% |
| ▪ Hospitals | 4 | 7.5% |
| ▪ Media agencies | 8 | 15% |
| ▪ Universities | 4 | 7.5% |
| Total | 53 | 100% |

These are stakeholders of ART who are addressing ART based on their comparative advantages; media agencies convey information on ART, hospitals give direct services on ART, PLWHA associations working on advocacy in collaboration with other non-governmental and governmental organizations. In addition to that governmental organizations like HIV/AIDS Control and Prevention Office (HAPCO) and Ministry of Health (MoH) are playing the leading role on the national effort of ART interventions. U. S based higher education institutions are also building the capacity of the ART service system to accelerate accessibility.

Table 2 presents the stakeholders' involvement in care and treatment as reported by respondents. Accordingly, all hospitals are fully involved in treatment and care service. Their involvement reaches to the utmost level; more than 90% (91-100%) of their overall services is related to treatment and care. PLWHA associations are the second largest group highly involved on care and treatment services. Almost all PLWHA associations are involved on care and treatment but they show different rate of involvement.

Table 2 Percent distribution of Stakeholders' Level of Involvement on Care and Treatment

| Stakeholders | | Level of involvement on Treatment and Care | | | | | | | | | | | Total |
|---|-------|--|--------|--------|--------|--------|--------|--------|--------|--------|---------|------|-------|
| | | 1-10% | 11-20% | 21-30% | 31-40% | 41-50% | 51-60% | 61-70% | 71-80% | 91-90% | 91-100% | none | |
| Governmental & non-governmental organizations | Freq. | 3 | 2 | 2 | 2 | 2 | 4 | 3 | 6 | 3 | - | 2 | 29 |
| | % | 10.3% | 6.9% | 6.9% | 6.9% | 6.9% | 13.8% | 10.3% | 20.7% | 10.3% | - | 6.9% | 100% |
| PLWHA associations | Freq. | - | - | - | - | - | 6 | 2 | - | - | - | - | 8 |
| | % | - | - | - | - | - | 75% | 25% | - | - | - | - | 100% |
| Hospitals | Freq. | - | - | - | - | - | - | - | - | - | - | - | - |
| | % | - | - | - | - | - | - | - | - | - | - | - | - |
| Media Agencies | Freq. | - | - | - | - | - | - | - | - | - | - | 8 | 8 |
| | % | - | - | - | - | - | - | - | - | - | - | 100% | 100% |
| Universities | Freq. | - | - | - | - | - | - | - | - | - | - | 4 | 4 |
| | % | - | - | - | - | - | - | - | - | - | - | 100% | 100% |
| Total | Freq. | 3 | 2 | 2 | 2 | 2 | 10 | 5 | 6 | 3 | 4 | 14 | 53 |
| | % | 5.7% | 3.8% | 3.8% | 3.8% | 3.8% | 19.0% | 9.6% | 11.0% | 5.7% | 7.5% | 24% | 100% |

According to Table 2 Seventy five percent of these associations are involved on care and treatment services which comprise more than 51% (51-66%) of their overall programs; where as 25% of the associations reported a higher involvement (61-70%) of

their overall services on care and treatment programs. More than 20% of governmental and non-governmental organizations give service on treatment and care, which comprise 71-80% of the over all programs given by the agencies. All media agencies and all higher institutions are not at all involved in treatment and care services directly.

4.2 Descriptive Analysis of Study Variables

Table 3 Percent Distribution of Stakeholders' Response on Media Coverage of ART

| ART Barriers | Reponses of Stakeholders on Media Coverage of ART Barriers | | | | | | | | | | | | |
|------------------------------|--|------------|----|-------------|-----|-----------|-----|----------------|-----|--------------|-----|-------|----|
| | | GOs & NGOs | | PLWHA Asso. | | Hospitals | | Media Agencies | | Universities | | Total | |
| | | Freq. | % | Freq. | % | Freq. | % | Freq. | % | Freq. | % | Freq. | % |
| Economic problems | Yes | 25 | 86 | 6 | 75 | 4 | 100 | 8 | 100 | 4 | 100 | 47 | 89 |
| | No | 2 | 7 | 2 | 25 | - | - | - | - | - | - | 4 | 7 |
| | No Ans. | 2 | 7 | - | - | - | - | - | - | - | - | 2 | 4 |
| Religious problems | Yes | 15 | 52 | 8 | 100 | 4 | 100 | 8 | 100 | 4 | 100 | 35 | 66 |
| | No | 12 | 41 | - | - | - | - | - | - | - | - | 12 | 23 |
| | No Ans. | 2 | 7 | | | | | | | 4 | | 6 | 11 |
| Stigma and Cultural problems | Yes | 18 | 62 | 8 | 100 | 4 | 100 | 8 | 100 | 4 | 100 | 42 | 80 |
| | No | 9 | 31 | - | - | - | - | - | - | - | - | 9 | 16 |
| | No Ans. | 2 | 7 | - | - | - | - | - | - | - | - | 2 | 4 |
| Misconceptions | Yes | 15 | 52 | 8 | 100 | - | - | - | - | - | - | 23 | 43 |
| | No | 12 | 41 | - | - | 4 | 100 | 5 | 63 | 4 | 100 | 25 | 47 |
| | No Ans. | 2 | 7 | - | - | - | - | 3 | 37 | - | - | 5 | 10 |

According to the data (Table 3), 86 % of non governmental and governmental organizations, 75 % PLWHA associations, all (100%) media agencies and all universities (100%) responded that there is an information gap on how to get ART. Free ART is not communicated for the public especially for the rural people. Interviews showed that the gap of financial problems identified during survey is associated with lots of support

which an impoverished society can't supply along with ART service for a patient, so it touches on the general poverty level of clients, unemployment, nutrition and care for opportunistic infection.

The survey data (Table 3) also showed that 56% of governmental and non governmental organizations, all PLWHA associations (100%), all media agencies (100%) and all universities (100%) responded that corrective information to dispel or correct religious problems, stigma and misconception towards ART are not communicated using broadcasting media. During the interviews the main religious issue that causes hindrance to ART accessibility are stigma and discrimination; especially the moral stigma cause a devastating effect to PLWHA. The larger community and clients still believe that HIV is God's punishment as a result they are not sure whether they should take HIV treatment or attend holy water. The interviews also revealed that as the media agencies do not give due emphasis on these problems the problem are still perplexing.

More than 60% of Non-governmental and governmental organizations and all PLWHA associations (100%), all media agencies (100%) and all universities (100%) responded the cultural problems especially the social stigma is not addressed using media. Interviews showed that social stigma is still complicated in the community as results so many people especially know individuals and celebrities prefer to die in silence to expose their status and face the hazard of stigma.

More than 50% of Non-governmental and governmental organizations and all PLWHA association (100%), more than 60% of media agencies and all universities (100%) responded there is misconception around ART. Interviews showed that these misconceptions with religious and cultural sources caused less readiness towards ART.

The limited coverage of radio and TV on ART and related problems as mentioned during interviews with broadcast agencies are caused by a range of issues which include lack of sufficient air time, lack of experts, lack of urgency of the issues and lack of technical and financial capacities are the main challenges the media agencies facing now.

A respondent from the Ethiopia Television said “We have only one expert who produces messages on HIV/AIDS and our coverage of HIV/AIDS is only once in every fortnight. If the producer can’t get any messages on HIV/AIDS we produce coverage on other social concerns; there are times we focus on other issues for a month without making programs on HIV/AIDS.” A health professional and IEC/BCC expert also informed that “the limited messages on ART are not continuous and consistent; they are always directed to individuals and the responsible body to evaluate the contents of the messages was Ministry of Health, but if the agencies who developed the message pay well to the media agencies the messages will transmitted without considering the pros and cons of the message. One example in this regard can be mentioned when ETV spot a couple who are taking ART and hiding the drugs from their kids so the message is not clear at all whether drugs should be hid or not,”

A respondent from radio agency said “The policy issue of the media agencies should also be considered because all social problems are expected to be covered and the media should address these problems and other entertaining programs, the policy and the plans are geared in these manner but we heard a lot of people are saying that the media agencies are not giving proper attention to HIV/AIDS in general and ART in particular.” At the time of this interview both in ETV and Ethiopian News Agency HIV/AIDS was

not mainstreamed in their programs and they don't know that the ART communicating strategy was developed by other agencies.

Table 4 Percent Distribution of Stakeholders' Advocacy Practice on HIV/AIDS

| Stakeholders | Advocacy Practice by Stakeholders | | | |
|--|-----------------------------------|------|-------|-----|
| | Yes | | No | |
| | Freq. | % | Freq. | % |
| Governmental & non- governmental organizations | 27 | 93.1 | 2 | 6.9 |
| PLWHA associations | 8 | 100 | - | - |
| Hospitals | - | - | 4 | 100 |
| Media Agencies | 8 | 100 | - | - |
| Universities | 1 | 25 | 3 | 75 |
| Total | 43 | 83% | 10 | 17% |

Table 4 shows distribution of Advocacy practice by the respondents. Over 93% of the governmental and non-governmental organizations are doing advocacy, and all PLWHA associations (100%) are doing advocacy work. All hospitals (100%) are not doing any advocacy work at all. During the interview one health professional said “advocacy is not our mandate it is the focus of ministry of health and NGO”. All media agencies (100%) are doing advocacy work. During interview with media agencies probing in the concept of advocacy showed that the agencies are now having informed understanding on the concept of advocacy; to them, simply transmitting messages on HIV/AIDS is doing advocacy work. Table 4 also showed that 25% of universities are involved on advocacy. An interviewee from one university said “We primarily build the capacity of the government and hospitals to help them to give better services of ART; advocacy is not our area of focus.” Of all participants 43 agencies (83%) are doing advocacy work on any HIV/AIDS related issues. During an interview most of the

agencies said even if they believed broadcast media is the best to do advocacy due to lack of expertise and finance they are not taking advantage of it.

Table 5 Percent Distribution of Stakeholders that Produced ART Related Messages

| Stakeholders | Adherence and/or Readiness Messages by Stakeholders | | | | | |
|---|---|------|-------|------|-----------|------|
| | Yes | | No | | No answer | |
| | Freq. | % | Freq. | % | Freq. | % |
| Governmental & non-governmental organizations | 9 | 31 | 17 | 58.6 | 3 | 10.4 |
| PLWHA associations | 5 | 62.5 | 3 | 37.5 | - | - |
| Hospitals | - | - | 4 | 100 | - | - |
| Media Agencies | 5 | 62.5 | 3 | 37.5 | - | - |
| Universities | - | - | 4 | 100 | - | - |
| Total | 19 | 35.5 | 31 | 58.5 | 3 | 6 |

Table (5) showed that 35.8 % of the agencies have responded they have produced media messages on adherence and/or readiness related to ART. Almost two thirds (62.5%) of PLWHA associations have responded in producing media messages on ART. Similarly almost two thirds of (62.5 %) of media agencies responded that they have produced messages on ART in their different programs. From GOs and NGOs, 31 % of the agencies are engaged on ART related messages, all hospitals (100%) and higher institutions (100%) do not engage in ART message production. For analysis they were divided into the following groups: Government and non-governmental organizations: PLWHA associations; hospitals, media agencies, and universities. These five groups were examined for differences on six dimensions (governmental organizations/non governmental organizations, media agencies, hospitals, PLWHA associations and higher

institutions). The difference in the mean/average for each group of agencies is statistically significant ($P < 0.05$), see appendix E.

During the interview, health professionals responded preparing ART messages for advocacy work is not their mandate but universities are involved indirectly in education and capacity building of agencies that are willing to work advocacy. Overall, 35.8 % of all agencies have produced ART messages either on adherence, on readiness or on both issues in general, but key informants interview showed that none of the stakeholders have prepared media advocacy messages on ART to influence policies or executives. The interviewees have also responded that messages by the media is being done haphazardly, e.g. “recently a TV spot on ART was transmitted which end resulting stigma and a lot of individuals expressed their displeasure for our agency. On the TV spot a man looks the face of a lady and guesses she is taking ART. Which cause a lot of misinformation that people who take ART are easily identified” Another respondent said “Our limited ART messages are fueling the stigma and can not address the whole situation the person with problem residing in, it only circles the person”

The participants who are involved on care and treatment and also involved on advocacy work to dispel the above mentioned problems have responded differently to different media outlets to propagate ART messages.

Table 6 Percent Distribution of Best Media Outlets to Address ART Issues as responded by the Stakeholders

| Stakeholders | Media Preference by Stakeholders | | | | | | | | | | | | | |
|---|----------------------------------|-----|--------|------|----------|-----|-----------|-----|-------|----|--------------|------|----------|-----|
| | Radio | | Poster | | Brochure | | Billboard | | TV | | Radio and TV | | Workshop | |
| | Freq. | % | Freq. | % | Freq. | % | Freq. | % | Freq. | % | Freq. | % | Freq. | % |
| Governmental & non-governmental organizations | 9 | 31 | 3 | 10.3 | 2 | 6.9 | 2 | 6.9 | 9 | 31 | 2 | 6.9 | 2 | 6.9 |
| PLWHA associations | - | - | - | - | - | - | - | - | - | - | 8 | 100 | - | - |
| Hospitals | 4 | 100 | - | - | - | - | - | - | - | - | - | - | - | - |
| Media Agencies | 6 | 75 | - | - | - | - | - | - | 2 | 25 | - | - | - | - |
| Universities | 4 | 100 | - | - | - | - | - | - | - | - | - | - | - | - |
| Total | 23 | 43 | 3 | 6.7 | 2 | 3.8 | 2 | 3.8 | 11 | 20 | 10 | 18.9 | 2 | 3.8 |

Table 6 shows that from governmental and non-governmental organizations 9 agencies (31%) responded that radio is the best channel, another 9 (31%) agencies responded TV is the best channel and two agencies (6.9%) prefer both TV and Radio are the best way to convey messages on ART, the rest prefer print materials and workshops. All hospitals (100%) responded radio is the best way; all PLWHA associations (100%) responded using both radio and TV at the same time will have a better impact. All higher institutions (100%) do prefer radio than any other means of releasing messages and 75% of the media agencies prefer radio but 2 agencies (25%) prefer TV to radio. The overall result shows that 23 agencies (43%) prefer radio and 11 agencies (20%) prefer TV, 10 agencies (18.9%) prefer TV and Radio. More than 80% (81.9 %) of all agencies prefer radio or/ and TV as the best media the rest prefer print media and workshops. Key informants interviews showed that radio is the most useful means to convey messages on

ART especially to reach the rural part of the country. But designing messages in respect to the culture and tradition of a specific people and tailoring messages for a specific segment of the audience seems not getting attention by the media and message designers.

Table 7 Percent Distribution of Level of Partnership among Stakeholders

| Stakeholders | Partnership among Stakeholders | | | | | |
|---|--------------------------------|------|-------|------|-----------|-----|
| | Yes | | No | | No answer | |
| | Freq. | % | Freq. | % | Freq. | % |
| Governmental & non-governmental organizations | 8 | 27.6 | 19 | 65.5 | 2 | 6.9 |
| PLWHA associations | 5 | 62.5 | 3 | 37.5 | - | - |
| Hospitals | | | 4 | 100 | - | - |
| Media Agencies | 3 | 37.5 | 5 | 62.5 | - | - |
| Universities | 1 | 25 | - | - | 3 | 75 |
| Total | 17 | 32 | 31 | 58.5 | 5 | 10 |

The majority of stakeholders do not believe that there is sound partnership among themselves (Table 7). All Participants from hospitals responded there is no partnership at all among stakeholders. Almost two thirds (62.32%) of media agencies responded that there is no partnership in a formal way. However, PLWHA associations believed that there is good partnership (62.5%) among stakeholders. The total figure shows 58.5% of the respondents replied there is no collaboration between stakeholders. An interviewee from local community media said “we have paid more than 1.8 million birr in 6 years for the government to transmit radio messages; our program was the best HIV/AIDS program in the country. Now due to lack of money we are on the verge of stopping our

services; no one is willing to cooperate with us. Even the government is not willing to give us free air time.”

An official from the governmental agency informed “There is a lack of cooperation among agencies especially with media agencies and the responsible body for coordination-HAPCO is not playing its role as coordinating body. As a result we can’t prioritize our agendas and make a synergistic voice on a specific issue of social concern.”

Table 8 Percent Distribution of Stakeholders by Method of Message Design

| Methods of Message Design | Stakeholders Response | |
|--|-----------------------|-------|
| | Freq. | % |
| Adaptation from other external resources | 13 | 24.5 |
| Need Assessment | 11 | 20.8 |
| Focus group with the target audience | 10 | 18.9 |
| External consultant | 9 | 17 |
| Based on national communication policy or strategy | 7 | 13.2 |
| Design by foreign experts | 3 | 5.7 |
| Total | 53 | 100.0 |

Table 8 depicts the method of message design on ART as reported by participants. Accordingly 24.5% of agencies design their messages by adaptation from other external sources; 20.8% design messages based on need assessment; 18.9 % agencies design messages based on focus group with the target audience, 17% of the agencies employ external consultant to prepare media messages for them, and only 13.2% develop messages based on national communication policy or strategy. Some agencies also used

foreign agencies and individuals to develop media messages. The difference in the mean /average for each group of agencies is statistically significant ($P < 0.05$), see appendix E

An informant from ETV mentioned that most of the broadcast messages produced by the stakeholders are very low quality in terms of content and technical input, so they are rejected them since they are not usable and professional to be aired. A respondent from PLWHA said that “We have seen a TV message on adherence and the lady on the TV pretend as if she takes the drug but before she took the drug the scene ends, so non of us believed whether what she is talking about is true or not? The problem is taking the drug and we couldn’t see her doing that.”

The collected data showed that the involvement of ART stockholders on care and treatment program is appreciable. And almost all responded that there are economical, cultural and religious problems that hinder accessibility of ART by PLWHA. Most of them treat advocacy as their strategy to address these and other ART related issues. Most the agencies (83%) claimed they are involved in advocacy work. In addition, of all the mediums of communication more than 80% of the agencies also prefer radio and/or TV as the best way of dissemination information on ART.

However, almost all of the agencies responded there is an information gap of ART, and of all the agencies only 35.8 % have responded they have produced media messages on adherence and/or readiness. Lack of collaboration between themselves and with media agencies, policy of media agencies, lack of expertise and financial resources to design media messages, limited air time and capacity of media agencies are some of the main challenges create hindrance to take advantage of the broadcast media as a medium of advocacy to address ART issues.

CHAPTER FIVE: Discussion

Based on the findings, the involvement of stakeholders in care and treatment is appreciable. According to table 2, all hospitals (100%), 75% of PLWHA associations and 20.7 % of governmental and non-governmental organizations are providing services on treatment and care. But the responses of the participants have shown that accessibility hindrances of ART aren't as such being communicated to the public and to the concerned bodies in search of solutions. With 83 % of ART stakeholders' engagement on advocacy (Table 4) only 35.8 % of them have produced messages on ART (Table 5) and the initiation to do media advocacy is limited.

Those limited advocacy practices in these agencies showed that a full blown advocacy strategy of blending science and politics with a social justice value orientation to make the system work better,(Wallack, Dorfman, Jernigan, & Themba 1993) particularly for those with the least resourced is not yet started. Still some of the messages are confusing and lack workable theoretical frameworks to address behavioral change by perceiving the person-in-environment. As a result, the prevailing approaches disassociate the victims from the root cause and the broader social and political factors (Iyengar, 1991).

Advocacy efforts to address adherence problems appear to be engagement in blaming the victim for lacking desire or being lenient to attend ART, rather than addressing the information gap or fear of stigma associated with the treatment. As Rayn (1976) implied, there is a natural tendency to craft messages by perceiving the person- in-situation which obstructs to notice gaps in the system as a result the advocacy goal to address the system will be self defeated.

Victim blaming is so strongly ingrained in the way that many of the broadcast media messages of HIV/AIDS are designed and this push to respond to problems that becomes second nature and invisible. For a person who prefers to die with silence rather than take HIV treatment and face severe stigma, our first response might be “why not he/her attend ART? It is for free after all.” This response is immediate, involuntary and intuitive. It is however, not a neutral response, this response immediately focuses on the behavior of the patient and deflects attention away from the more basic question of safe and secure environment. This reinforces the element of personal choice and with it personal responsibility and blame, giving no room for advocacy. The fragmented and episodic, effort to communicate ART showed that there is lack of underlying theoretical base for our ART related behavior communication.

PLWHA are still stigmatized and still need help to influence their behavior towards ART. Social cognitive theory is recommended in this regard. According to this theory reciprocation among behavior, person, and environment is common (Bandura, 1986). People and their behaviors are shaped by their environments, yet people also shape their environments through behavior and expectations. PLWHA can shape peoples’ behavior towards HIV/AIDS and ART. And, the changed behavior of the community in the end will give PLWHA a better environment to live with HIV/AIDS.

The notion of environment in this juncture will call practical social work theory and knowledge to address the crux of the issues. In social work practice, environment may be defined as a combination of people and their social and environmental interaction in a particular personally, culturally and socially constructed geographic space (Compton, Gallaway, & Cournoyer, 2005). Social workers incorporate systems and ecosystems

thinking in their efforts to understand the influence of environmental events and conditions in which PLWH resided.

Message tailoring for a specific stage of behavior change is also important. The message for PLWHAs at the precontemplation stage who have not yet decided to attend ART should be different from the messages designed for those who are considering ART is important at contemplation stage. Those who have started to attend ART should get support through messages to maintain their behavior of attending ART. But the widely practiced method of message design on ART as reported by participants seems to have no room to accommodate these practical theoretical based approaches. According to the findings, only 20.8 % of the agencies design messages based on needs assessment, others design messages based on adaptation from external sources, by hiring an external consultant, by designing based on a national policy without involving the audience or by conducting needs assessment and testing the message to the target audience before aired in the media.

In Ethiopia, radio is the best means of disseminating information. According to Ellene, Mesfin, & Alemayehu (2003) there are 4 television sets for every 1,000 people in the country, but at the same time, there are 193 radios per 1,000 people, which makes radio the most widely used source of information in the country. According to the findings of the study, 23 agencies (43%) prefer radio, 11 agencies (20 %) prefer TV and 10 agencies (18.9%) prefer TV and Radio together. Over 81 % of all agencies respond that radio or/and TV is the best channel of communication; the rest prefer print media and workshops. This shows that broadcast media especially radio is the best media to communicate ART messages. But, short air time, lack of expertise on media

communication and lack of expertise on HIV/AIDS and ART in the media agencies will create challenges in ART communication in the foreseeable future. ETV is not yet mainstreaming HIV/AIDS in its programs so using the air time free of charge is not happening now or in the near future. Had it been mainstreaming by all media agencies they were expected to plan and implement any HIV/AIDS related issues by themselves. But the trend shows different directions, the other stakeholders pushing the media agencies to address HIV/AIDS related issues. And, media agencies are reluctant to be in the frontline to undertake HIV/AIDS communication activities.

The limited amount of collaboration and partnership between agencies shows there is a problem of coordination in the national effort to combat HIV/AIDS. HAPCO is in place but most informants reported that it has not executed its mandated role of coordination, capacity building and Advocacy. So the agency has immersed itself in program implementation which will overlap with other agencies direction, and it risks its assigned responsibilities.

The pervasive thought that media is “exclusive” of the community puts the media outside of the community. But, as a primary stakeholder its mandate to communicate ART issues should be stressed. Health professionals and health institutions should communicate the necessary information to the media agencies to be conveyed to the public and policy makers.

The following model (Fig. 5) summarizes my study of ART Media advocacy in a systems approach. The study shows that around the three sides of the media three subgroups of ART stakeholders are strategically located and this will give an opportunity

to undertake a vigorous media advocacy work through collaboration among themselves and with the media agencies.

One subgroup of ART stakeholders clustered on one side of the media are GOs, NGOs, CBOs, FBOs and academia. These agencies can make use of media for agenda setting and policy influence by addressing the person-in-environment (systems approach). Issues of this group include treatment literacy, donor advocacy and policy issues. The second subgroup of ART stakeholders found on the other side of media are PLWHA associations who are strategically located on this side of the media and by the virtue of the nature of their association they can make use of media to bring effective behavior change toward ART through social cognitive and transtheoretical approach (systems approach). Issues in this group include misconceptions, stigma, behavior change towards ART, adherence and readiness to ART. On the third side of the media are direct service givers of ART, which includes hospitals, VCT centers, clinics and health posts. These can give service information about ART using thematic approach (a systems approach). Issues in this group include treatment literacy, counseling, and drug quality control.

These stakeholders have to collaborate among themselves and with the media agencies to score a dramatic result in ART communication. For example through cooperation those clusters of organizations GOs and NGOs can build the capacity of PLWHA associations to enable these associations to work on behavioral change communication towards ART. The associations can address specific issues or ART related policy gaps which need immediate attention to be addressed by the GOs and NGOs. Once the agenda has set the service information given by the hospitals and the

behavioral change messages by PLWHA associations towards ART can compliment each other; but to achieve this model collaboration between agencies should be attained.

Any corner of the media triangle in this media advocacy tool represents the collaboration between any two adjacent subgroups of ART stakeholders. Based on their comparative advantage and the type of service they give to PLWHA, their collaboration to do media advocacy will result one of the following changes:

- Collaboration between GOs, NGOs, CBOs, and Academia in one sub group and PLWHA associations in the other subgroup will result in agenda setting of ART and then behavior change towards ART.
- Collaboration between GOs, NGOs, CBOs, and Academia in one subgroup and direct ART service givers in the other subgroup will result making ART as public agenda and then giving service information.
- Collaboration between PLWHA associations in one subgroup and Direct ART service givers in the other subgroup will result behavior change towards ART then service information about ART.

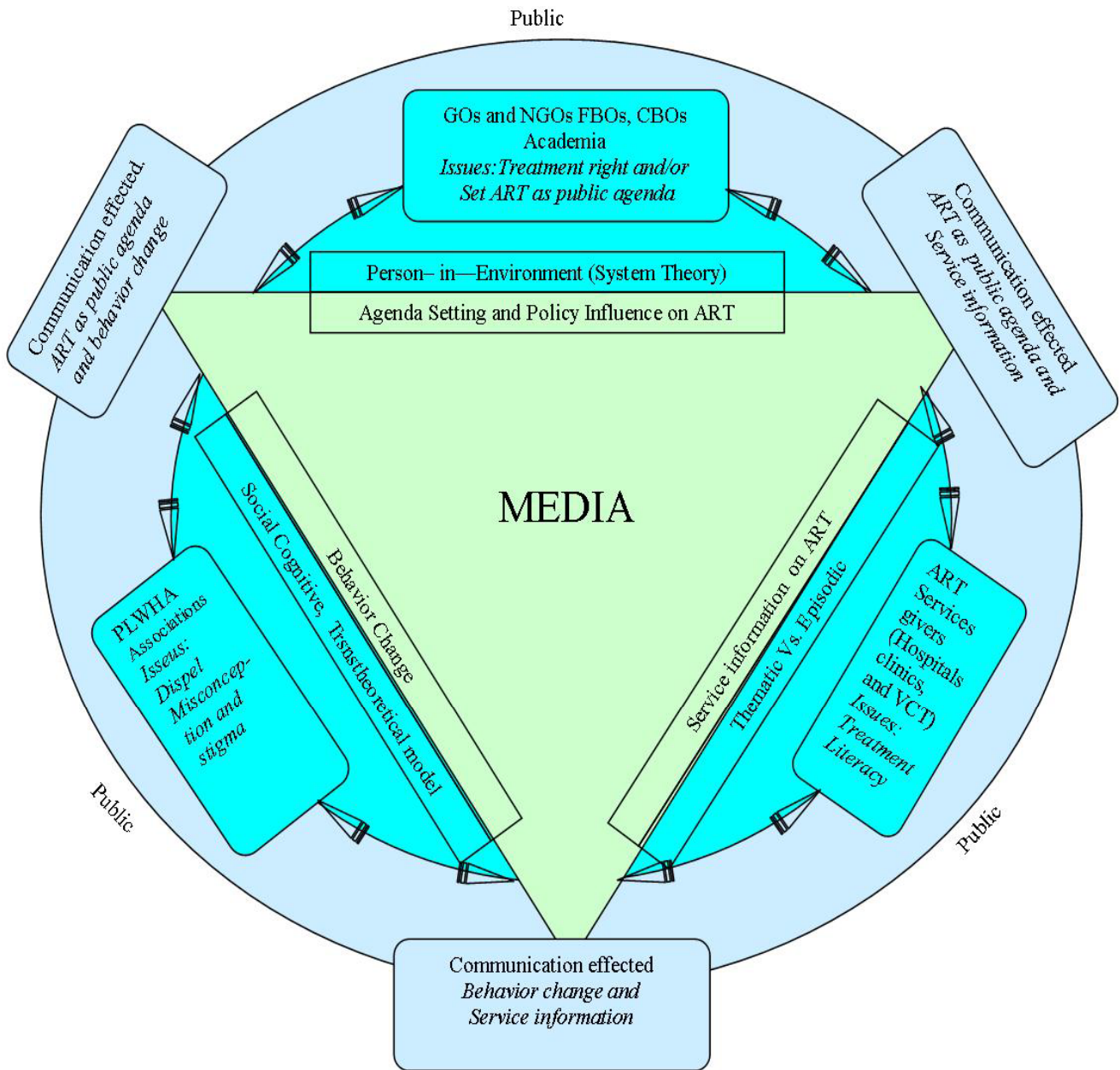


Figure 5 A System approach to ART media Advocacy

CHAPTER SIX: Conclusion and Recommendations

6.1 Conclusions

The experience of ART stakeholders in addressing problems caused hindrance to accessibility of ART using broadcast media is limited and accordingly it is hard to conclude that ART is public agenda by now. This is due to many factors including coordination and collaboration problems, limited air time, high broadcasting price, lack of expertise in producing media messages, and lack of knowledge on how to approach problems related to ART. HAPCO is the national office whose exclusive objective is coordinating, capacity building and facilitating advocacy undertakings. As these functions are not yet fully practiced by the agency it should concentrate on its mandated activities to help the stakeholders to run a coordinated advocacy activities based on the national ART communication strategy.

The media agencies have not yet mainstreamed HIV/AIDS in their programs; as a result they can't design programs and allocate funds by themselves to address ART and other HIV/AIDS issues. The ART communication strategy was supposed to be developed by media agencies. Designing it by other agencies caused the media agencies to be outsiders of ART communications. If unable to develop it by themselves, media agencies should have been the main actors during the development of ART strategy.

Post evaluation systems should also be developed to check if the media agencies are working to make ART the public agenda by giving a notable coverage, which will result community ownership of the issue. The media agencies gap of skilled human resource on media communication, media equipment, and HIV/AIDS expert need

immediate response by the agencies themselves or other agencies working on capacity building.

PLWHA associations are mushrooming in these days and the importance of their involvement in ART advocacy can't be over emphasized. Their access to the media should be ensured and their capacity must be addressed; besides all advocacy undertakings must put them in the frontline to bring an effective result.

Direct service givers of ART like hospitals and VCT centers are facing with so many problems with their day to day encounter with the beneficiaries. They have to have an information and documentation section which help to identify issues to be addressed using media.

6.2 Recommendations

1. HAPCO is the national office whose exclusive objective is coordinating, capacity building and facilitating advocacy undertakings should concentrate on its exclusive roles and it should concentrate on its mandated activities to help the ART stakeholders to run a coordinated advocacy activities.
2. Broadcast media agencies limited capacity of financial expertise and policy issues should be addressed by the relevant governmental or non-governmental agencies. For the time being special treatments of HIV/AIIS issues should be given with the given condition if limited air time, high broadcasting price, lack of expertise in producing media messages, and lack of knowledge on how to approach problems related to ART.
3. The media agencies have not yet mainstreamed HIV/AIDS in their programs; as a result they can't design programs and allocate funds by themselves to address

- ART and other HIV/AIDS issues. Immediate efforts by the concerned bodies should be made to mainstream HIV/AIDS in all media agencies and reformulate their policy accordingly and plan ART communication strategy together with other ART stakeholders. Designing it by other agencies made the media agencies outsiders of ART communications.
4. Pre and Post evaluation systems of media productions should also be formulated and a defined body like Ministry of Health should evaluate or censor its quality before aired to the audience.
 5. Monitoring and evaluation methods should be developed to check if the media agencies are working to make ART the public agenda by giving a notable coverage, which will result community ownership of the issue.
 6. PLWHA associations' access to the media should be ensured and their capacity must be addressed; besides all advocacy undertakings must put them in the frontline to bring an effective result. ART advocacy media products must be pre-tested with a focus group comprised PLWHA.
 7. Direct service givers of ART like hospitals and VCT centers are facing with so many problems with their day to day encounter with the beneficiaries. They have to have an information and documentation section which help to identify issues to be addressed using media by collaborating with other ART stakeholders.
 8. The schools of social work should integrate social media component in the curriculum and address pressing issues of social concern in the country by introducing practical social work theories of ecosystem and system theories to address a person in its environment.

6.3 Social Work Implications

6.3.1 Individual Counseling for Health Professionals

With limited number of hospitals and health infrastructure, turnover and burn out of health professionals is higher in the big hospitals like Alert and Black Lion where 3000 patients are handled by 4-5 health professionals. As the treatment is free the number is getting higher with a limited number of professionals and health infrastructure. This condition inevitably caused high amount of burn out on health professionals. Individual counseling service for health professionals should be in place to assist the health professionals.

6.3.2 Case Management for PLWHA

Case management in its generic form is a mode of service integration that begins with a service request from a client and ends with feedback data for evaluation of client satisfaction and goals (Chazdon, 1991). ART is being served freely but there is much unmet need leading to dissatisfaction of clients so case management which includes client assessment, case organizing, planning and referrals to service providers, client advocacy, developing client support systems and reassessment evaluation should be the arena of Social Work.

6.3.3 Political/Policy Advocacy

There are many policies and strategic plans related to HIV/AIDS but most of them are not known and are not being implemented. To mention one, the national ART communication strategy was developed without involving media agencies so most of the agencies are not aware of it. An implementation plan to make ART communication

effective is not developed on the document, hence, political/policy advocacy is uncharted terrain in Ethiopia that should be assumed by Social Workers in the future.

6.4 Social Media Implications

Social Media which gives a special emphasis on social and economic problems of a community have a pivotal role to play in the fight against AIDS. It is often said that education is the vaccine against HIV and many media organizations are rising to the challenge by promoting awareness of HIV/AIDS and educating listeners and viewers about the facts of the epidemic and how to stop it. Implications of the study to the social media can be summarized as follows.

6.4.1 Social Media as Enabler

Stigma is malicious and it clogging the way access to ART. Social media can create social binding amongst the HIV positive and with HIV negative individuals. Enabling PLWHA can be achieved by ‘voicing’ and ‘representing’ them actively through media.

6.4.2 Social Media as Educator and Informer

Detailed information, on HIV natural history, viral load, CD4 counting, combination choices, possible side effects, newly emerging drugs, resistance and compliance should be addressed using social media. Lack of knowledge on the issues can't be an excuse; however, these detailed matters should be systematically handled by working with health professionals. These media should give voice to the experiences of people taking the treatments, and those voices feed back into changing clinical practices,

research agendas and advocacy for better regimen to help in making treatments decisions by the target audience.

6.4. 3 Social Media as Entertainer

Social media can convey messages of HIV/AIDS treatment information by creating ways of making the information relevant, interesting and palatable by making it 'entertaining'. Knowing the cultural and language disposition of a specific target audience and instilling the designed messages by means of drama, music or cultural traditions will have the power to grab the audience to educate as well as entertain.

6.4. 4 Social Media as Broker and Negotiator

From the perspectives of people living with HIV, getting access to ART means living with a chronic disease and this means living with service providers, researchers, clinicians, policy makers and funders. Social media understandings of what brokering and negotiation of informed opinion in this context should address the challenges of living with the chronic illness from the PLWHA perspective.

Tensions associated with accessibility and use of ART can be mediated variously by the messages transmitted by social media. These messages have various amounts of social power attached to them that are situational specific and that affect matters of access, vulnerability, equality, social capacity and resilience.

Generally speaking, media advocacy is an environmental strategy that can be used to support any social problem prevention and policy development effort, In this regard it helps shift the focus from understanding common socials problem as individual problems to understanding them as social conditions; and initiates a collective behavior change.

Successful media advocacy uses the media as a vehicle to convey campaign and organizational messages about any social issues including HIV/AIDS to large audience. Social service agencies (both governmental and non- governmental) and academic including the newly emerging school of social work should give concern for media advocacy training for community groups and government agencies to leverage the impact of media to address these problems.

6.5 Future Research Areas

Governance and Challenges of HIV/AIDS on the Public Sector in Ethiopia:

Response Analysis on the multi-sectoral Response to the Pandemic

A number of researchers have already argued that the HIV/AIDS epidemic poses a serious challenge to governance both at the local and national levels (Willan, 2000; Manning, 2003; Waal, 2003). The aim of this research is to make a response analysis on the multi-sectoral response by the governments of Ethiopia to challenges posed by the pandemic on the public sector.

The Response Analysis will address questions such as:

- What is the HIV/AIDS impact on the different sectors of the country?
- What is being done to respond to HIV?
 - o What is working and needs to be continued?
 - o What is working and can be expanded?
 - o What is not working and needs a new, more strategic approach?
- Is the national response relevant to the current situation?
 - o What is not relevant to current needs and should be dropped?
- Is the response working in priority areas?

- Why is a response working or not working?
- What has not been addressed at all?

This study designed to involve government bodies, both federal and regional; academic institutions; community-based organizations; NGOs; private companies; international organizations; and the media.

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Appendices

APPENDIX A: Research Questionnaire for Governmental and Non-governmental Organizations

Agency's Profile

| | |
|---|------------------|
| Name of Agency: | |
| Contact person: | |
| Address: | |
| Country: | |
| Telephone: | |
| Email: | |
| Web address/URL: | |
| Agency's mandate or specific objectives related to HIV: | |
| Total number of staff at a) headquarters: | b) in the field: |

PART I

The first set of questions is designed to assess the extent of your agency's involvement in Treatment and Care of HIV/AIDS.

Question 1

a) In which of the following areas (see the table below) is your agency currently involved primarily? Please tick all that apply in column A.

b) In which area would your agency become involved if it could possible? Please tick all that apply in column B.

c) Are there any areas of work your agency would never consider? Please tick all that apply in column C.

| | A | B | C |
|---|---|---|---|
| Prevention | | | |
| Care and treatment | | | |
| Voluntary counseling and testing (VCT) | | | |
| Prevention of Mother-to-Child Transmission (PMTCT) | | | |
| Human rights | | | |
| Vulnerability | | | |
| Children orphaned and made vulnerable by HIV/AIDS (OVC) | | | |
| Social and economic impact | | | |
| Research and development | | | |
| Conflict and disaster affected regions | | | |
| Other. Specify _____ | | | |

| | | | |
|----------------------|--|--|--|
| Other. Specify _____ | | | |
| Other. Specify _____ | | | |

Question 2

a) How much of your agency's work is related to Treatment and Care of HIV/AIDS? (Give an estimate by placing an X in one of the following boxes.)

| None | 1-10% | 11-20% | 21-30% | 31-40% | 41-50% | 51-60% | 61-70% | 71-80% | 81-90% | 91-100% |
|------|-------|--------|--------|--------|--------|--------|--------|--------|--------|---------|
| | | | | | | | | | | |

Question 3

b) Are there any barriers that currently prevent your agency from doing more on HIV/AIDS treatment?

| Yes | No |
|-----|----|
| | |

c) If yes, please describe if these barriers of treatment of HIV/AIDS have get converge on the broadcast media:

| |
|---|
| <p>Economic Problems:</p> <p>Religious problem:</p> <p>Cultural problems:</p> <p>Misconception and myths:</p> <p>Lack of Health professionals:</p> <p>Others: specify:</p> |
|---|

c) What other problems do you think affect scaling up of ART in terms of the following points?

Availability of ART?

Accessibility of ART?

Acceptability of ART

Affordability of ART

PART II

In relation to AIDS epidemic advocacy can be described as a process designed to influence positive political, social, economic and cultural change to tackle AIDS. Advocacy seeks to move specific constituencies into action to change the status quo and to promote and support key initiatives to tackle AIDS (UNAIDS). Advocates help people use their power, articulate other (or own) needs as they perceive them, or secure series resources, legal decisions they require and or the right to which they are entitled (Braye and Preston. 1995)

The following questions are intended to assess the extent to which your agency is involved in media advocacy to frame accessibility of Anti Retroviral Treatment(ART) for persons living with the virus (PLWHA).

Question 4

a) Does your agency have HIV/AIDS guideline, strategy or policy? (Please tick)

| | | | |
|-----|--------------------------|----|--------------------------|
| Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|-----|--------------------------|----|--------------------------|

b) If yes, what is the focus of the guideline, strategy or policy?

| |
|------------------|
| |
|------------------|

Question 5

a) Does your agency have a web site? (Please tick)

| | | | |
|-----|--------------------------|----|--------------------------|
| Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|-----|--------------------------|----|--------------------------|

b) Do you have HIV/AIDS content on the web site? (Please tick)

| | | | |
|-----|--------------------------|----|--------------------------|
| Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|-----|--------------------------|----|--------------------------|

c) If yes, does it refer to (check all that apply)

- General HIV/AIDS information
- Listing of services provided
- Prevention information
- Information about treatment and care

d) What does the treatment information contain?

_____Hospitals

_____Health posts

_____Voluntary Counseling and Testing centers (VCTs)

_____Contact address of concerned agencies working on ART

Question 6

a) Has your agency worked on HIV/AIDS – related advocacy work before?

| | | | |
|-----|--------------------------|----|--------------------------|
| Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|-----|--------------------------|----|--------------------------|

b) If yes, which of the following proved most effective in achieving positive change? (Please tick one only)

| | |
|--|--------------------------|
| Raising AIDS issues at public meetings and conferences | <input type="checkbox"/> |
| Contributing to public AIDS campaigns | <input type="checkbox"/> |
| Working through the media to raise public awareness | <input type="checkbox"/> |
| Targeting parliamentarians and policymakers | <input type="checkbox"/> |
| Engaging new leaders and partners | <input type="checkbox"/> |
| Events to mark World AIDS Day | <input type="checkbox"/> |
| Attending international/regional AIDS conferences | <input type="checkbox"/> |
| Working with celebrities | <input type="checkbox"/> |
| Community conversation | <input type="checkbox"/> |
| Partnership with media agencies | <input type="checkbox"/> |
| other , specify _____ | <input type="checkbox"/> |
| _____ | <input type="checkbox"/> |

c) Please give a brief description as to how the work was effective in achieving positive change:

| |
|--|
| |
|--|

Question 7

a) Has your agency ever made media message for the general public on HIV/AIDS treatment?

| | | | |
|-----|--------------------------|----|--------------------------|
| Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|-----|--------------------------|----|--------------------------|

b) If yes, describe when and content:

| |
|--|
| |
|--|

c) Has your agency ever made media messages for the general public on social services needed to ensure effectiveness of ART?

| | | | |
|-----|--------------------------|----|--------------------------|
| Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|-----|--------------------------|----|--------------------------|

d) If yes, describe when and content:

| |
|--|
| |
|--|

e) Has your agency ever made media message for the general public on preparedness and adherence to ART?

| | | | |
|-----|--------------------------|----|--------------------------|
| Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|-----|--------------------------|----|--------------------------|

f) If yes, describe when and content:

| |
|--|
| |
|--|

Question 8

a) In which of the following areas might your agency need more support? (Please describe briefly the kinds of support that would help)

| | |
|--|--|
| Raising AIDS treatment issues at public meetings and conferences: | |
| Contributing to public AIDS treatment campaigns: | |
| Working through the media to raise AIDS treatment issues: | |
| Targeting parliamentarians and policymakers about AIDS treatment issues: | |
| Engaging new leaders and partners in HIV and AIDS treatment: | |
| Events on ART to mark World AIDS Day: | |
| Attending international/regional AIDS treatment Conferences: | |

| | |
|---|--|
| | |
| Working with celebrities to raise AIDS treatment issues: | |
| Local VCT Campaigns: | |
| Forming partnership with media agencies to address AIDS treatment: | |
| Community Mobilization through community conversation: | |
| Peer (interpersonal) persuasion: | |
| Others, Specify: | |

Question 10

a) Is there any training needs pertaining to media advocacy by your agency to do more advocacies around issues of ART to your target beneficiaries? (Please specify topics)

| |
|--|
| |
|--|

Question 11

a) Has your agency been involved with any of the following? (Tick all that apply)

| | |
|---|--|
| World AIDS Campaign | |
| The Millennium Campaign | |
| Stop AIDS Campaign | |
| Local community conversation campaign | |
| Other global or local campaigns (please name): | |

b) Does your agency produce any Information Communication Education (IEC) and Behavioral Change Communication (BCC) materials?

| | | | |
|-----|--|----|--|
| Yes | | No | |
|-----|--|----|--|

Specify the topics:

| |
|--|
| |
|--|

c) Which media were utilized? (Check all that apply on the table under C.)

d) Does your agency produce IEC/BCC materials on ART

| | | | |
|-----|--|----|--|
| Yes | | No | |
|-----|--|----|--|

e) If yes can you check on the type of media utilized on the table on E

| | C | E |
|-----------------------------------|---|---|
| Radio. | | |
| Television. | | |
| Newspapers. | | |
| Billboards. | | |
| Posters. | | |
| Pamphlets. | | |
| Newsletters. | | |
| Workshops - meetings - trainings. | | |
| Media interviews. | | |
| Other media. (Specify.) | | |

f) How did you design the content of the IEC/BCC materials? (Check all that apply.)

| | |
|---|--|
| Based on pre-existing national or local communication strategy and other government guidelines. | |
| Focus groups with intended audience. | |
| Need assessment | |
| Adaptation / replication of successful materials used in other places. | |
| External consultants | |
| Other (Specify.) | |

Question 12

Finally, do you have any other comments that you want to highlight on the constraints, challenges and/or opportunities you encountered on the effort to frame messages of ART to ensure its accessibility (Please specify)

The next phase of this research will be key informants interview and examining specific media and advocacy messages and campaigns with regards to anti-retroviral therapy. Are you willing to be contacted to participate in phase II.

_____ yes, there are messages I would be glad to provide for the 2nd phase

_____ No, there are no messages related to our programs that would meet this

purpose.

_____ While we may have some related materials they are not available for analysis at this time.

Thank you for your time.

**Please complete and return to:
Moges Tafesse at mogesdigital@yahoo.com**

Should you have any questions please telephone: 0911-642670

APPENDIX B : Research Questionnaire for Media Agencies

Agency's Profile

| | |
|---|------------------|
| Name of Agency: | |
| Contact person: | |
| Address: | |
| Country: | |
| Telephone: | |
| Email: | |
| Web address/URL: | |
| Agency's mandate or specific objectives related to HIV: | |
| Total number of staff at a) headquarters: | b) in the field: |

PART I

The first set of questions is designed to assess the extent of your agency's involvement in Treatment and Care of HIV/AIDS.

Question 1

a) In which of the following (see the table below) is your agency currently convey frequent messages? Please tick in column A.

b) In which area would your agency become involved if it could possible? Please tick all that apply in column B.

c) Are there any areas listed below your agency would never consider? Please tick all that apply in column C.

| | A | B | C |
|------------------------------------|---|---|---|
| HIV/AIDS treatment and care | | | |
| Human rights | | | |
| Corruption | | | |
| Vulnerability | | | |
| Commercials | | | |
| Other. Specify _____ | | | |
| Other. Specify _____ | | | |
| Other. Specify _____ | | | |

PART II

In relation to AIDS epidemic advocacy can be described as a process designed to influence positive political, social, economic and cultural change to tackle AIDS. Advocacy seeks to move specific constituencies into action to change the status quo and to promote and support key initiatives to tackle AIDS (UNAIDS). Advocates help people use their power, articulate other (or own) needs as they perceive them, or secure series resources, legal decisions they require and or the right to which they are entitled (Braye and Preston. 1995)

The following questions are intended to assess the extent to which your agency is involved in media advocacy to frame accessibility of Anti Retroviral Treatment (ART) for persons living with the virus (PLWHA).

Question 4

a) Does your agency have Media protocol (guideline)?

| | | | |
|-----|--------------------------|----|--------------------------|
| Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|-----|--------------------------|----|--------------------------|

b) Does the protocol or guideline has anything to do with HIV/AIDS

| | | | |
|-----|--------------------------|----|--------------------------|
| Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|-----|--------------------------|----|--------------------------|

c) If yes, please specify?

| |
|--------------|
| |
|--------------|

Question 6

a) Has your agency worked on HIV/AIDS related Media advocacy work in partnership with other governmental or non-governmental agencies before?

| | | | |
|-----|--------------------------|----|--------------------------|
| Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|-----|--------------------------|----|--------------------------|

b) If yes, which of the following proved most effective in achieving positive change using messages of radio and TV? (Please tick one only)

| | |
|------------------------------------|--------------------------|
| Raising awareness on AIDS issues | <input type="checkbox"/> |
| Avoiding Stigma and discrimination | <input type="checkbox"/> |
| Promoting ART | <input type="checkbox"/> |
| other , specify: | <input type="checkbox"/> |

c) Please give a brief description as to how the work was effective in achieving positive change:

| |
|--------------|
| |
|--------------|

| |
|--|
| |
|--|

d) Has your agency made a media campaign on ART before

| | | | |
|-----|--------------------------|----|--------------------------|
| Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|-----|--------------------------|----|--------------------------|

For the campaigns

| | | |
|--|--|--------------------------|
| | Why do you call this campaign? | |
| | When did this campaign begin? (mm/yy) | |
| | What was the length of the campaign (in weeks)? | |
| | What was the objective? (Check all that apply.) | |
| | Raise awareness on ART | <input type="checkbox"/> |
| | Inform about the availability of the services. | <input type="checkbox"/> |
| | Adherence | <input type="checkbox"/> |
| | Promote ART | <input type="checkbox"/> |
| | Other (Specify.) | |

e) Describe the target audience:

| |
|--|
| |
|--|

Question 7

In which of the following areas might your agency lack expertise? (Please describe briefly the kinds of support that would help to improve it)

| | |
|--|--|
| Media Advocacy skill | |
| Media communication strategy | |
| Documentation, lobbying and promotion skill | |
| Communication skill | |
| Empowerment skill | |
| Journalism skill | |
| Community Mobilization skill | |
| Others, Specify: | |

Question 8

Who evaluate the messages on social issues like HIV/AIDS before it conveyed to the public?

Question 9

Finally, do you have any other comments that you want to highlight on the constraints, challenges and/or opportunities you encountered on the effort to frame messages of ART to ensure its accessibility (Please specify)

The next phase of this research will be key informants interview and examining specific media and advocacy messages and campaigns with regards to anti-retroviral therapy. Are you willing to be contacted to participate in phase II.

_____ yes, there are messages I would be glad to provide for the 2nd phase

_____ No, there are no messages related to our programs that would meet this

purpose.

_____ While we may have some related materials they are not available for analysis at this time.

Thank you for your time.

Please complete and return to:

Moges Tafesse at mogesdigital@yahoo.com

Should you have any questions please telephone: 0911-642670

| | | | |
|---|--|--|--|
| Research and development | | | |
| Conflict and disaster affected regions | | | |
| Other. Specify _____ | | | |
| Other. Specify _____ | | | |
| Other. Specify _____ | | | |

Question 2

How much of your agency's work is related to Treatment and Care of HIV/AIDS? (Give an estimate by placing an X in one of the following boxes.)

| None | 1-10% | 11-20% | 21-30% | 31-40% | 41-50% | 51-60% | 61-70% | 71-80% | 81-90% | 91-100% |
|------|-------|--------|--------|--------|--------|--------|--------|--------|--------|---------|
| | | | | | | | | | | |

Question 3

a) Are there any barriers that currently prevent your agency from doing more on HIV/AIDS treatment?

| | | | |
|-----|--|----|--|
| Yes | | No | |
| | | | |

b) If yes, please describe:

| |
|---|
| <p>Economic Problems:</p> <p>Religious problem:</p> <p>Cultural problems:</p> <p>Misconception and myths:</p> <p>Lack of Health professionals:</p> <p>Others: specify:</p> |
|---|

c) What other problems do you think affect scaling up ART in terms of the following points?

Availability of ART?

Accessibility of ART?

Acceptability of ART

Affordability of ART

PART II

In relation to AIDS epidemic advocacy can be described as a process designed to influence positive political, social, economic and cultural change to tackle AIDS. Advocacy seeks to move specific constituencies into action to change the status quo and to promote and support key initiatives to tackle AIDS (UNAIDS). Advocates help people use their power, articulate other (or own) needs as they perceive them, or secure series resources, legal decisions they require and or the right to which they are entitled (Braye and Preston. 1995)

The following questions are intended to assess the extent to which your agency is involved in media advocacy to frame accessibility of Anti Retroviral Treatment (ART) for persons living with the virus (PLWHA).

Question 4

a) Does your agency have HIV/AIDS guideline, strategy or policy? (Please tick)

| | | | |
|-----|--------------------------|----|--------------------------|
| Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|-----|--------------------------|----|--------------------------|

b) If yes, what is the focus of the guideline, strategy or policy?

| |
|------------------|
| |
|------------------|

Question 5

a) Does your agency have a web site? (Please tick)

| | | | |
|-----|--------------------------|----|--------------------------|
| Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|-----|--------------------------|----|--------------------------|

b) Do you have HIV/AIDS content on the web site? (Please tick)

| | | | |
|-----|--------------------------|----|--------------------------|
| Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|-----|--------------------------|----|--------------------------|

c) If yes, does it refer to (check all that apply)

___ General HIV/AIDS information

___ Listing of services provided

- ___ Prevention information
- ___ Information about treatment and care

- d) What does the treatment information contain?
- ___ Other Hospitals and health centres
 - ___ Health posts
 - ___ Voluntary Counselling and Testing centres (VCTs)
 - ___ Contact address of concerned agencies working on ART

Question 7

a) Can you mention any Radio/TV programs that address the common problems you face in administering ART in your health centre?

| | | | |
|-----|--------------------------|----|--------------------------|
| Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|-----|--------------------------|----|--------------------------|

b) If yes, describe which and content:

c) Can you mention any Radio/TV programs that address the social services needed to ensure effectiveness of ART?

| | | | |
|-----|--------------------------|----|--------------------------|
| Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|-----|--------------------------|----|--------------------------|

d) If yes, describe which and content:

Question 10

Which issues of ART do you think should be addressed through media to scale up ART service for beneficiaries? why?

Question 11

a) Has your agency been involved with any of the following? (Tick all that apply)

| | |
|--|--|
| World AIDS Campaign | |
| The Millennium Campaign | |
| Stop AIDS Campaign | |
| Local community conversation campaign | |
| Other global or local campaigns (please name): | |

b) Does your agency produce any Information Communication Education (IEC) and Behavioral Change Communication (BCC) materials in partnership with other governmental or non-governmental organizations?

| | | | |
|-----|--------------------------|----|--------------------------|
| Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|-----|--------------------------|----|--------------------------|

Specify the topics:

| |
|--|
| |
|--|

c) Which media were utilized? (Check all that apply on the table under C.)

| | C |
|-----------------------------------|--------------------------|
| Radio. | <input type="checkbox"/> |
| Television. | <input type="checkbox"/> |
| Newspapers. | <input type="checkbox"/> |
| Billboards. | <input type="checkbox"/> |
| Posters. | <input type="checkbox"/> |
| Pamphlets. | <input type="checkbox"/> |
| Newsletters. | <input type="checkbox"/> |
| Workshops - meetings - trainings. | <input type="checkbox"/> |
| Media interviews. | <input type="checkbox"/> |
| Other media. (Specify.) | <input type="checkbox"/> |

The next phase of this research will be key informants interview and examining specific media and advocacy messages and campaigns with

regards to anti-retroviral therapy. Are you willing to be contacted to participate in phase II.

_____ yes, there are messages I would be glad to provide for the 2nd phase

_____ No, there are no messages related to our programs that would meet this

purpose.

_____ While we may have some related materials they are not available for analysis at this time.

Thank you for your time.

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Moges Tafesse at mogesdigital@yahoo.com

Should you have any questions please telephone: 0911-642670

APPENDIX D: Interview Questions

Introduction

The main objective of this interview is to collect data on the attention and coverage that the media have given to HIV/AIDS treatment issues. The data will be used for a study to improve the role of Media advocacy in framing accessibility ART.

1. Which kind of electronic and print media outlets does your agency use to convey messages on HIV/AIDS? Why?
2. What are the media agencies your organization working with? Why?
3. Do you believe partnership with media is so important to address ART? Why?
4. Do media policy makers like the ministry of information influences your agency's policy in addressing issues of ART? How?
5. Does your organization address ART issues regularly and sensitively? How?
6. Are the programs on ART non-discriminatory and broadcasted at appropriate times so far? What lesson have you learnt from that?
7. Do the journalists/writers you approach have a good background of the problem they report/write about to ensure its accuracy and effectiveness?
8. Is there anything you have always wanted to do for media outlets but have been unable to do in the past because of lack of training or information?
9. In the case of journalists what would you like writers to learn about ART to make your work easier? In the case of editors what would you like the owners/directors of media agencies to learn about ART to make your work easier?
10. How important do you believe ART issues are in the context of the newsworthy topics, development topics, health topics that are being transmitted in the electronic and print media?

11. What do you believe is the media's role in addressing issues of accessibility of ART?
12. What do you believe the roles of the reporter, editors, media owners, etc in framing accessibility of ART?
13. What are the main issues of ART and how do you think these issues should be addressed using media?
14. What do you believe are the biggest barrier to create accessibility of ART in your intervention areas on ART?
15. Do you think there is much faulty or inaccurate reporting or messages on ART issues?
16. Do you think there are as many sensational stories about ART as the intensity of the problem?
17. How does your organization keep media professionals informed about new ART researches?
18. Do you know any radio program dedicated to ART?
19. What is the use of weekly (monthly) ART column or commentary in the news by asking a local newspaper, magazine or radio station owner?
20. What use does it bring meeting with producer or writers of television and radio soap opera or show writers regularly.

Appendix E: Mean Report and one way ANOVA

Mean Report

| Organization by service type | | Treatment and care | Barriers of ART | Advocacy experience | Adherence and readiness | Media message on ART | Design the content of the IEC/BCC materials | Which media utilized | Partnership with media agencies |
|---|----------------|--------------------|-----------------|---------------------|-------------------------|----------------------|---|----------------------|---------------------------------|
| Governmental and non-governmental organizations | Mean | 6.0345 | 1.0000 | 1.0690 | 1.7931 | 1.2414 | 1.2069 | 5.5172 | 1.7931 |
| | N | 29 | 29 | 29 | 29 | 29 | 29 | 29 | 29 |
| | Std. Deviation | 3.0529 | .0000 | .2579 | .6199 | .4355 | .4123 | 3.3233 | .5593 |
| PLWHA Associations | Mean | 2.5000 | 1.0000 | 1.0000 | 1.3750 | 1.0000 | 1.0000 | 9.0000 | 1.3750 |
| | N | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 |
| | Std. Deviation | 2.7775 | .0000 | .0000 | .5175 | .0000 | .0000 | .0000 | .5175 |
| Hospitals | Mean | 10.0000 | 1.0000 | 2.0000 | 2.0000 | 1.0000 | 1.0000 | 1.0000 | 2.0000 |
| | N | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| | Std. Deviation | .0000 | .0000 | .0000 | .0000 | .0000 | .0000 | .0000 | .0000 |
| Media Agencies | Mean | 9.1250 | 1.7500 | 1.0000 | 1.3750 | 1.3750 | 1.3750 | 1.0000 | 1.6250 |
| | N | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 |
| | Std. Deviation | 1.5526 | 1.0351 | .0000 | .5175 | .5175 | .5175 | .0000 | .5175 |
| Universities | Mean | 12.0000 | 3.0000 | 2.0000 | 2.0000 | 2.0000 | 1.0000 | 5.0000 | 3.0000 |
| | N | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| | Std. Deviation | .0000 | .0000 | .0000 | .0000 | .0000 | .0000 | .0000 | .0000 |
| Total | Mean | 6.7170 | 1.2642 | 1.1887 | 1.6981 | 1.2642 | 1.1698 | 4.9811 | 1.8113 |
| | N | 53 | 53 | 53 | 53 | 53 | 53 | 53 | 53 |
| | Std. Deviation | 3.6394 | .6836 | .3950 | .5746 | .4451 | .3791 | 3.4999 | .6219 |

ANOVA Test of the Study Variables

| | | Sum of Squares | df. | Mean Square | F | Sig. |
|--|----------------|-----------------------|------------|--------------------|----------|-------------|
| Treatment and care | Between Groups | 356.914 | 4 | 89.229 | 12.907 | .000 |
| | Within Groups | 331.841 | 48 | 6.913 | | |
| | Total | 688.755 | 52 | | | |
| Barriers of ART | Between Groups | 16.802 | 4 | 4.200 | 26.883 | .000 |
| | Within Groups | 7.500 | 48 | .156 | | |
| | Total | 24.302 | 52 | | | |
| Economic problems | Between Groups | 12.911 | 4 | 3.228 | 15.103 | .000 |
| | Within Groups | 10.259 | 48 | .214 | | |
| | Total | 23.170 | 52 | | | |
| Religious problems | Between Groups | 12.375 | 4 | 3.094 | 13.291 | .000 |
| | Within Groups | 11.172 | 48 | .233 | | |
| | Total | 23.547 | 52 | | | |
| Cultural problems | Between Groups | 14.035 | 4 | 3.509 | 15.075 | .000 |
| | Within Groups | 11.172 | 48 | .233 | | |
| | Total | 25.208 | 52 | | | |
| Misconceptions | Between Groups | 11.821 | 4 | 2.955 | 10.872 | .000 |
| | Within Groups | 13.047 | 48 | .272 | | |
| | Total | 24.868 | 52 | | | |
| Advocacy experience | Between Groups | 6.251 | 4 | 1.563 | 40.285 | .000 |
| | Within Groups | 1.862 | 48 | 3.879E-02 | | |
| | Total | 8.113 | 52 | | | |
| Adherence and readiness | Between Groups | 2.661 | 4 | .665 | 2.201 | .083 |
| | Within Groups | 14.509 | 48 | .302 | | |
| | Total | 17.170 | 52 | | | |
| Media messages on ART | Between Groups | 3.117 | 4 | .779 | 5.205 | .001 |
| | Within Groups | 7.185 | 48 | .150 | | |
| | Total | 10.302 | 52 | | | |
| Adaptation | Between Groups | 4.109 | 4 | 1.027 | 5.535 | .001 |
| | Within Groups | 8.909 | 48 | .186 | | |
| | Total | 13.019 | 52 | | | |
| External Consultant | Between Groups | .780 | 4 | .195 | 1.556 | .201 |
| | Within Groups | 6.013 | 48 | .125 | | |
| | Total | 6.792 | 52 | | | |
| Need assessment | Between Groups | 3.184 | 4 | .796 | 4.391 | .004 |
| | Within Groups | 8.703 | 48 | .181 | | |
| | Total | 11.887 | 52 | | | |
| Focus group with intended audience | Between Groups | 3.770 | 4 | .942 | 5.077 | .002 |
| | Within Groups | 8.909 | 48 | .186 | | |
| | Total | 12.679 | 52 | | | |
| National communication strategy(guideline) | Between Groups | 2.566 | 4 | .642 | 2.989 | .028 |
| | Within Groups | 10.302 | 48 | .215 | | |
| | Total | 12.868 | 52 | | | |
| Design the | Between Groups | .838 | 4 | .210 | 1.516 | .212 |

| | | Sum of Squares | df. | Mean Square | F | Sig. |
|----------------------------------|----------------|-----------------------|------------|--------------------|----------|-------------|
| content of the IEC/BCC materials | Within Groups | 6.634 | 48 | .138 | | |
| | Total | 7.472 | 52 | | | |
| Which media to utilized | Between Groups | 327.740 | 4 | 81.935 | 12.718 | .000 |
| | Within Groups | 309.241 | 48 | 6.443 | | |
| | Total | 636.981 | 52 | | | |
| Partnership with media agencies | Between Groups | 7.605 | 4 | 1.901 | 7.295 | .000 |
| | Within Groups | 12.509 | 48 | .261 | | |
| | Total | 20.113 | 52 | | | |