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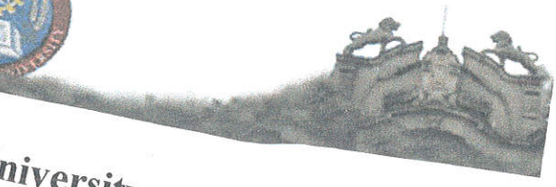

Addis Ababa University

Graduate school of Journalism and communication

A STUDY ON THE HEALTH COMUNICATION STRATEGIES OF FHAPCO TO PREVENT HIV/AIDS IN MARPS AND VULERABLE GROUPS, PARTICULARLY TO ADDRESS COLLEGE AND UNIVERSITY STUDENTS

By: Ayenabeba Abiye W/Amanuel

A Thesis Submitted to the Graduate School of Journalism and Communication

Presented In partial fulfillment of the requirements for the degree of Master of Arts in Journalism and Communication

July, 2016

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Advisor: Zenebe Beyene (Ph.D)

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This is to certify that the thesis is prepared by Ayenabeba Abiye entitled "A study on the health communication strategies of FHAPCO to prevent HIV/AIDS in MARPS and vulnerable groups, particularly to address college and university students", and submitted for the in partial fulfillment of the requirements for the Degree of Master of Arts in Journalism and Communication. It complies with the regulations of the University and meets the accepted standards with respect to originality and quality.

Approved by the Examining Board

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Examiner	Signature	Date
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Examiner	Signature	Date
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Advisor	Signature	Date

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Head, Department Graduate Committee

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List of Acronyms

1. ART- Anti- Retroviral Treatments
2. BCC- Behaviour Change Communication
3. DHS- Demographic Health Survey
4. EE- Entertainment Education
5. FHAPCO- Federal HIV Prevention and Control Office
6. FHI- Family Health International
7. FMOH- Federal Ministry Of Health
8. GBV- Gender Based Violence
9. HIV/AIDS- Human Immune Virus Acquired Immune Deficiency Syndrome
10. ICT- Information Communication Technology
11. IEC- Information Education and Communication
12. IPS- Interpersonal Communication
13. M&E- Monitoring and Evaluation
14. MARPs- Most at Risk Populations
15. MDG- Millennium Development Goal
16. MRIS- Multi- sectoral Response Information System.
17. MSM- Male Having Sex With Male
18. NCI- National Cancer Institute
19. NGOs- Non Governmental Organizations
20. OVS- Orphans and Vulnerable Children

21. PASDEP- The plan for Accelerated And Sustained Development To End Poverty

22. PCA- Participatory Communication Assessment

23. PLA- Participatory Learning Approach

24. PLHIV- People Living with HIV

25. SBCC- Social and Behaviour Change Communication

26. SNNPR- Southern Nations And Nationalities People Region

27. SPMII- Strategic Plan II for intensifying Multi-Sectoral HIV/AID Prevention

28. SRH- Sexual and Reproductive Health

29. STIs- Sexually Transmitted Infections

30. UNAIDS- United Nation Joint Programme on HIV/AIDS

31. UNICIEF- United Nation Children's Fund

32. USAID- United State Agency for International Development

33. WHO- World Health Organization

Abstract

A study on the health communication strategies of FHAPCO to prevent HIV/AIDS in MARPS and vulnerable groups, particularly to address college and university students.

Ayenabeba Abiye

Addis Ababa University, 2016

Annual reports and researches show that HIV/AIDS is still the cause of death for the people around the world especially for the third world countries like Ethiopia. Hence, this study is designed to assess the health communication strategies of FHAPCO to prevent HIV/AIDS in most at risk population (MARPS) and vulnerable groups, particularly to address college and university students.

In the study, qualitative research inquiry was employed. Document analysis and an in-depth interview were data collection tools. The qualitative method followed purposive sampling to select interviewees from the members of the technical team that has designed the SBCC strategy of FHAPCO and personnel in AAU and analyzed the health communication strategy to prevent HIV/AIDS, MARPS and vulnerable groups in Ethiopia.

Additionally the document (health communication strategy for MARPS and vulnerable groups) HIV/AIDS and sexual and reproductive health (SRH) communication for higher education institutions were analyzed thoroughly. The study was informed by participatory communication theory.

Therefore, the study hasrevealed that the social and behavior communication (SBCC) strategy is a strategy which was designed to prevent HIV/AIDS in MARPS and vulnerable groups. Members of the technical team who were assigned to design the SBCC strategy were followed the P-process systematic health communication approach as a guideline.

According to the findings of the study, the controversies between the high risk behaviour of university students to sexually transmitted HIV/AIDS and the availability of the perceived health communication strategies is due to some gaps which were in all stages of the strategy development (lack of key stakeholders participation) and on its implementation.

And the study concluded that the participation of key stakeholders in all stages of communication strategies and communication interventions at all levels of the society is vital to bring about the desired behavior change.

CHAPTER ONE: INTRODUCTION

1.1 Background of the study

Health communication is defined as the crafting and delivery of messages and strategies, based on consumer research, to promote the health of individuals and communities. And health communication strategy is the systematic design and implementation of programs that increases their impact on behaviour and social change (McKee, et al, 2004). In this respect, health communication strategy has the capacity to influence the target audience to bring about the needed behavioural and social change. Em Griffin, 2003 stated communication as the socio-psychological tradition of communication as interpersonal influence in which there is a cause and effect relationship that will predict when a communication behaviour will succeed and when it will fail. Strategic health communication is based on combination of facts, ideas and theories integrated by visionary design to achieve behavioural change with active participation of stakeholders and beneficiaries (Rice & Atkin, 2001).

On the other hand, health communication is explained as different from other communications in that it is intended to inform and persuade the public to sustain the health of the society and the country as well. Because, health communication is the study and use of communication strategies to inform and influence individual and community decisions that enhance positive health behaviour (Parvanta, David, et al, 2011) in which health communication is considered as the core element of the health sector so as to be effective in keeping the health of the public.

In this respect, there are there types of health communication strategies: Behavior change communication (BCC) is a type of health communication strategy that targets in the change of ***individuals*** health behaviours. Whereas, the social and behavior change communication

(SBCC) is a type of health communication strategy which reflects a strategic shift from providing information, education and communication (IEC) in order to influence ***individual*** behaviours towards a multifaceted process that addresses the broader ***social*** systems and ***environments*** that influence behaviour. And communication for advocacy is the third type of health communication which is designed to influence ***decision makers*** and ***policy makers*** towards the desired effect (McKee, et al, 2004).

Therefore, this study is aimed at investigating the health communication strategy of the federal HIV/AIDS prevention and control office (FHAPCO) which is used to influence the positive health behaviour basically on HIV/AIDS prevention along with most at risk population (MARPS) and vulnerable groups in the broader social system and environments that influence their behaviour in Ethiopia.

The federal HIV/AIDS prevention and control office (FHAPCO) is a body that is responsible to coordinate the national HIV/AIDS multi-sectored response to combat HIV/AIDS in Ethiopia (FHAPCO, 2015). The office has developed guiding documents based on the second strategic plan for intensifying multi-sectorial HIV/AIDS response in the country in order to succeed social mobilization efforts to address the specific target groups for HIV/AIDS prevention interventions (ibid).

The Federal HAPCO reported that prevention of new HIV infections among young people, women and adult population must be intensified by using combined prevention approaches which address the risk factors that increase one's chance of HIV infection. To this end, the federal HAPCO designed a health communication strategy, which has various approaches of behaviour change communication for HIV prevention across most at risk population (MARPS) and vulnerable groups in Ethiopia.

According to FHAPCO, most at risk population and vulnerable groups (MARPS) include; commercial sex workers, mobile workers, in-school youths, members of the uniformed services and inmates.

From the above groups, this study then seeks to investigate the health communication strategies of FHAPCO to address college and university students, which are one part of in-school youths under MARPS and vulnerable groups.

1.2 Statement of the problem

According to the Federal HIV/AIDS Prevention and Control Office (FHAPCO, 2015), Ethiopia is among the countries that are mostly affected by Human Immune deficiency Virus (HIV/AIDS). HIV stands for human immunodeficiency virus that can lead to acquired immunodeficiency syndrome (AIDS) (WHO, 2011). Both the virus and the infection it causes are called HIV/AIDS. HIV/AIDS is transmitted through the sharing of blood contaminated sharp materials, unprotected sex with HIV/AIDS infected partner, breastfeeding (from HIV/AIDS infected mother to the child) and birth from mother who has HIV/AIDS are the commonly identified ones. But, unprotected sex (sexually transmitted HIV/AIDS) is the major transmission of the HIV epidemic (WHO, 2011). Unlike some other viruses, the human body cannot get ride off HIV (ibid). Therefore, HIV/AIDS is the leading cause of death around the globe for the last three decades. The existence of HIV infection in Ethiopia was recognized in the early 1980s with the first two reported HIV/ AIDS cases in 1986 (FHAPCO, 2015).

Therefore, for the last 30 years, many people have been affected and suffered due to the direct and indirect consequences of HIV/AIDS. So many people lost their lives, many lost their relatives, many children lost their parents and remained orphans, many elders were left

without supporters, many people committed suicide, and many people living with HIV suffered from stigma and discrimination (WHO, 2011).

Although reports show that there is a declining rate of HIV/AIDS prevalence in the county due to the collaborated efforts exerted on the prevention, care and treatment of HIV/AIDS, studies argue that it is not the time to ignore issues about HIV/AIDS as it continues to affect many youths and females.

For example, if we see the 2014 country progress report on the HIV/AIDS response of Ethiopia, it is stated that high risk sexual behaviours have been reported among universities and high school students in the country. The report cited a study on students from five universities (Hawasa, Bahir Dar, Jimma, Gonder and Haromaya) in which 81% of male and 63% of female students had unsafe sex with a non-regular partner in the last 12 months (country progress report on HIV response, 2014) which strengthens the fact that university students are sexually active and are still highly vulnerable groups to HIV/AIDS in the society.

As the Federal HIV Prevention and Control Office (FHAPCO) identified, in school youths aged 15-24 years are highly vulnerable groups to HIV/AIDS and other STIs (FHAPCO, 2015) and categorized under MARPS and vulnerable groups. Since university students are expected to be well informed, relatively knowledgeable, have access to information, are capable of protecting themselves from any kind of risk, but it is also reported that there is unsafe, risky and vulnerable sexual behaviour of youths especially university students to sexually transmitted HIV/AIDS and other STIs.

More specifically, it is observed that not many studies have been conducted on how university students, especially female students are addressed by the HIV/AIDS prevention interventions so as to make them confident and capable of avoiding unsafe sex and so that

they can contribute to the creation of HIV free generation. The researcher understands that Ethiopia needs HIV free generation that can secure the growth of economic, political, social, cultural and developmental aspects of the country as expected, and in fact, the first who could make this development a reality is the literate population: i.e. university students.

In this regard, health communication intervention is an integral component of health promotion, health protection, disease prevention and treatment and is recognised as a core competency in public health and health promotion practice, because communication plays a pivotal role in achieving public health objectives (NCI and CDC, 2001) and health communication strategy is a core element for public health improvements (ibid).

Therefore, this study attempted to study the health communication strategies that are used to address college and university students which are parts of most at risk populations (MARPS) and vulnerable groups, the approaches that are followed to design the strategy and the gap if any, why university students especially females demonstrate high HIV/AIDS risk behaviours since a perceived health communication interventions exist on these target groups.

1.3 Objectives of the Study

1.3.1 General Objective

The general objective of this study was to examine the health communication strategies of FHAPCO to prevent HIV/AIDS among MARPS and vulnerable groups particularly to address college and university students in Ethiopia.

1.3.2 Specific Objectives

This study is specifically intended:

- To identify the health Communication strategy of FHAPCO to address most at risk population (MARPS) and vulnerable groups, particularly to address college and university students in Ethiopia,
- To find out the systematic approach that the FHAPCO has followed for the design and implementation of the health communication strategy for MARPS and vulnerable groups, and
- To find out the gap why university students demonstrate high risk behaviours towards sexually transmitted HIV/AIDS since a perceived health communication interventions exist on these target groups.

1.3.3 Research Questions

In this study, the researcher aimed to find out answers for the following questions.

1. What are the health communication strategies do the FHAPCO use to prevent HIV/AIDS among MARPS and vulnerable groups particularly to address college and university students?
2. Which systematic approach did the FHAPCO follow to design and implement the health communication strategy for HIV/AIDS prevention intervention on the selected audience groups?
3. Why do university students still demonstrate high risk behaviour towards HIV/AIDS since there is a health communication strategy to prevent these target groups from HIV/AIDS?

1.4 Significance of the Study

Health issues like HIV/AIDS epidemic have been a burning issue around the globe for the last three decades (WHO, 2011). Since Ethiopia is one of the hardest hit sub-Saharan African countries by the HIV Epidemic (ibid), the researcher strongly believes that findings of this study will have the following significances.

Firstly, the paper would serve as a researched data on the design, implementation and M&E of the health communication strategies of the FHAPCO to prevent HIV/AIDS.

Secondly, since the study comes up with widely accepted literatures on how health communication strategies should be designed, implemented and how objectives can be achieved, it could also serve the FHAPCO as a research, monitoring and evaluation document for the health communication strategy which is currently implemented.

And thirdly, it is hoped that the paper would serve as a spring board for those who have an interest to make further investigation on the topic area.

1.5 Scope of the study

The Federal HAPCO has health communication strategies for different target audience groups in HIV prevention interventions. Health communication strategies for MARPS and vulnerable groups in Ethiopia contains strategies for five audience segments; for commercial sex workers, for mobile workers, for in- school youths, for members of uniformed services and for inmates. Therefore, this study is limited to the health communication strategy for MARPS and vulnerable groups, i.e. in- school youths, particularly college and university students is selected. And for the sake of the research objective the strategy is analysed with respect to female university students.

1.6 Limitations of the Study

When this paper was conducted, some limitations were faced. Lack of sufficient reference books and related studies on the area of health communication was the main challenge during the course of conducting the study. The other problem was on the time of collecting data. That means some informants were not available during the scheduled time. Therefore, it was mandatory to postpone the schedule and wait the informants for longer period of time. Since the study employed an in-depth interview for data collection tool, some informants were not willing to spend longer period of time to have the interview. But above all the researcher exerted the maximum effort to overcome the aforementioned limitations.

CHAPTER TWO: REVIEW OF RELATED LITRATURE

2.1 Introduction

The purpose of this study was to examine the health communication strategy of FHAPCO to prevent HIV/AIDS among MARPS and vulnerable group, particularly to address college and university students in Ethiopia. To this end, this chapter mainly focused on four aspects. The first one is literature or situational analysis of HIV/AIDS around the globe and in sub Saharan countries including Ethiopia. After highlighting the fact that HIV/AIDS is still the cause of deaths and is the major health defect in our country especially in most at risk population (FHAPCO, 2014), prevention strategies which were designed and implemented in Ethiopia are summarized. In relation with prevention strategies, it is obvious that the role of communication is the most important subject. Therefore, in the third part, health communication vs health communication strategy, characteristics of effective health communication strategies and the systematic approach used to design and implement effective health communication strategy to bring about the intended health behaviour change towards HIV/AIDS prevention are discussed. And finally the theoretical framework and the health communication model in which the study is informed by are explained.

2.2 HIV/AI1DS and its Magnitude in the World, Sub- Saharan Africa and Ethiopia

2.2.1 HIV/AIDS around the World

Though the decline in the prevalence of the epidemic HIV/AIDS is seen in the world in general (UNAIDS, 2014), in 2013, there were 3.5 million people living with HIV/AIDS around the world (ibid). Since the start of the epidemic, around 78 million people have become infected with HIV/AIDS and 39 million people have died of AIDS related illnesses.

Even if new HIV infections have fallen by 38% since 2001 worldwide (UNAIDS, 2014), 2.1 million people become newly infected with HIV/AIDS in 2013, which is down from 3.4 million in 2001. AIDS related deaths have fallen by 35% since the peak 2005. In 2013, 1.5 million people died from AIDS related causes worldwide compared to 2.4 million in 2005 (ibid).

According to the UNAIDS report, which was presented on the 2014 world HIV/AIDS day, HIV/AIDS is still the leading cause of death around the globe. When one sees nationwide, in Asia and Pacific countries, there were 4.8 million people living with HIV/AIDS and an estimated 350, 000 new HIV infections in 2013. New HIV infection is declined by 6% between 2005 and 2013. But Indonesia is cause for concern – new HIV infections have risen by 48% since 2005. In Asia and the Pacific, on average 250 000 [210 000 – 290 000] people died of AIDS-related causes in 2013. Between 2005 and 2013 the number of AIDS-related deaths in the region feli by 27%. And India accounts for 51% of all AIDS-related deaths in the region (UNAIDS, 2014).

In Latin America, there were 1.6 million people living with HIV/AIDS and an estimated 94,000 new HIV infections in the region in 2013. But in the country, new HIV infections declined by 3% between 2005 and 2013. In Latin America, 47 000 [39 000 – 75 000] people died of AIDS-related causes in 2013. Between 2005 and 2013 the number of AIDS-related deaths in the region fell by 31% (ibid).

In Western and Central Europe and North America, there were 2.3 million people living with HIV/AIDS and there were an estimated 88,000 new HIV infections in the regions in 2013. In Western and Central Europe and North America, 27 000 [23 000 – 34 000] people died of AIDS-related causes in 2013. And between 2005 and 2013 the number of AIDS-related deaths in the region fell by 2% (ibid).

In the Caribbean countries, there were 250,000 people living with HIV/AIDS and an estimated 12,000 new HIV infections in the region in 2013 even though, new HIV infections declined by 40% between 2005 and 2013. In the Caribbean, on average 11 000 [8300 – 14 000] people died of AIDS-related causes in 2013. Between 2005 and 2013 the number of AIDS-related deaths in the region fell by half. Haiti accounted for 59% of all AIDS related deaths in the region in 2013 (UNAIDS, 2014).

In the Middle East and North Africa, there were 230,000 people living with HIV/AIDS and an estimated 25,000 new HIV infections in the regions in 2013. New HIV infections rose by 7% between 2005 and 2013. In the Middle East and North Africa, on average 15 000 [10 000 – 21 000] people died of AIDS-related causes in 2013. Between 2005 and 2013 the number of AIDS-related deaths in the region rose by 66% (ibid).

2.2.2 HIV/AIDS in Sub-Saharan Africa

When one sees sub Saharan-Africa, UNAIDS reported that there were 24.7 million people living with HIV/AIDS and women accounts for 58% of the total number of people living with HIV/AIDS (UNAIDS, 2014). There were also an estimated 1.5 million new HIV infections in the region in the same year. Although new HIV infection is declining between 2005 and 2013, sub- Saharan Africa accounts for almost 70% of the global total of new HIV infections. And 1.1 million people died of AIDS related causes in 2013 (ibid).

If one sees the prevalence of HIV/AIDS in some Sub-Saharan African countries, South Africa's epidemic is one of the worst in the word with an estimated 5.5 million people living with HIV/AIDS in mid of 2014 and there are an estimated 10.2% of the total population is HIV positive in the same year (South African statistics, 2014).

Whereas in Nigeria, there were an estimated 3.23 million people living with HIV/AIDS and 220,394 HIV infections occurred in 2013 in the region (NACA, 2014).

While in Tanzania, there were 1.14 million people were living with HIV/AIDS and 79,338 new HIV infections occurred in 2013 (The United republic of Tanzania, 2014).

And in Uganda there were 1.6 million people living with HIV/AIDS and an estimated 140,000 new HIV infections in 2013 (Uganda Country Progress report, 2013). Uganda is one of the countries which showed successful prevention and control of the epidemic HIV/AIDS in the last five years (UNAIDS, 2014).

In neighbouring country Kenya, 1.6 million people were living with HIV/AIDS and 100,000 new HIV infections reported in the year 2013 (Kenya AIDS response progress report, 2014)

As the report demonstrated, the decline in new HIV infection seems to be less in the Sub-Saharan countries than the rest of the world for different reasons. It may be attributed to *poverty* that led many people to be exposed to the epidemic; the other being *lack of appropriate channels of communication* to raise awareness among the different sections of the society and among different age groups (UNAIDS, 2014) are considered as remarkable reasons for the high prevalence of HIV/AIDS and less decline in new HIV infection in sub Saharan Africa. And lack of appropriate channels of communication to raise awareness is directly related to the effective design and implementation of health communication strategies.

2.2.3 HIV/AIDS in Ethiopia

The 2014 country progress report on the HIV response reported that there are an estimated 793,700 people living with HIV/AIDS including children according to the latest demographic health survey of Ethiopia (DHS, 2011). There were approximately 45,200 AIDS related death in the same year and about 898,400 AIDS orphans are reported in DHS, 2011. The national HIV/AIDS prevalence among adults aged 15-49 is estimated at 1.5% in 2011, the year in

which the last Ethiopian demographic health survey (DHS) was conducted and it was 1.4 % in the 2005 (Ethiopian DHS, 2011).

However, the prevalence varies according to age, gender and geographical location of a country. According to 2011 DHS, adult prevalence was almost twice as high among females compared to males at 1.9 % versus 1.0% respectively. The distribution of HIV prevalence also differs by age. According to various surveys and studies, women are more affected in their early age than men and DHS, 2011 also found that HIV prevalence on young women have a two to six fold higher than young men (ranging from 15-19 years: 0% males Versus 0.2% female, 20-22 years: 0.1% males Versus 0.6% females) as females are infected in their teen and early twenties (McKee, 2004; 123).

Variations in HIV prevalence were also observed among regions of Ethiopia. According to the demographic health survey (DHS,2011), Gambella region and the urban administrations of Addis Ababa and Dire Dawa have the highest prevalence (6.5%, 5.2% and 4.0%) respectively while SNNPR and Oromia region have the lowest (0.9% and 1.0%) prevalence rate respectively. Marked variation in urban and rural prevalence is again reported in DHS (2011) with urban areas showing seven fold higher HIV prevalence compared to rural areas (4.2% versus 0.6%) respectively.

Although Gambella is not as such an urban area like Addis Ababa and Dire Dawa, the reason why there is a high HIV prevalence has been demonstrated was not explained and it has to be given due attention by the responsible body.

On the other hand, 2014 country progress report on HIV response reported that young women and men aged, 15-45 years who correctly identify ways of preventing the sexual transmission of HIV/AIDS and who reject major misconceptions about HIV transmission are Females:

23.9% and Male: 34.2% respectively (DHS, 2011), which indicates there is still a low level of comprehensive knowledge towards HIV/AIDS.

Viewed from annual progress reports of the world countries, the spread of HIV virus seems to be high among the young, which are the most active section of the society. In the report, young people are among those people who are at most- risk (MARPS) to HIV/AIDS. According to the report of Federal HAPCO, 2014, the following population groups: commercial sex workers, uniformed services, long-distance-trucker drivers, refugees and displaced people, daily labourers, mobile/migrant labourers including cross-border population, street children, high school and university students, out-of-school youth and indigenous populations in remote foreign tourist destinations involved in transactional sex are at higher risk of HIV infection (FHAPCO, 2014).

Since the aforementioned groups of people are the most important and productive sections of the society, losing them with HIV epidemic is a serious problem for a country. And one can easily understand that if these sections of the society are at risk, it is easier to estimate that the whole population is endangered (Adem and Lemma, 2012). With an estimated 1.5 million people living with HIV/AIDS, Ethiopia has one of the largest populations of HIV infected people in the horn of Africa (WHO) and adult prevalence is estimated 1.5% in which, young women accounts for 1.9% almost twice as high as compared to males 1.0% in the same age (ibid).

The fact that reports indicate that young population (15-24 years old) are sexually active and highly vulnerable to risky practises, the researcher understands that university students are the most exposed people to different life endangering situations like, sexually transmitted HIV/AIDS and other infections due to peer pressure and others risk and vulnerability factors.

These risk and vulnerability factors could be much more on female than male university students as data has showed (FHAPCO, 2014).

But whatever the reason could be which makes youths in most at risk population group, finding a solution for each and every risk and vulnerability factors through coordinated and effectively designed communication strategies for these population groups so as to create HIV free generation should be the most important thing.

2.3 HIV/AIDS Prevention Strategies in Ethiopia

The National AIDS Council was established in 2000 and was charged with directing and overseeing the multi-sectoral response of HIV/AIDS in Ethiopia. The Council, chaired by the President of the country and comprising members from government, NGOs, religious bodies, civil society, and PLHIV, has declared HIV/AIDS as a national emergency. Therefore in June 2002, the National HIV/AIDS Prevention and Control Office (HAPCO) was established by proclamation to coordinate and lead the multi-sectoral response (FHAPCO).

The Federal HAPCO, which is the responsible body on HIV/AIDS related issues in Ethiopia has a mission to see HIV/AIDS free generation, and has a mission to prevent and control HIV/AIDS epidemic and mitigate its impacts by creating universal access to HIV prevention, treatment, care and support services through intensified community mobilization and empowerment, by building capacity and ensuring the active involvement and ownership across sectors, enhancing partnership under the principle of the "three ones" (i.e. one country plan, one monitoring and one evaluation programme), and mobilizing and ensuring appropriate use of resources. And also has a goal to reduce new HIV infection by 50% (from 0.28% in 2009 to 0.14% by 2014/15) and HIV related mortality and morbidity in its strategic Plan II for Intensifying Multi-sectoral HIV and AIDS Response in Ethiopia (2010/11-2014/15).

To make these visions true, the federal HAPCO has HIV prevention communication strategies in structural, biomedical and behavioural approaches. And established five thematic areas of service in the fight against HIV/AIDS prevention, care and treatment and social support and has implemented five measurable goals with objectives and strategic actions for each area of service as follows.

The first one is to consolidate the capacity in the community to achieve universal access to HIV/AIDS service and MDG 6. The second is to reduce new HIV infection, AIDS related morbidity and mitigate its impact. The third one is that to create an enabling environment scaled up and comprehensive HIV/AIDS multi-sectorial response. The fourth objective is to strengthen care and support service to mitigate the impact of HIV/AIDS of the needy orphans and other vulnerable children (OVC) and people living with HIV (PLHIV) and the fifth one is to strengthen generation and utilization of strategic information about HIV/AIDS in Ethiopia (FHAPCO, 2014).

To that effect, the Federal HAPCO has designed specific health communication strategies to implement the prevention interventions so as to achieve the desired objective in behavioural approach in addressing different audience segments. Therefore, this study made a scholarly analysis on the health communication strategy of FHAPCO in the behavioural approach for MARPS and vulnerable groups particularly, to address college and university students in Ethiopia, the systematic approach followed to design and to implement the strategy and the strengths and weaknesses of the strategy with regard to the theoretical framework.

2.4 Health Communication Vs Health Communication Strategy

2.4.1 Health Communication

There are several definitions of health communication by different scholars and researchers. But for the most part, all of them point to a similar role of communication in individual or public health outcome.

In 1993, the director of the Center for Disease Control and Prevention (CDC), William Roper, formalized the agency's definition of health communication as "the crafting and delivery of messages and strategies, based on consumer research, to promote the health of individuals and communities." (Parvanta, David, et al, 2011). This definition characterized the public as consumers whom agency staff needed to understand in order to serve them. It also clarified the role of health communication as not only providing information, but also working with the public as partners in prevention (ibid).

Similarly, the NCI pink book, Making Health Communication Programs Work, defines health communication as, the study and use of communication strategies to inform and influence individual and community decision that enhance health of the public (NCI, 2001). Because, it is argued that, health communication programs affect behaviour changes among individuals, organizations, communities, and also the society as a whole (ibid).

Some scholars say that the essence of health communication is all about developing the strategic health communication plan that focuses on specific change objectives, audiences, messages, and media. But NCI and CDC argue that health communication initiatives must use the most effective and efficient strategies for the promotion, protection and maintenance of health through the use of the best available evidence at practice and policy level and health communication strategy is a core strategy for public health improvement (NCI and CDC, 2001).

For the past 30 years or more, governments have used a scientific, goals-oriented approach in their health communication to prevent and treat different kinds of health problems (WHO). Health communication can take many forms, both written and verbal and can be directed towards individuals, communities or the entire nation. In addition, health communication is an integral component of health promotion, health protection, disease prevention and treatment and is recognised as a core competency in public health and health promotion practice, playing a pivotal role in achieving public health objectives (NCI and CDC, 2001).

UNICIEF, on the other hand, described health communication as much science as it is an art. Because the science of communication is a research driven consultative process involving planning, design, and implementation of strategic intervention. Whereas, the artistic side of communication involves designing creative message and products and identifying effective interpersonal, group, and mass-media channels based on sound knowledge of the participants we seek to reach (UNICIEF). A field Guide to Designing A health Communication Strategy also stated that a blending of science and art is essential to crafting a sound strategy of health communication. This implies that health communication links the field of communication and health and is increasingly recognised as a necessary element of efforts to improve personal and public health care (WHO, 2011).

As mentioned in the previous sub topic, HIV/AIDS is one of the burning pandemic that countries engaged to design communication strategies to fight against and to promote the health of their people. Since Sub- Saharan countries are the highly affected areas with the HIV pandemic, Ethiopia is also one of the countries that has designed and implemented strategic health communication approach to combat HIV/AIDS. Because it is acknowledged that developing strategic health communication approach for addressing the key areas of vulnerability and risk reduction is crucial (UNICIEF).

2.4.2 Strategic Health Communication Approach (Health Communication Strategy)

The concept of strategic health communication approach encompasses a wide variety of public health interventions, including community mobilization; client- centered counselling, social network interventions, social marketing, entertainment-education by means of TV or radio dramas and music, provider promotion, public relations, mass media information dissemination, and so forth, including any type of communication process that leads to behaviour change in order to promote positive health of the public (Piotrow, 2001, Rice & Atkin, 2001).

According to Parvanta, David, et al, strategic health communication is a plan that focuses on specific change objectives, audience, message and media. And it is an evidence-based, result-oriented process, undertaken in *consultation* with the participant group, intrinsically linked to other program elements, cognisant of the local context and favouring a multiplicity of communication approaches to stimulate positive and measurable behaviour and social change (Parvanta, David, et al 2011). On the other hand, Rice & Atkin argued that strategic health communication is based on a combination of facts, ideas, and theories integrated by visionary design to achieve behaviour change with *active participation* of stakeholders and beneficiaries (Rice & Atkin, 2001).

Here, difference in the level of participation of stakeholders is demonstrated as: participation by consultation and as active participation. According to Tufte and Melfalopulos, participation by consultation is a level when stakeholders provide answers to questions which posed by experts or professionals for the formulation of communication policies and plans. Whereas, active participation refers to a level when primary stakeholders are capable and willing to initiate the process and take part in the analysis project which is referred *empowerment* (Tufte and Melfalopulos, 2009). And according to participatory

communication theory, the direct involvement of stakeholders in development process and determine the outcome instead of imposing a pre-established outcomes is the crucial and the key element of theory (ibid).

Neill McKee also articulated strategic health communication as an approach that offers a powerful set of tools for designing, implementing and evaluating health programs (McKee, et al, 2004) which strengthens the idea that health communication strategy is a key element in health promotion programs.

Hence, it is true that strategically designed communication program is effective to bring about the desired change in its effective implementation. Because over the past twenty years, health communicators have come to realize that collaboratively designed, implemented, and evaluated health communication strategy will help to achieve the goal of improving health in a significant and lasting way by *empowering* their behaviour change communication strategies (Field Guide to Design A Health Communication Strategy, 2003: 4).

2.5 Types of Health Communication Strategy

2.5.1 Behaviour Change Communication (BCC)

Behaviour Change Communication (BCC) is the first type of strategic health communication. WHO, FHI and NCI define that Behaviour Change Communication (BCC) as evidence and research-based process of using communication to promote behaviours that lead to improvements in health outcomes. BCC intends to foster necessary actions in home, community, health facility or society that improve health outcomes by promoting healthy lifestyles or preventing and limiting the impact of health problems by using an appropriate mix of interpersonal, group, and mass-media channels maintaining effective communication strategies rely on formative research with beneficiaries to understand the context from their

perspective and factors that influence improved practice (WHO, 2011, FHI, 2002 & NCI, 2001).

Similarly, McKee defines behaviour change communication;

> *is a research-based, consultative process of addressing knowledge, attitude and practice through identifying, analysing and segmenting audience and participants in programs and by providing with them relevant information and motivation through well-defined strategies, using an appropriate mix of interpersonal, group and mass-media channels, including participatory methods. (McKee, et al, 2004:72)*

But in recent years, theories and models moved towards changes in social groups, communities and on larger contextual factors rather than focusing on individual behaviour changes (ibid).

2.5.2 Social and Behaviour Change Communication (SBCC)

In the recent years, social scientists have come to recognise that the socio-cultural factors strongly influence complex health behaviours and they moved from behaviour change communications at the individual level towards theories and models that focus on social groups (McKee, et al, 2002) which is the second type of strategic health communication. Communication for social and behaviour change (SBCC) is a process of public and private dialogue through which people define who they are, what they want and how they can get what they need in order to improve their own lives (ibid:72).

In other words, it is a process of bringing together all feasible and practical inter-sectoral social partner and allies to determine felt-need and raise awareness of and demand for, a particular development objectives. It involves enlisting the participation of such actors, including institutions, groups, networks and communities, in identifying, raising and

managing human and material resources, thereby increasing and strengthening self-reliance and sustainability of achievements (UNICEF). In this regard, the social and behaviour change communication is interrelated with the socio-ecological model of health communication in the argument that the interrelation among environmental conditions and human behaviour and well-being is highly tight and it should be addressed by communicators to bring behavioural change. This is clearly stated in the socio-ecological model as follow.

2.5.2.1 Socio-ecological Model of Health Communication

The socio-ecological model of health promotion has its origin in the field of psychology and human development in the mid-20th century which is the work of Lewin, Barker and Bronfenbrenner and others who began to understand behaviour in a context of the interplay of the individual and the environment (Ruderman, 2013). Early ecological analysis of the relations between plant and animal populations and their habitats where later extended and applied to the study of human communities and environment with in the fields of sociology, psychology and public health (Barker, 1968, cited by Stokols, 1995).

According to Daniel Stokols, the socio-ecological model is rooted in certain core principles or themes concerning the interrelations among environmental conditions and human behaviour and well-being. First ecological analysis characterize environmental settings as having multiple physical, social and cultural dimensions that can influence a variety of health outcomes including physical, health status, developmental maturation, emotional well-being and social cohesion (Stokols, 1995).

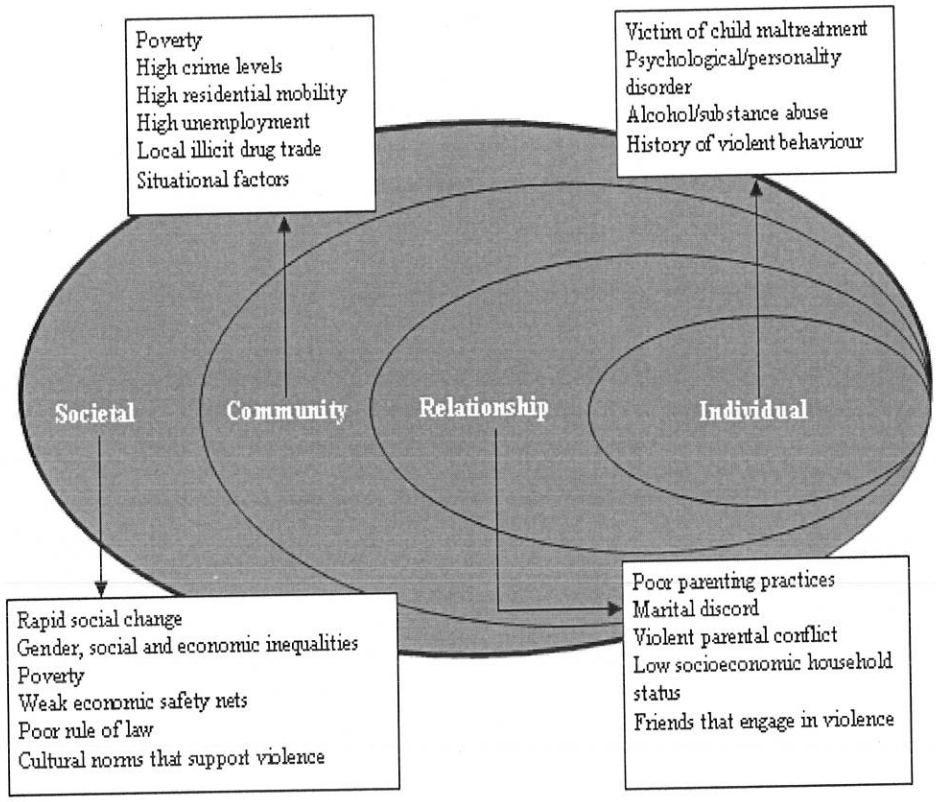
Another core theme of socio-ecological research is that human health is influenced not only by environmental influences, but also by a variety of personal attributes including genetic heritage, psychological dispositions and behavioural patterns (ibid). Socio-ecological model

takes in to account the interconnected influence of family, peers, community and society on behaviour as we can in the figure below (Sallis and Owen, 2002).

Therefore, ecological models need to be tailor-made for each behaviour or health condition (Oxford Journal, 2015) and implementation of strategies could differ for each population although components of the model could be used across various populations is similar (ibid). As a summary, effective interventions must influence multiple levels of a society.

According to socio-ecological model, because health is shaped by many environmental subsystems including family, community, work place, beliefs and traditions, economics and the physical and social environments it is necessary to influence multiple levels of a society (CDC, 2002). Daniel Stokols also emphasises to the socio-ecological model, families, community and socio-structural domains are vital in bringing behaviour change (Stokols, 1995). In other words, McLory et al expresses the situation as; individual behaviours shape and shaped by the social environment (McLory et al, 1988).

The socio-ecological model is explained by the following figure.



The social ecology model of communication and health

Source: Douglas Strorey and Maria Elena Figueroa, The handbook of global health communication

From this perspective, effective intervention must influence multiple levels because health is shaped by any environmental sub-systems including family, community, workplace, beliefs and traditions, economics, and the physical and social environments (CDC).

Therefore, the main contribution of the ecological model is to emphasize how higher levels facilitate or constrain change at lower levels of analysis by suggesting that communication interventions should address all four levels to be effective (Storey & Figueroa, 2012).

2.5.3 Communication for Advocacy

Communication for advocacy is the third type of strategic health communication which is defined as a continuous and adaptive process of gathering, organizing and formulating information into argument, to be communicated to decision makers through various interpersonal and media channels, with a view to influence their decision towards raising resources or political and social leadership acceptance (McKee et al, 2004 & UNICEF). So differently from BCC and SBCC, communication for advocacy is intended to influence decision makers, but not the individual audience or the social system.

2.6 Characteristics of Effective Health Communication Strategy

Rice & Atkin, (2001), McKee, et al, (2004), Schiavo, (2007) and others adopted the characteristics of effective health communication strategy from the centre for communication programs at the Johns Hopkins Bloomberg School of public health and Center for Disease Control (CDC) and describe effective heath communication strategy should be:

Science and research based: A science and research based approach to communication requires both accurate data and relevant theory. It begins with formative or preliminary research and adequate data to define a specific health problem, identity feasible solution to the problem, and describe the intended population and audience. Formative research is used to improve project design. Strategic communication also depends on appropriate social science models or theories of behaviour change.

Client-centered. A client-centered approach requires starting with an understanding from the client's point of view of what the health needs are. Discussions with the potential audience provide insights about those health needs and the barriers to meeting the expressed needs. Through research, especially qualitative research and participatory learning approaches (PLA), makes it possible to segment based on relevant characteristics; members of the

intended audience can help shape appropriate messages and can offer insights for other communication-related decisions that need to be made. Health communication planners need to consult with the target population and its representatives. Because the intended audience's ability and willingness to make a behaviour change affects the extent to which communication objectives are reasonable and realistic.

A client-centered approach also implies understanding of strategic changes that can affect the balance of power, including the gender balance of power, in service programs. For example, encouraging greater community participation, allowing clients to choose their own methods and treatment, or having clients set the program priorities for health services are ways to strengthen a client-centred approach.

Results-oriented. The ultimate proof that a strategic communication effort is effective lies in health outcomes. Research should be designed to gauge increases in audience knowledge, approval, and adoption of healthy behaviours. Equally important is increasing the capacity of local partners to carry out these kinds of programs on their own.

Participatory. Strategic communication promotes participatory decision making by stakeholders and beneficiaries in all stages of the "P" Process, including planning, implementation, and evaluation. It is critical to involve the key stakeholders at the inception of the strategy design process. Building a sense of ownership will help ensure that the strategy will be implemented in a meaningful way for health and social change.

Benefit-oriented. The audience must perceive a clear benefit in taking the action promoted by the communication effort. This characteristic is closely associated with the long-term identity and with the notion of positioning.

Service-linked. Health promotion efforts should identify and promote specific services, whether through health care delivery sites, providers, brand name products, or ways to increase access to services and products. This approach reinforces the concept of individual

self-efficacy or the ability to resolve a problem oneself and also supports the concept of collective self-efficacy or the ability of a community to assert its will.

Technically high quality. The strategic health communicator works with competent agencies and individuals to:

- Design high-quality communication messages and materials.
- Produce professionally designed materials.
- Ensure that community-based activities are appropriate and well done.
- Strengthen counselling skills.

Investing resources wisely to design effective strategies and materials at the outset will ultimately is more economical than cutting corners and producing a campaign that conveys a substandard image. Simply put quality costs less. Another important point to remember is that focus demands sacrifice. Strategic communication is specific in what it attempts to accomplish and does not try to be all things to all people.

Advocacy-related. Advocacy occurs on two levels: the personal/social level and the policy or program level. Personal and social advocacy occurs when current and new adopters of behaviour acknowledge their change and encourage family members and friends to adopt a similar behaviour. For example, individuals who have quit smoking often advocate to other smokers that they should quit. Policy or program advocacy occurs when the advocacy is aimed at change in specific policies or programs. Seeking to influence alone is insufficient if the underlying social factors that shape the behaviour remain unchanged. Behaviour change objectives will address individual behaviour, but policies, laws, strategies, and programs may also need to be influenced, so that they support sustained behaviour change. The two levels of advocacy reinforce one another.

Expanded to scale. It is easy to ensure the effectiveness of a communication intervention when applied to a small village or district. The real challenge is whether the intervention can

effect change on a much wider scale beyond a village or the usual pilot areas. Communication strategies can be scaled up to reach ever-larger populations and areas. In general, mass media interventions are easier to scale up than community or interpersonal interventions. The latter two can be costly to scale up and can be difficult to monitor.

Multi-channelled. Effective strategic communication uses a variety of means. Communication strategies often integrate interpersonal communication (IPC), community-based channels, and various media to create a dynamic, two-way exchange of information and ideas. Additionally, research has shown that often the effectiveness of messages being understood and acted upon increases with the number and type of channels used to disseminate them. This is sometimes called the "dose" effect. Like a good carpenter who knows when to use a hammer or a chisel, an effective communicator does not argue whether mass media is better than IPC. Each tool has a role, and the communicator uses the tool or combination of tools that is most appropriate for the situation (Rice & Atkin, 2001, McKee, etal,2004,Schiavo,2007).

Different scholars in different books define channel as a means by which a message gets from a source to a receiver. And they categorize communication channels as either;

-mass media or

- Interpersonal in nature

2.7 Channels (tools) used to implement Effective Health Communication Strategy

2.7.1 Mass media channels for Effective Health Communication

Mass media channels are all those means of transmitting messages that involve a mass medium; traditional or new media such as radio, Television, newspaper, social media and so on which enable a source of one or a few individuals to reach an audience of many (Rogers, 1983). Mass media are characterized by; reaching a large audience rapidly, can create knowledge and spread information and lead to change audience attitude (ibid). Mass media

channels in health includes; a. Edutainment (Education entrainment), b. Telephone Hotline and c. Information Communication Technology (ICT)

a. Entertainment Education

Entertainment education or edutainment and sometimes EE is the process of purposely designing and implementing a media message to both entertainment and educate in order to increase audience members knowledge about an issue, create favourable attitudes, shift social norms and change the overt behaviour of an individual and communities (Singhal and Rogers, 2003 cited by McKee, et al, 2004).

Therefore in short, edutainment is the use of drama or music, theatre and other entertainment elements for educational purpose (Servaes, 2002). Here, South Africa's soul city entertainment is one the highly mentioned edutainment experienced in which with their fourth Television series reached 16.2 million South Africans. From that 79% of 16-24 years old, 71% 25-35 years old, and 49% of 46 years old and over (Soul city, 2000 cited by (Servaes, 2002, Rice and Atkin, 2001).

b. Telephone Hotline

Hotline also the other effectively used channel as mass media since it uses the medium phone. "Even just the idea of sharing silence with another person and knowing that the two of you connected through a phone line for that moment is something that is important." (Stratten, and Robert, 2003) which shows how hotline is supporting the users.

A hotline is a specialized telephone service that provides an effective way to listen to the counsel caller (ibid).

Hotlines are mostly used in many countries for a variety of reasons such as crisis lines or providing information on family planning, reproductive and sexual health, HIV/AIDS, and human rights. McKee in his book stated that hotlines have a multitude of advantages since

they combine the strength of interpersonal communications with the reach of a mass medium, the telephone (McKee, et al, 2004).

Hotlines are characterized by;

- Offering correct information,
- Providing a safe environment,
- Making correct referrals,
- Reinforcing prevention messages and
- Providing a tracking system.

South Africa's HIV/AIDS helpline has become a model for hotline worldwide with 30,000 calls per month (ibid).

c. Using Information Communication Technology

Information communication technologies (ICT) have clearly advanced the way individuals and groups are informed, involved, and able to collaborate across the world. Since ICT is making the world connected, then it could also play the greatest role as a media for the public.

ICTs are not limited to the transfer of information, but have the potential to be used to promote healthy behaviours, improve decision-making, increase information exchange among peers, and promote self-care and professional support as well as to improve the effectiveness of health institutions (UN/ECA, cited by McKee, et al, 2004). And one can understand that currently, the widely used ICTs are; internet-based portals, electronic mail (e-mail) and social media like Face book twitter and so on.

2.7.2 Interpersonal channel (peer education) for Effective Health communication

Peer education is defined as an approach that involves training and supporting members of a given group to affect change among members of the same group (Horizons, 2001 cited by

McKee, et al 2005). This means peer education can involve youth talking to youth, company workers with their respective staffs, commercial sex workers together and so on.

Some researches show that peer education is an effective approach in disseminating important HIV/AIDS messages. Thailand is the country which brought a remarkable change in condom use through peer education (UNAIDS, 2002). Community conversation can also be considered as type of interpersonal channel.

2.8 Systematic Health Communication approach

The systematic approach refers to a sequence of steps that guide the planning and implementation of the program in which elements of design and execution are interspersed with data collection and analysis that inform decision making of the target audience (McKee, et al, 2004).

Accordingly, the Center for Communication Programs at John Hopkins Bloomberg School of public health has promoted the "p-process" approach as a preferable systematic health communication approach since 1982 to enhance behaviour change communication effectively. And the "p-process" approach is a widely accepted and implemented approach by many health communication departments in the world, like CDC, NCI and FHI to guide the planning and implementation of health communication strategies. The "P- process" systematic health communication approach has five steps; Analysis, Strategic design, Development, pre-testing and production, Implementation and monitoring and Impact evaluation and preplanning which can be expressed with the letter "P" in diagram as follows.

Source: JHU/CCP, 1982

The "P" Process was developed in 1983 and is depicted by the above figure. The "P-Process" steps are explained as follow:

1. Analysis— Understand the nature of the health issue and barriers to change: listen to potential audiences; assess existing program policies, resources, strengths, and weaknesses; and analyse communication resources.
2. Strategic Design—Decide on objectives, identify audience segments, position the concept for the audience, clarify the behaviour change model to be used, select channels of communication, plan for interpersonal discussion, draw up an action plan, and design for evaluation.
3. Development, Pretesting, Revision, and Production—Develop message concepts, pre-test with audience members and gatekeepers, revise and produce messages and materials, and retest new and existing materials.
4. Management, Implementation, and Monitoring—Mobilize key organizations; create a positive organizational climate; implement the action plan; and monitor dissemination, transmission, and reception of program outputs.

5. Impact Evaluation—Measure impact on audiences, and determine how to improve future projects.

2.9 Theoretical Framework

In the 1970s and 1980s, strategic communication approaches to enhance individual behaviour change evolved to be known as behaviour change communication (BCC). In which behaviour change communication is associated closely with social marketing strategies that are a mean to promote particular behaviour or social norms via communication including family planning and more recently in HIV/AID communication (Tufte and Mefalopulos, 2009).

But, in these early models of strategic communication, there was no participatory element. The assumption was that the power of communication to enhance development was in the correct crafting of the content and in the adequate targeting of audiences like that of Lasswell's theory of communication which was understood as a transfer of information (ibid).

By the early 1990s, Information, Education and communication (IEC) activities began and two models of communication became dominant. First, the diffusion model of communication which relies on the practice and theory of Everett Rogers and second the participatory communication emerged from the experience of Brazilian adult educator Paulo Freier which worked with adult literacy campaign among the poor peasants in north eastern Brazil. Hence, participatory communication theory informed the study on the health communication strategies of FHAPCO to prevent HIVAIDS, by explaining how health communication strategies should be designed and be implemented so as to solve the health problems of the society and to bring about the intended change. And it is discussed in detail as follows.

2.9.1 Participatory Communication Theory

This position arose during the 1980s and 1990s from individuals who felt that the post-positivist assumptions imposed structural laws and theories that did not fit marginalized individuals or groups or did not adequately address issues of social justice (Creswell, 2003 & Baran & Davis, 2010).

Historically, some of the advocacy/participatory (or emancipatory) writers have drawn on the works of Marx, Adorno, Marcuse, Habermas, and Freire (Neuman, 2000).

The participatory communication theory incorporates the concepts in the emerging framework of multiplicity/another development (Servaes, 2002) which stresses the importance of the cultural identity of local communities and democratization and participation of all levels, international, national, local and individual (Ibid) because there is no universal path to development according to the theorists.

According to Frier, the participatory theory points to a strategy that is not merely inclusive of, but largely emanates from the traditional "receivers" (Freire, 1983 cited by Servaes, 2002) which refers this to as the right of all people to individually and collectively speak their words: "This is not the privilege of some few men, but the right of every man. Consequently, no one can say a true word alone, nor can he say it for another, in a prescriptive act which robs others of their words." (ibid, 2002: 88)

The international commission for the study of communication problems explained participatory theory as a call for new attitude to avoid or minimize stereotyped thinking and to promote more understanding of diversity and plurality, with full respect, dignity and equality of peoples living in different condition and acting in different ways (MacBride, 1980 cited by Servaes, 2002).

Therefore, in the 1990s to the present it has evolved into what may be called the "strategic era" characterized by multichannel integration, multiplicity of stakeholders, increased attention to evaluation and evidence-based programming, large-scale impact at the national level, more pervasive use of mass media, and a communication process in which participants ("senders and receivers") both create and share together (Rimon, 2001) which implies to the characteristics of participatory communication theory.

The central feature of participatory theory is that on letting the stakeholders get involved in the development process and determine the outcome rather than imposing a pre-established outcome (Tufte and Mefalopulos, 2009).

2.9.1.1 Phases of Participatory Communication Program Cycle

Tufte and Mefalopulos (2009) on their book, Participatory Communication; A Practical Guide, identified four phases of participatory communication strategies.

1. **Participatory communication assessment (PCA);**

It is where communication methods and tools are used to investigate and assess the situations. There are five steps in PCA. First, Understanding the socio-cultural context while identifying and defining key issues (including definition of key stakeholders), second, create a common/public space, establish dialogue and build trust among key stakeholders, third, Assess needs, problems, risks, opportunities and solutions, fourth Prioritize key issues for change and reconcile different perceptions and fifth, Validate findings and define solutions/ objectives.

2. **Participatory communication strategy design;**

It is based on the findings of the PCA that defines the best way to apply communication to achieve the intended change. To design a communication strategy based on PCA helps to avoid problems of vague intent. The design of participatory communication strategy is divided in to two modalities. Monologic and Dialogic.

The Monologic modality is a one way communication approach which promotes a public reform, raising awareness of innovations that can benefit stakeholders or designing a health campaign to promote a desired behaviour. The level of change addressed by this approach concerns one or a mix of the following awareness, knowledge, attitude, behaviour and practices. The basic steps of strategy design are to define: SMART objective (SMART stands for specific, measurable, achievable, relevant and time bound), Identify primary and secondary audiences, Identify type/ level of change (awareness, knowledge, and behaviour), Communication approaches and activities, Channels and media, Messages and Expected outputs/outcomes.

The Dialogic modality concerns strategies requiring a change in the level of collaboration, mediation, conflict resolution, mobilization or partnership, and coalition building. Participatory communication here enhances here social accountability and transparency in the growing sector of good governance, which promotes various constituencies meet to air and negotiate different positions.

The basics are to define SMART objective, stakeholders, level/type of change (collaboration, mobilization, mediation, partnership building etc.), communication approaches and activities, partners, channels and eventually venues, target issues and expected outputs/outcomes (Tufte and Mefalopulos, 2009).

The main difference between monologic and dialogic modalities is that audiences in the monologic mode are substituted by the more active conception of stakeholders in the dialogic mode and in the third step, the level of expected change differs; in the monologic mode it usually refers to a change in awareness, knowledge, attitudes, practices or behaviours while in the dialogic mode it refers to the level of trust, collaboration or partnership established.

3. **Implementation of communication activities;**

Is to determine where activities planned in the previous phase are carried out. Once the communication strategies have been defined, it is important to draw an action plan to implement and facilitate the management and monitoring of all relevant activities.

4. **Monitoring and evaluation;**

Indicators should be defined, validated, and assessed from the very beginning to ensure the planning and implementation of the activities stay on track.

2.9.1.2 Typology of Participation

No consensus exists around a common definition of participation. It depends on the perspective applied. Servaes described participation as a higher level of public involvement in communication systems (Servaes, 2002). It includes the involvement of the public in the production process, and also in the management and planning of communication systems (ibid). Others define participation as the reach and inclusion of inputs by relevant groups in the design and implementation of a development project (Tufte and Melfalopulos, 2009). But both arguments the idea that participation is the involvement of ordinary people in a development process leading to change however the scope and methods can differ (ibid).

Cutting across the distinction of participation as a goal versus participation as a tool used in specific stages allow participation to be identified as passive participation: which is the least

level participation and stakeholders participate by being informed about what is going on, participation by consultation: when stakeholders provide answers to questions posed by experts or professionals, participation by collaboration: when stakeholders participate in the discussion and analysis of predetermined objectives set by the project, and empowerment participation: when primary stakeholders are capable and willing to initiate the process and take part in the analysis project (Tufte and Melfalopulos, 2009) . In this case the public exercises and is also fully involved in the formulation of communication policies and plans (Seraes, 2002).

Besides the above discussion, participatory communication theory is a widely used model which stresses mutual collaboration throughout all levels of participation. As a result, the focus moves from a "communicator" to a more "receiver-centric" orientation than the information transmitted (Servaes, 2002). Mckee also supported the idea that communication is not isolated activities that a group of specialists do separately from others working on health initiatives; rather, it is a process for converting the national health strategy in to tangible interventions that affect people's lives (McKee, et al, 2004).

Therefore, one can say that the purpose of communication should be to make something common, or to share meanings, perceptions, and worldwide views. This directly implies that from the onset the focus of participatory communication was on dialogical communication rather than on linear communication (Tufte and Mefalopulos, 2009). In participatory communication theory, the definition of a problem is due to lack of stakeholders' engagement and the main notion of change: is individual and social behaviour, social norms and power relation. While the way of communication should be in a form of horizontal dialogue and bottom-up rather than top to down and culture is considered as a way of life but not an obstacle (ibid: 8).

In participatory communication theory, monitoring is process based learning for action in collaboration with stakeholders which aims to improve our understanding of results while also strengthening local capacity and sustainability of efforts (FHI, 2004). Participatory monitoring endeavours to put the power to the people that programs are intended to benefit (Ibid).

This implies that understanding what works in programs should not be exclusive domain of evaluation experts rather the people who affected by the program should also understand it (Servaes, 2002) and the purpose of evaluation is to benefit the participant themselves. It does not function to test the efficiency of an exogenous program or to collect dust on a ministry shelf but it is just an on-going process as oppose to an end product of a report for funding structure (ibid). Hence it is argued by the scholars that the core element in participatory communication theory is that the active participation of the public in the design, implementation and evaluation of strategies so as to bring about the sustainable needed change.

Therefore participatory communication theory informed the study with the idea that, the active participation of the primary stakeholders in all stages of strategic communication process is crucial for converting the national health strategy in to tangible interventions that can affect the health of the people (Mckee, et al, 2004). And the definition of a problem is due to lack of stakeholders' engagement in the development programs (Tufte & Melfalopulos, 2009).

CHAPTER THREE: RESEARCH METHODOLOGY

This study is intended to examine the health communication strategy of the Federal HAPCO to prevent HIV/AIDS to address the most at risk population and vulnerable groups, particularly to address college and university students in the HIV prevention interventions.

Qualitative inquiry is, therefore, found to be the most appropriate methodology in order to understand how the Federal HAPCO has designed and implement the health communication strategies to prevent the spread of HIV/AIDS among MARPS and vulnerable groups, college and university students in Ethiopia.

3.1 Qualitative Research Methods

Qualitative research is a broad term that can be applied to a range of research approaches that have their theoretical origins in the range of disciplines (Anderson, 2010) including anthropology, sociology, philosophy, social psychology and linguistics.

Qualitative research method is an approach which gives a naturalistic explanation and interpretation to a given text or data. It embraces the influence of the researcher and theorist's value. Personal and professional values are the lens through which social phenomena are observed (Baran & Davis, 2010).

And also Servaes (2002) explained qualitative research approach as an approach that view the social world not as objective, but as subjective. And knowledge relies on the subjective interaction between the observer and the community which is informed by critical paradigm.

Qualitative research is designed to reveal the target audiences range of behavior and the perceptions that drive it with reference to specific topics or issues (Wimmer & Dominic, 2011) and it uses in-depth studies of small groups of people to guide and support the construction of hypothesis (ibid).

Therefore, the method was selected because qualitative research uses interpretative approach to understand meanings that humans attach to a phenomenon within their social world and qualitative research method helps to get appropriate data collection and analysis tool so as to provide sound and valid outcome which fits with the theoretical framework that the study is informed by.

Although considerable diversity exists in the type of studies that can be described as qualitative research method, Moriarity (2011), Anderson (2010), Griffin (2003), and Creswell (2003) agreed on the following advantageous features of qualitative research method.

Qualitative research methods are directed at providing an in-depth and interpreted understanding of the social world of research participants by learning about their social and material circumstances, their experiences, perspectives, and histories.

Since, samples that are small in scale and purposively selected on the basis of salient criteria, data collection methods which usually involve close contact between the researcher and the research participants, which are interactive and developmental and allow for emergent issues to be explored, the data are very detailed, information rich and extensive.

Qualitative research analysis which is also open to emergent concepts and ideas and which may produce detailed description and classification, identify patterns of association or develop typologies and explanations, and outputs tend to focus on the interpretations of social meaning through mapping and 're-presenting' the social world of participants.

Qualitative research method also has its own limitations. Some of them are widely accepted by Moriarity (2011), Andesson (2010), Griffin (2003) and Creswell (2003).

Knowledge produced by qualitative research might not generalized to other people or other settings (i.e., findings might be unique to the relatively few people included in the research

study), it is difficult to make quantitative predictions, it is more difficult to test hypotheses and theories with large participant pools, it might have lower credibility with some administrators and commissioners of programs, it generally takes more time to collect the data when compared to quantitative research, data analysis is often time consuming and the results are more easily influenced by the researcher's personal biases and idiosyncrasies (ibid).

3.4. Data Collection Tools

Data collection in qualitative research involves a variety of techniques such as; participant observation, document analysis, an in-depth and semi-structured interview, focus group discussion are some of the widely used data collection tools in qualitative research method. But to answer the research questions of this study, document analysis (the SBCC strategy of the FHAPCO) and an in-depth interview with nine informants were employed.

3.4.1 Document Analysis

In the study, the document, the social and behavior change communication (SBCC) strategy which was produced by the federal HAPCO in 2015 to prevent HIV/AIDS in most at risk population and vulnerable groups in Ethiopia is analyzed. The Federal HAPCO segmented the audience in to different segments so as to design appropriate strategy for each segmented audience.

Accordingly, the SBCC strategy for HIV/AIDS to address MARPS and vulnerable groups in Ethiopia is segmented for; commercial sex workers, mobile workers, in school youths, members of the uniformed services and inmates (HAPCO, 2015).

In the process, the SBCC strategy for MARPS and vulnerable groups, particularly the communication strategy for college and university students, the strategy for higher education

which was introduced by FMOH in 2012, the SPM II, annual HIV responses and other related documents are analyzed thoroughly. Document analysis is used to answer research question number 1,

- To identify the health communication strategies of FHAPCO that are used to address college and university students under MARPS and vulnerable groups.

When the document was analyzed, it is from the point that effectively and strategically designed and implemented health communication could benefit the audience to promote good health behavior; to prevent the onset of the health problems, to cure the development of health problem or to cure or treat an existing problem (Keller & Lehmann, 2008).

Therefore, the study provided a brief analysis on: 1. the health communication strategy of the federal HAPCO to prevent HIV/AIDS among MARPS and vulnerable groups, particularly to address college and university students.

3.4.2 In- depth Interview

Interviews remain the most common data collection method in qualitative research method. Interview is the familiar and flexible way of asking people about their opinions and experiences (Moriarty, 2011).

An In-depth interview is a qualitative method of data collection tool in which the researcher used it to find elaborated data concerning respondents' opinions, values, motivations, recollections, experiences, and feelings of the respondent (ibid). In-depth Interview usually involves orally asking questions for individuals to answer orally. The most important advantage of the in-depth interview is the wealth of detail that it provides to the researcher (Wimmer & Dominick, 2011).

Hence, individual in-depth interviews were conducted with nine key informants who were members of the technical team that designed the behavior change communication (SBCC) strategy for MARPS and vulnerable groups in Ethiopia and key stakeholders for the health interventions Addis Ababa University to get detailed information on how health communication strategies are designed and implemented so as to prevent university students from the HIV epidemic.

An individual in-depth interview is used to answer research question number 2 and 3, i.e.

- To find out the systematic health communication approach that the FHAPCO has followed for the design and implementation of the strategy , and
- To find out the gap why university students demonstrate high risk behavior towards HIV if there is strategic health communication approach which address them.

3.5 Sampling Technique

3.5.1 Purposive sampling

Purposive sampling is an information tool widely used in qualitative research method. It is also called judgment sampling which means the deliberate choice of an informant due to the qualities that the informant possesses (Moriarty, 2011). This sampling technique can prove to be highly effective when primary data needs to be obtained from a very specific group of respondents and when only representatives of certain professions can contribute to the study (ibid).

Accordingly, 28 individuals were participated in the development workshop of the strategy which was held in Adama representing different organizations that work on HV prevention interventions like; FHAPCO, World learning Ethiopia, PS/Ethiopia, FHI 360, ministry of labour and social affairs, DKT Ethiopia, UNICEF, ministry of education etc. Therefore, purposive sampling is used to select 6 individuals (5 male and 1 female) for the interview

from the members of the technical team who designed the SBCC strategy and 3 individuals (2 male and 1 female) from AAU HAPCO who implement the strategy in AAU based on their information and experience which is relevant to the study and due to their willingness to share the information and experience that they have.

3.6 Data Management and Analysis

3.6.1 Recording

The entire in-depth interviews with the members of the technical team were conducted in local language Amharic and were recorded both in notes and audio recording. Almost around 64 minutes of interview were obtained in parallel to the notes taken during the interview.

All tape recorded data were transcribed in English. All transcribed data included the detailed demographic information of informants, the place and time. This is also done with codes of interviewees. As every interviewee was given codes before the interview and these codes were used to identify who said what.

3.6.2 Ethical Consideration

The researcher has tried to establish a good understanding with all the informants by making herself clear i.e. where she came from, why she decided to conduct the study, why she choose the informants for the study etc. she also informed the informants that the information they provide will be used only for the study purpose. Accordingly, the researcher used the information only for the study purpose. In addition to this the researcher ensured confidentiality by making the informants unnamed (coded).

3.6.3 Thematic analysis of data

A thematic analysis of the data which was collected from document analysis and an in-depth interview cuts across all the data to group the common issues that recur and identify the main

themes to summarize all the views that are collected. This is the most common method for qualitative research. To arrive at a certain themes, explanation and identification of the commonly repeated ideas into same group was the major technique.

The collected data were categorized into different themes based on the research questions. Similar data obtained from document analysis and an in-depth interview which answer the same questions were clustered under same theme and discussed accordingly. As a result, based on the research questions, the data were grouped into three major categories: the health communication strategies of FHAPCO to prevent HIV/AIDS among MARPS and vulnerable groups, particularly to address college and university students and its organization, the systematic approach that the FHAPCO has followed to design and to implement the strategy and the gap why do university students demonstrate high risk factors towards HIV/AIDS.

The study took the systematic health communication approach, the elements of effective communication strategies which was introduced and accepted by the center for communication programs at the Johns Hopkins Bloomberg School of public health and participatory communication theory is employed as a theoretical framework to analyze the collected data.

CHAPTER FOUR: DATA ANALYSIS AND FINDINGS

4.1 Introduction

This study is designed to examine the health communication strategy of FHAPCO to prevent HIV/AIDS among MARPS and vulnerable groups, particularly to address college and university students, how it was designed and to get the gap why university students are still at risk of HIV infection. The study is informed by participatory communication theory.

This chapter, therefore, presented the data which are classified into various thematic areas so as to give possible answers for the research questions. The thematic areas are categorized under the collected data through document analysis and an in-depth interview.

The first theme presented the health communication strategy of FHAPCO to prevent HIV/AIDS in MARPS and vulnerable groups and in particular college and university students according to its main parts. The second theme presented the systematic health communication approach i.e. how the SBCC strategy of FHAPCO has designed; implement and practice the M&E process. And finally, the gap why university why university students are still at risk of sexually transmitted HIV infection is presented.

4.2 The Health Communication Strategy of FHAPCO to prevent HIV/AIDS in MARPS and Vulnerable Groups in Ethiopia

One of the questions that this study sought to address was what are the health communication strategies of FHAPCO to prevent HIV/AIDS in MARPS and vulnerable groups particularly to address college and university students? In this connection, the study found that the federal HAPCO has developed two major documents as a strategy for HIV prevention interventions. The first strategy is HIV behaviour change communication framework for Ethiopia, which was published in 2011. The framework was a complementary document to the BCC material

development which has been developed and disseminated five years before. The 2011 BCC framework outlined the various elements of behaviour change communication for HIV prevention across all priority audience groups to be scaled up to achieve the intended behavioural change in targeted groups and effective HIV prevention. It was designed to guide the communication needs of different population groups in the country (FHAPCO, 2011).

The second strategy is the social and behaviour change communication strategy (SBCC) for MARPS and vulnerable groups in Ethiopia which was published in January 2015. The strategy is an extension of the previous document which is designed to provide guidance in the development of high impact, simplified and clear communication that would help the identified population to bring about change and sustain behaviours for healthier lives (FHAPCO, 2015). It focused on the combination prevention needs of selected MARPS and vulnerable groups.

The SBCC strategy for MARPS and vulnerable groups to prevent HIV/AIDS is a part and parcel of the strategic plan (SPM II) for intensifying multi-setoral HIV/AIDS response in Ethiopia (SPM II, 2010-2015) and it is also the area of this research paper. But before going to see the SBCC strategy, what is SPMII?

The Strategic Plan for intensifying Multi-sectoral response to HIV/AIDS in Ethiopia (SPMII) is a programme which is guided by; the National HIV/AIDS Policy, 1998; the Strategic Plan for Intensifying Multi-sectoral HIV/AIDS Response, SPM I (2004-2008); the Plan for Accelerated and Sustained Development to End Poverty, PASDEP (2007-2010); the Road Map for accelerated access to HIV prevention, treatment and care in Ethiopia, (2007-2010), and the Plan of Action for Universal Access to HIV prevention, treatment, care and support in Ethiopia, (2007-2010).

This strategic plan (SPM II) is developed as a guide towards universal access to HIV/AIDS services in the country. The SPM II has five thematic areas (along with their objectives and key strategies) which include;

1. Creating enabling environment,
2. Intensifying HIV prevention,
3. Increasing access to and improving and quality of chronic care and treatment,
4. Intensifying mitigation efforts against the epidemic and
5. Strengthening the generation and utilization of strategic information (SPM II, 2010-2015) in which each of the thematic areas have their detailed components.

According to the federal HAPCO, the fight against HIV/AIDS cannot be successful unless further spread of the epidemic is reversed and ultimately halted. And this requires social transformation to reduce social, cultural and economic factors that make people individually or collectively vulnerable to HIV infection, as well as creating comprehensive knowledge and behavioural change on a mass basis among the population with particular focus on MARPS (SPM II, 2010).

Therefore, prevention of new HIV infection among young people and adult population must be intensified using a combination prevention approach to address structural, behavioural and biomedical issues in the prevention (FHAPCO, 2015). Therefore, the SBCC strategy for MARPS and vulnerable groups is the second package of SPM II for HIV prevention services for key population (MARPS and vulnerable groups) is an approach to address behavioural issues towards the prevention strategy.

4.2.1 The Social Behaviour Change Communication (SBCC) Strategy for HIV, MARPS and Vulnerable groups on Ethiopia

The SBCC strategy of FHAPCO for HIV to address MARPS and vulnerable groups in Ethiopia has three main parts. The first part is the introductory part which contains rationale,

definition for the SBCC strategy, objectives, guiding principles, strategic approaches and conceptual framework. The second part contains definition for MARPS in Ethiopia, strategic communication approaches for each segmented primary audiences with their respective profiles and for secondary audiences, risk and vulnerability factors of the five identified MARPS and vulnerable groups individually. And the third part identified the research, monitoring and evaluation indicators. Each part is explained as follows.

The introductory part of the SBCC strategy for HIV to address MARPS and vulnerable groups in Ethiopia defines the heterogeneous characteristics of the epidemic and its seriousness with the support of DHS. Figures of demographic health survey of Ethiopia (DHS) reported that there are an estimated 711,446 people are living with HIV, out of which 436,655 (61%) are females and 138,906 are children under the age of 14. And an estimated 21,263 HIV positive pregnant women are in need of service for the prevention of mother to child transmission of HIV (PMTCT). There are also an estimated 4.2 million orphans in the country of which 733,462 children orphaned due to HIV. The document also identified the main factors that derive the epidemic to the worst level. Low level of comprehensive knowledge about HIV/AIDS, low risk perception, mobility, unprotected sex, intergenerational and transactional sex, high prevalence of sexually transmitted infections (STI), alcohol abuse and gender inequality are the main ones. Such marked geographic and demographic contrasts in exposure to HIV point to the need for targeted HIV prevention intervention tailored to a wide range of different contexts in the country, which include social and behaviour change communication (SBCC) (FHAPCO,2015).

Social and behaviour change communication (SBCC) is defined as a research –based, consultative process that uses communication to promote and facilitate behaviour change and supports social change for the purpose of improving health outcomes (ibid).

Based on this assumption, the FHAPCO developed the social and behaviour change communication strategy for MARPS and vulnerable groups to put in place the specific social and behaviour change communication tools required for the selected target groups and help all stakeholders to have a better understanding of SBCC needs, strategies and proposed channels for the identified population groups (FHAPCO, 2015).

Understanding that behavioural interventions are critical in HIV/AIDS prevention packages, the SBCC strategy of FHAPCO has the general objective; to contribute to the national plan of prevention of new HIV infections and saving of lives from HIV/AIDS by creating awareness and enhancing the desired behaviour change towards the HIV epidemic (ibid). And specifically it has the aim to:

- Prevent HIV transmission among MARPS and vulnerable groups,
- Increase demand and uptake of bio-medical services among MARPS and vulnerable groups,
- Increase the involvement and control of the different population groups over their working and social conditions for health and
- To enhance enabling environment to overcome barriers to social and behaviour change among MARPS and vulnerable groups through behavioural approach.

The socio-ecological model is stated as a conceptual framework for the SBCC intervention which informs the social and behaviour change communication needs to go beyond individual needs and focuses on the different domains that affect the behaviours of individuals and communities.

The most at risk population (MARPS) and vulnerable groups which sometimes are called key population are globally defined as groups that have higher HIV prevalence when compared to the general population (WHO) which is also adopted and used by FHAPCO. Therefore, in the Ethiopian context, the HIV prevention package for MARPS and vulnerable groups identified

five groups as having greater risk for HIV when compared with the rest of the people. These groups are;

1. Sex workers
2. Mobile workers
3. In-school youth
4. Members of uniformed service and
5. Inmates

And communication strategies is developed for each groups. Hence, communication strategy for In-school youths, particularly for college and university students is explained as follows

4.2.1.1 Health Communication Strategy for In-school youths, College and University Students

The classification of Ministry of Education categorizes in-school youths as primary second cycle (students n grade 5-8), secondary school students (students in grade 9-12) and tertiary level (college and university students) is used by the strategy to categorize different in-school youth groups (FMOE).

Therefore, the health communication strategy for in-school youths identified risk and vulnerability factors, current behaviour, desired behaviour, communication approaches, channels and secondary audiences and communication approaches for each target audience groups. Since, the focus of this study is the communication strategy of FHAPCO to address college and university students, the strategy for the third MARPS group (in-school youth) particularly the strategy for college and university students is explained in this part.

The SBCC strategy of FHAPCO for HIV to address college and university students contains audiences profile, risk and vulnerability factors, strategic approach and channels and the desired behaviour for primary and secondary audiences.

According to the document, college and university students are students whose age ranges between 17 and 24. And these young people remained at the center of HIV/AIDS epidemic in terms of rates of infection, vulnerability, impact, and potential for change (FHAPCO, 2015). The document stated that these audience groups still lack comprehensive and correct knowledge about how to prevent HIV infection (ibid) and they are also segmented under the primary or key audience in SBCC strategy. The document also stated that female university students as highly vulnerable groups to HIV due to the following different risk and vulnerability factors.

The risk factors that expose university students particularly females for HIV and other STI (but which can be controlled by the target population) are stated as; casual and unprotected sex, incorrect and inconsistent condom use, transactional and intergenerational sex, unsafe abortion and substance use like chat, alcohol, drug etc. And the vulnerability factors (which are out of the students control) are stated as; gender based violence, gender inequality, peer pressure, availability of drugs and alcohol, detachment from family, low risk perception, economic problems, absence of youth friendly services, lack of comprehensive knowledge about HI/AIDS and SRH, and lack of assertiveness, negotiation and decision making skills are the remarkable ones.

According to FHAPCO, currently, college and university students are vulnerable to the above risk and vulnerability factors (FHAPCO, 2015). The federal ministry of education also confirmed that young people still remained at the center of HIV/AIDS epidemic in terms of rates of infection, vulnerability, impact, and potential for change as well. And they also still lack comprehensive knowledge about how to prevent HIV infection (MOE, 2011).

Therefore, the federal HAPCO designed strategic communication approaches, and channels to render these risk and vulnerability factors of these audience groups. And the communication strategies are; *peer education, edutainment, school community discussion, using model youth students who are successful in their education, empower girls to exercise their rights with accessing quality SRH and establish, strengthen and use campus health facilities for accessible HIV and SRH information.*

The key messages to get the desired behaviours are aimed to enhance risk perception and to increase knowledge on HIV/AIDS and SRH. Such as; delay of sexual debut or secondary abstinence, appropriate use of condom and emergency contraceptive pill, prevent unintended pregnancy, increase awareness about the risk of engaging in transactional sex, enhance skill and efficacy to practice essential life skills, quit or reduce substance abuse, increase ART service users, early diagnosis and treatment of STI, and increase proportion of students tested for HIV are the main ones.

The channels and communication tools through which the messages disseminated are; more of interpersonal communication like peer education, school community conversation, events, building partnership with clubs and student unions, and edutainment (comic books) as a single mass media that is used to improve the health behaviour of the target audience.

The strategy also identified teachers, school administration staffs and college and university surrounding community as secondary audience groups, which can also influence or affect the health behaviour of university students. And the document contains strategic approaches and channels to address the secondary audiences to bring about the desired behaviour change as, building partnership with clubs, student unions, school community events, community conversation and mass media (radio), print media (broacher, billboards) etc. to make secondary audiences take responsibility to resist GBV, coercion, gender inequality, rape, and to resist people who want the surrounding rental houses for purpose that contribute to risky

behaviour among students so as to avoid vulnerability factors to HIV and other STI among students (FHAPCO, 2015).

Finally, the strategy identified the structural, behavioural and bio-medical research, monitoring and evaluation indicators for the intervention at the end. The research, monitoring and evaluation (RM&E) are critical to better understand issues, to track progress of implementation and to ensure impacts. Therefore, the FHAPCO developed the multi-sectoral response information system (MRIS) to track non-clinical HIV response outcomes and impacts in the country (FHAPCO, 2015). And the strategy adopted indicators relevant to social and behaviour change communication from MRIS, and other international monitoring and evaluation tracking tools for structural, behavioural, and bio-medical interventions (ibid). Major indicators for behavioural interventions are considered as; percentage MARPS population who

- correctly identifies ways of preventing the sexual transmission of HIV and who rejects major misconceptions about HIV transmission,
- Become educated about the use of correct use of condom in order to prevent HI/AIDS,
- Have had sexual intercourse before the age of 15,
- Have two or more concurrent partners,
- Have had STI within the last one year,
- Reported they ever faced forced sex, and the like.

From this part, the study found out that the FHAPCO developed a social and behaviour change communication strategy (SBCC) for college and university students to prevent HIV infections among these groups. The study found out the strategy is informed by relevant theory (socio- ecological model) which states effective health communication interventions must influence multiple levels in the society i.e. family, community and socio-structural

domains in bringing the intended behaviour change (Stokols, 1995) which leads the strategy to effectiveness. Because, although theories cannot substitute for effective planning and research, they offer many benefits for the design of health communication programmes by answering any questions like why the problem exists, whom to select, how to reach the intended audience, which strategy is most likely brings the desired change (Stokols, 1995).

4.3 Systematic Health communication approaches that the FHAPCO has followed for the design and implementation of SBCC strategy

The second objective of the study was to found out the systematic health communication approach that the FHAPCO has followed in the design and implementation of health communication strategies for HIV. Accordingly, the study found out that the p-process systematic health communication approach to design, to implement and to practice the M&E of the SBCC strategy was followed. And it is analysed based on the phases of participatory communication programme cycle as follow.

4.3.1 The Design

The design of the SBCC Strategy for HIV to address MARPS and vulnerable group was held in Adama in 2015. In the design stage, representatives from national and international partner organizations, NGOS, Government sectors and FHAPCO Officials participated in the technical team who were delegated to design the strategy. Delegates of DKT Ethiopia, UNICEF, FHI 360, MOE, MOLSA, World learning Ethiopia, PSI/ Ethiopia, MWCY, save your generation, JHU, CCP, MOE, March project and FHAPCO are some of the partners that work on HIV and related health areas on different audience groups, and were participants of the design process. On the five days' workshop which was held in Adama, the technical team followed the procedures of P- process systematic health communication approach so as to

develop the SBCC strategy of HIV to address MARPS and Vulnerable groups in Ethiopia. And it is presented as follows.

Analysis

Regarding the design of the strategy, the study found that the first stage of the design was need assessment by the FHAPCO. The national HIV prevention package for MARPS and vulnerable groups identified female sex workers, mobile workers, in school youths, members of the uniformed services and in mates as a key population which should be particularly addressed so as to bring about behavior change to prevent HIV/AIDS due to their higher vulnerability rate than other population groups.

Therefore, based on the result of the need assessment, the FHAPCO aimed to guide stakeholders on the HIV prevention intervention works and collected formative researches, strategies and back ground works done by partner organizations on these target audience groups to conduct situational analysis. But these all were done before the workshop. And presentation of the situational analysis was the first thing on the workshop.

Informant code number 04 explained the first day of the workshop as:

...The first thing we did on the workshop was to review the formative researches, reports and background information on each MARPS and Vulnerable groups which were done by different partner organizations and stakeholder and presented by FHAPCO officials. Then we analyzed it in order to identify the current behavior, HIV prevalence rate, current behavior and barriers of HIV prevention interventions on the given audience groups... ***(Personal interview- 04: Sep2, 2015).***

Informant code number 08 also strengthened the above response in that:

...There was a presentation of information, and researches which were conducted on different parts of Ethiopia particularly on these MARPS and Vulnerable groups so as to show the seriousness of the problem in such MARPS and vulnerable groups ***(Personal interview-08: Aug5, 2015).***

After doing so, the second step with in the analysis stage was audience segmentation. In the process of audience segmentation, the technical team took the risk and vulnerability factors of each target population in to consideration and identified their profiles.

Informant code number 04 said

... Then we made the profile of each of the audience groups based on their demographic (age, sex, educational background) and psychographic characteristics, value, life style...) aspects of the audience groups and segmented them accordingly ***(Personal interview- 04: Sep2, 2015)***

On the segmentation process, the researcher asked members of the technical team why did university students are segmented under MARPS and vulnerable groups while they are expected to be relatively highly informed and aware of HIV transmission and its prevention methods than other population groups.

Informant code number 03 explained the reason why university students are segmented as MARPS and vulnerable groups as:

... There were many researches done by partner organizations particularly on five universities like Hawassa, Gonder, Haromaya and others two which indicated the high risk and vulnerability rate of university students especially females. Even though university students are expected to be more informed about the pandemic, but still they are highly

vulnerable. That is why university students are segmented under MARPS and vulnerable groups... ***(Personal interview- 03: Aug26, 2015).***

But according to UNAIDS and WHO, MARPS groups are identified as; Commercial sex workers, MSM and injected drug users, but doesn't include university students. Therefore, the researcher asked why MARPS in Ethiopia is different from MARPS in other countries.

Informant code number 01 explained about the reason as;

...Globally, three population groups are segmented under MARPS due to their vulnerability in day to day activities or their living styles like commercial sex workers, injecting drug users and MSM. Because commercial, sex workers have sex with multiple partners, drug users share or use common syringe to be injected with the drug, and MSM are exposed for irritation and fusion of blood from one man to another. But in Ethiopian context, there is no national survey which confirms this definition to work. Hence, by taking the concept of MARPS due to its use for HIV intervention, it was necessary to contextualize and define the segmentation. Due to the availability of relevant data and research on commercial sex workers, there was no problem to identify them as MARPS. But the remaining two, injecting drug users and MSM, not only due to the lack of researched data, but also due to the national low especially towards MSM (it is not lawful and acknowledged to work with MSM in Ethiopia low), we contextualized and defined commercial sex workers as MARPS and the rest two as vulnerable groups because of their vulnerability to HIV/AIDS ***(Personal interview- 01: Aug, 2015).***

After identifying behavior determinants and barriers of the target audiences, the technical team set objectives. Of course, the general objective is the same as the objective of the national, SPM II as well as MDG 6 objective which is to the reduce HIV prevalence

incidence of the population particularly with key population. And informant code number 04 said that

...specifically we set specific objectives which scaffolds to meet the general objective ***(Personal interview- 04: Sep2, 2015).***

From the above explanations, the study found that, including definition of key stakeholders, the design process assessed needs, problems, risks and solutions, prioritized key issues for change and reconciled different perceptions and defined objectives. According to the data which was found from the in-depth interview, the analysis stage of the SBCC strategy design of FHAPCO was done accordingly with participatory communication program cycle phase 1 (PCA), and the P-Process systematic health communication approach step 1- analysis which instructs to understand the nature of the health issues, barriers to change definition of key (target audience) stakeholders, and to define solutions or objectives in the first stage.

But, during document analysis and an in-depth interview, the study also found that *to create a common/public space, establish dialogue and trust among key stakeholders* which is the second step in participatory communication assessment (PCA) was missed. In the design process, there was no direct participation of key stakeholders. In which participatory communication theory states, the definition of a problem is due to lack of stake holders' engagement and the main notion of change is individual and social behavior which results from the direct participation of the target audiences (Tufte and Mefalopolos 2009).

And all the respondents agreed on the point that there was no participant from the key stakeholders in the SBCC strategy development workshop.

4.3.2 Communication strategy Design

Based on the situational analysis, the second stage was to decide on the communication strategy for each audience groups. Informant code number 04, remembered the situation as:

... After we defined our objective, we developed themes, communication strategies, messages and channels which we thought it is relevant to address each of the target audiences. (Personal interview ***(Personal interview- 04: Sep2, 2015).***

Informant code number 01, 02 and 03 also shared the above idea.

Regarding the communication strategy design sage, the technical team set SMART objective as mentioned on the literature part, and identified primary and secondary audiences (teachers and administration staffs, college and university surrounding community), identified type of change expected (behavioural), communication approaches and channels (peer education, edutainment, school community conversation etc.), and expected out comes or behaviors(exercise secondary abstinence, be more assertive, use condoms correctly and consistently etc.) as well.

Therefore, the study found out that the design of the SBCC strategy of FHAPCO to prevent HIV/AIDS in Ethiopia is guided by participatory communication program cycle phase 2/a. This is monologic modality which is setting an objective to bring about positive behavior change towards HIV/AIDS prevention with the target audiences as explained on the literature part

4.3.3 Implementation of the SBCC strategy

According to participatory communication program cycle, once the communication strategies have been defined, it is important to draw an action plan to implement. With this base, the

study found out that the federal ministry of education (FMOE) drew an action plan (HIV/AIDS and SRH communication strategy for higher education institutions, 2012) which is an extension of the SBCC strategy of FHAPCO to facilitate effective implementation of the strategy. According to participatory communication program cycle phase 3, once communication strategies have been defined, it is important to draw an action plan to implement and facilitate and monitoring all relevant activities (Tufte and Melfalopulos, 2009).

Since the implementers of health communication strategies are partner organizations that are working on HIV/AIDS prevention interventions, the study identified that university HAPCOs and other partners use an action plan (HIV/AIDS and SRH communication strategy for higher education institutions, 2012) which was drawn by FMOE.

4.3.4 Monitoring and evaluation (M&E)

Monitoring and evaluation (M&E) are practiced based on the indicators defined, validated and assessed from the very beginning. From document analysis, the SBCC strategy of FHAPCO for HIV defined and validated M&E indicators from the very beginning. In relation to this, informant code number 09 described this:

...FHAPCO is responsible for the M&E practice of the SBCC strategy according to the indicators which identified in the design stage... ***(Personal interview- 09: Aug28, 2015).***

Informant code number 04 on the other hand, argued that the FHAPCO is not responsible for the M&E practice and said

...The FHAPCO gives joint supportive supervision for the implementers through periodic reports. But partner organizations are responsible for M&E practice of the SBCC strategy. ***(Personal interview- 04: Sep2, 2015).***

From the document analysis, it is found out that the research, monitoring and evaluation (RM&E) indicators of the SBCC are adopted from multi -sectoral response information systems (MRIS) to track non-clinical HIV response outcomes (FHAPCO, 2015) which is in accordance with participatory communication program cycle phase 4.

Therefore, the study stated that both partner organizations and the FHAPCO are responsible for the M&E practice of the strategy. But it can be seen that there is a gap that has to be filled in taking the RM&E practices to measure the impact of the intervention and to determine how to improve future projects.

4.4 Why Do University Students Demonstrate High Risk Behaviour since There is a Health communication intervention in Universities?

The third question that the study attempted to answer was, why do university students demonstrate high risk behavior towards HIV/AIDS since there is a perceived health communication strategy is designed and implemented for these target groups? Therefore the study identified some points. But before that, the study wanted to know if the health communication strategies of FHAPCO are really implemented in universities. In this respect, informant code number 07 explained the point as:

… Of course, *we are implementing different communication strategies which were designed by the FHAPCO in the HIV prevention interventions. And we are effectively using the strategy. So that the use of condom in universities is very high and we believe that we are approaching and influencing students' behavior positively…* ***(Personal interview- 07: Sep5, 2015).***

Although informant code number argued that `there is a good result in influencing students behavior positively, annual responses and researches show that there is still a high HIV/AIDS

prevalence rate and low level of comprehensive knowledge on university students particularly, with females as explained in the literature part.

On the other hand, informant code number 02 explained that of course, there is implementation of health communication strategies to halt HIV/AIDS in universities and high risk behavior is also demonstrated at the same time. But he argued that the risk behavior of students is not the result of fail of the strategies, but there are different factors. And he stated the point as:

... The high rate of HIV prevalence in universities does not have direct relationship with the strength or limitation of the communication strategy. Rather it is the characteristics of campus life. As far as I know, every year, universities accept fresh student who have risk and vulnerability factors. On the other hand, students who developed their awareness leave the campus for good every year. Therefore in the meantime there might be a gap which is considered as a limitation caused by the very nature of campus life but not the strategy... ***(Personal interview- 02: Aug3, 2015).***

But on the contrary, informant code number 05 said

... I think the controversy between the reports presented on annual responses and the implementation of the HIV/AIDS prevention intervention is due to the lack of dynamism on the strategies. Because as we all can understand, students' behavior is dynamic and inconsistent. Therefore the strategy which was effective once could not be effective again. So the strategy should be revised and redesigned periodically to address/get the heart and mind of the students. But in our cases, strategies are designed for longer period of time like for five years which results generation gap. And this might be one of the reasons... ***(Personal interview- 05: Sep2, 2015).***

Informant code number 05 added that the crafting and designing of HIV prevention communication strategies need careful, creative and dynamic or updated state of approach and should be supported by new technologies.

The informants also explained that these days, youths mostly are interested on fun things and prefer to go to clubs and restaurants rather than attending HIV prevention panel discussions. Because they may think these kinds of phenomena do not match with their modernity.

In addition, informants explained that the risk and vulnerability factors students, especially female university students are deep rooted and complicated. Peer pressure, lack of information, lack of assertiveness gender based violence and poverty are some of the problems that forces students to be highly vulnerable. But on the contrary implementation of the health communication strategies are as such effective and deep rooted.

Although the problem of HIV infection in universities, especially on females is still a headache for the country, the informants agreed on the point that there should be another way to effectively prevent the epidemic.

In this regard, informant code number 09 said that since university students are exposed to such constraints, the health communication strategy to prevent them from HIV/AIDS or supporting students in SBCC interventions should be implemented not as extra- curriculum, but must be part of major curriculum.

Informant number 04 also emphasized the SBCC strategies and implementations for university students especially for females should be; deep as the problem is, should be participatory to the society, vast, specific and the target audiences should be part of every stage of the health communication strategy which supports the core idea of participatory health communication theory.

Informant code number 09 also added that interventions should be from the very root of their early age and should be vast so as to change the behavior of students at their university level.

From the above explanations, the study found out that although there are communication strategies for college and university students to prevent HIV/AIDS, there are still gaps that have to be filled. Lack of direct participation of students at all stages of the strategy which builds trust and among all stakeholders, lack of dynamism of the strategy in using new information technologies as a channel and crafting of attractive messages for both students (for students who come from rural and urban areas), lack of newness or periodicity of strategies (redundancy of messages every year), and students background knowledge and exposure to HIV prevention interventions (less attention for interventions at lower age levels) are the main gaps that brought a controversy between the availability of communication strategies for college and university students and the demonstration of high risk behavior towards sexually transmitted HIV/AIDS on university students.

CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusion

Even though annual HIV responses demonstrate there is a declining rate of new HIV/infections worldwide and nationwide, the people of the world especially people living in the sub- Saharan countries are still suffering with HIV/AIDS infections.

As a sub- Saharan country, Ethiopia is also one of the highest hit countries with HIV/AIDS infections. Young women also have the highest infection rates due to different reasons. Therefore, the FHAPCO designed the SBCC strategy for MARPS and Vulnerable groups to prevent HIV AIDS in Ethiopia.

Hence, in this study, the health communication strategy of FHAPCO for MARPS and Vulnerable groups to prevent HIV/AIDS, particularly to address college university students has been analyzed through qualitative inquiry. Document analysis, an in-depth interview with members of the technical team who designed the SBCC strategy and with individuals who are personnel at AAU HAPCO was conducted to get answers for the research questions. And the study is informed by participatory communication theory.

Therefore, the study identified that the federal FHAPCO has designed a social and behavior change communication strategy for HIV in MARPS and vulnerable groups in Ethiopia. MARPS and vulnerable groups in Ethiopia identifies: sex workers, mobile workers, in-school youths, members of uniformed services and inmates.

The SBCC strategy of FHAPCO to prevent HIV/AIDS in MARPS and vulnerable groups particularly to address college and university students are; peer education, edutainment, school community discussion, using model youth students who are successful in their education, empower girls to exercise their rights with accessing quality SRH and establish, strengthen and use campus health facilities for accessible HIV and SRH information.

The SBCC strategy of Ethiopia for HIV in MARPS and vulnerable groups was designed by the members of the technical team that was assigned to design the SBCC document. In the process, the technical team used the p-process systematic health communication approach as a guideline. Analysis of the existing problem, identifying audience segmentation, identifying risk and vulnerability factors of each audience groups, selecting message concepts and channels and identifying relevant indicators to the SBCC was the major steps that the technical team has followed.

Although there were representatives of partner organization who are considered as having full information about the target audiences, it is difficult to say that there was a direct participation of the target audiences in all stages of the SBCC strategy of Ethiopia for HIV prevention in MARPS and vulnerable groups.

However the level of participation is identified as; passive participation, participation by consultation, participation by collaboration and empowerment, as discussed on the literature part, when primary stakeholders are capable and willing to initiate the process and take part, therefore it is said that the public fully exercise their right (Servaes, 2002). And according to participatory communication theory, communication is not an isolated activity that a group of specialists do separately from others (McKee et al. 2004) and it should be in a form of horizontal dialogue and bottom- up rather than top to down (ibid).

Therefore the researcher identified the absence of the target audience groups in all stages of the SBCC strategy design process as the limitation of the strategy.

Regarding the implementation, the SBCC strategy is implemented by partner organization and key stakeholders. And the M&E practice is also the responsibility of FHAPCO with its respective package and other implementers (partner organizations).

In conclusion, the study found out that the controversies between the low level of comprehensive knowledge and high risk behavior of university students to sexually transmitted HIV/AIDS on one hand and the availability of HIV prevention intervention strategies on the other hand is due to the following gaps.

Lack of direct participation of students at all stages of the strategy which builds trust and among all stakeholders, lack of dynamism of the strategy in using new information technologies as a channel and crafting of attractive messages for both students (for students who come from rural and urban areas), lack of newness or periodicity of strategies (redundancy of messages every year), and students background knowledge and exposure to HIV prevention interventions (less attention for interventions at lower age levels) are the main gaps that brought a controversy between the availability of communication strategies for college and university students and the demonstration of high risk behavior towards HIV/AIDS on university students.

5.2 Recommendations

The concept of universal human right that evolved in the second half of the twentieth century not only claims Civil and political rights for all, but social and economic right as well. The lack of progress in realizing these social and economic rights manifest in malnutrition, unemployment, illiteracy, lack of basic primary health care syst poor sanitation, and low status of women's conditions that create a favourable setting f arge – scale spread of HIV/AIDS (McKee, et al, 2004).

As McKee, et al, 2004 pointed out, in recent years, HIV/AIDS program managers have increasingly insisted that HIV/AIDS is not a public health issue alone, but is a development issue that must be treated systematically by addressing structural causes of disparity in society and the overall lack of realization of human rights (ibid). As the field shifts in

response to international political mandates (e.g. widespread distribution of ARVs) or technological innovation (e.g. rapid testing kits), communication has a key role to pay in bringing these innovations to specific audience or the general public (McKee, et al, 2004).

To this end based on the findings on the SBCC Strategy of FHAPCO, the following points are recommended.

- In the fights against HIV/AIDS, communication strategies have to be participatory. As long as the technical team followed scientifically accepted procedures of systematic health communication approach like P-process and participatory communication program cycle, it is very critical to exercise the very soul of these procedures; which is participation. As discussed in chapter two, although there are different assumptions on the level of participation, participatory communication stresses mutual collaboration throughout all level of participation and as a result, the focus moves from "a communicator- centric" to a more "receiver- centric orientation" (Servaes, 2002).

And this time, communication is considered not as isolated activities that a group of specialists do separately, rather it is a process by which involves the public in the production design implementation and M&E practices as well (McKee, et al, 2004). While the way of communication should be in a form of horizontal dialogue and bottom-up rather than top to down and culture is considered as a way of life but not an obstacle (Tufte and Melfalopulos, 2009).

- Effective health Communication strategy also uses a variety of means of communication channels like mass media edutainment, radio, television, comic books, pamphlets, broachers, films telephone and interpersonal communication

Channels like peer education, community conversation are the effective channels of effective communication strategy. Updating communication strategies and new information technologies ICTs has to be given due attention on the way to address college and university students.

- In addition, the implementation of SBCC strategy has to be done by all stakeholders in all levels (individual, family, community and society) particularly by universities in integrating HIV prevention programs in the university curriculum to bring about change in behaviour towards HIV /AIDS. Monitoring and evaluation (M&E) practice also has to be practised as its indicators timely. Because M&E measure the effectiveness of the strategy and determine how to improve future projects.

- For better effectiveness, the health communication interventions should start at the childhood level. The researcher found out that implementation is the main and critical stage that makes the designed strategy fruitful or not. Because if effectively designed communication strategy is not well implemented, there is no way to get the desired output. That is why informants agreed that so as to bring about the desired change not only FHAPCO and some NGOs, but also all the stakeholders should work for the effective implementation of the SBCC strategy.

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Appendices

Appendix 1

Codes of persons interviewed

No	Position	Code no
1	SBCC Advisor in FHAPCO	01
2	SBCC Advisor in JHU	02
3	SBCC Advisor in FHI	03
4	SBCC Senior Advisor in World Learning	04
5	SBCC officer in AAU HAPCO	05
6	AAU-HAPCO Director	06
7	M&E Advisor in AAU	07
8	SBCC Advisor in MOLSA	08
9	Impact Mitigation Advisor	09

Appendix 2

Guiding questions for an in-depth interview with the members of the technical team that have designed the BCC strategy of the federal HAPCO.

1. Please tell me about yourself, your position and experience, and your role in the design of the BCC strategy of FHAPCO to prevent HIV/AIDS.
2. Would you explain to me the steps and guidelines (systematic approach) followed when you (the team) designed the BCC strategies of the federal HAPCO to prevent HIV/AIDS?
3. What was the role (participation) of the target audiences in the design of the BCC strategy?
4. Can you tell me the reason(s) why university students are segmented under (high risk behaviour groups) with commercial sex workers and with other (MARPs) in the framework?
5. Tell me the specific communication strategies and the channels designed to address most at risk population, (MARPs) particularly college university students.
6. To what extent do you think the strategy to address university students with the health communication strategies which were designed to address other (MARPS) have been effective?
7. Would you tell me who does the monitoring and evaluation practice of the strategy?
8. Why do you think university students still demonstrate high risk behaviour to HIV/AIDS?
9. If there is something else that you want to share with me.

Appendix 3

Guiding questions for an interview with Implementer of SBCC Strategy in Addis Ababa University

1. How do you describe the risk behavior of university students?
2. Who is the responsible body for the health communication interventions to prevent HIV/ AIDS in AAU?
3. Please tell me about the strategic health strategies and channel dominantly implemented in AAU to change the risk behaviour of students.
4. Does the AAU HAPCO have any partnership with the federal HAPCO?
5. How do you describe the effectiveness of the SBCC intervention to address college and university students and what are the indicators for its effectiveness.
6. Please tell me the monitoring and evaluation practice of the SBCC intervention.
7. Why do you think university students still demonstrate high risk behaviour to HIV/AIDS?
8. If there is something else you want to share me please.

Thank you!!!