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VBC PROJECT

Tropical Disease Control for Development

See So That They May See

Communication for Ivermectin Delivery Programs

A Pilot Project in Northeastern Nigeria

March 1993

Volume 2

Annexes

by

Deirdre LaPin

VBC Report No. 81340B

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Annex A-1
Plan of Action

**IVERMECTIN DELIVERY PROGRAM (IDP)
HEALTH COMMUNICATION PLAN OF ACTION**

Program Goal: To reduce the impact of onchocerciasis in target communities.

Purpose: To develop an IDP Health Communication Program to assist PVOs in using health education and communication as an integral part of implementing regular, comprehensive and sustainable treatment programs.

Outputs:

- 1) Individuals with essential knowledge and skills available to work with target communities.
- 2) Effective educational and promotional materials available for use at the community level.

Phase One: Plan

1. DC: VBC and R&D/H finalize the SOW
 - A. Consultant - July 27
 - B. HEALTHCOM - July 31
2. DC: Consultant begins late August/early September
3. DC: VBC, HEALTHCOM and consultant prepare for TPM — August - September (3 weeks)
 - A. Review existing materials
 - B. Discussions with Africare, IEF, HKI, RBF, INMED, UNICEF
 - C. HEALTHCOM prepares a background paper on lessons learned in Nigeria and West Africa, and from other relevant projects. (The paper should include information on experience with institutional development, partnerships with private sector firms, and using mass media in Nigeria. It should identify known constraints and recommended alternatives, and give additional guidance.)
 - D. Consultant prepares a presentation on KAP gaps and info needed

Plan of Action

7. Nigeria: Formative Research (VBC/HEALTHCOM team with PVO and MOH assistance)

2nd - 5th weeks

- A. Organize and conduct formative research (3 weeks)
- B. Analyze data and write draft report

8. Nigeria: Preliminary Planning Workshop

6th week

- A. Begin analyzing data and writing draft report.
- B. Present preliminary results to all interested parties and get feedback for comprehensive plan (2 days)

9. Reconnaissance visit to Cameroon (2 days)

10. DC: Prepare comprehensive IDP Health Communication Plan including monitoring evaluation protocols and indicators and training plan (with VBC - HEALTHCOM to review and advise) — December-January (2-3 weeks)

Phase Two Products: IDP Health Communication Plan

Phase Three: Pretest

Trip 2: 4 weeks

11. Nigeria: Materials Development — February - March

1st week

- A. Materials Development Workshop with PVO and govt. personnel, HEALTHCOM, health educators, media (1st day - decision makers, 1-2 days with implementers)

1. Present data and plan.
2. Reach consensus on operational plan.
3. Draft creative brief.

1st - 3rd weeks

- B. Develop draft materials and pretest (local firm or health education unit if possible) (3 weeks)

4th week

- C. Make final revisions under PVO/MOH supervision (1 week) (consultant could go to Cameroon to hold initial planning meeting during that week)
 - D. Consultant returns to review revisions, discuss them with decision makers, and bring materials to DC for final review
12. DC: VBC/A.I.D. and HEALTHCOM review materials, approve or suggest revisions, communicate changes to PVO rep. by fax or phone (1 week)
13. Nigeria: Nigerian health education unit (HEU), private firm or local NGO produces materials (3-4 weeks)

Phase Three Products: Health communication materials

Phase Four: Implement

Trip 3 - 3 Weeks

14. Nigeria: Implementation

1st - 2nd weeks

- A. Train CBWs in interpersonal communication and how to use the educational materials (possibly in conjunction with regular PVO training) (1-2 weeks)

2nd - 3rd weeks

- B. Launch health communication plan in targeted LGAs.

Phase Four Products:* x CBWs trained and working in IDP areas using IDP health communication materials

additional materials distributed - dissemination plan proceeding

any planned special events on schedule

*Nos. & other specifics will depend on plan.

Phase Five: Monitor and Evaluate

(To be included in IDP Evaluation activity)

15. Nigeria: Monitoring and Evaluating

- A. PVOs will monitor health communication activities following the protocol developed as part of the comprehensive plan.
- B. A HEALTHCOM or VBC consultant will evaluate the impact of the health communication program, possibly as part of an IDP evaluation team (if the timing is right). This evaluation will include a KAP studying selected areas/households.

Phase Five Products: IDP reports including information from health communications monitoring.

Evaluation report and recommendations.

Annex A-2
Scope of Work

SCOPE OF WORK

(VBC Health Education Consultant)

IVERMECTIN DELIVERY PROGRAM (IDP) HEALTH COMMUNICATION

- Program Goal:** To reduce the impact of oncocerciasis in target communities
- Purpose:** To develop an IDP Health Communication Program -- with initial, pilot focus on Africare's IDP activity in Adaniawz and Taraba States -- to assist PVO's in using health education and communication as an integral part of implementing regular, comprehensive and sustainable treatment programs.
- Outputs:**
1. Individuals with essential knowledge and skills available to work with target communities.
 2. Effective educational and promotional materials available for use at the community level.
- Note:** This activity will be carried out in cooperation with HEALTHCOM. For Details on HEALTHCOM's contribution are contained in the "Health Communication Plan of Action"
- Phase One:** Washington: Planning (August 31- October 2)
1. Review existing materials.
 2. Hold discussions with HEALTHCOM, Africare, IEF, HKI.INMED, UNICEF, and other organizations participating in IDP activities.
 3. Consultant assists VBC plan and conduct workshop on "Future Directions in Health Education for IDP" October 1-2.
 4. Prepare an issues paper on opportunities and constraints in designing health education materials for IDP in the Nigerian context for presentation at Workshop.
[Healthcom prepares a background paper on lessons learned in Nigeria and West Africa, and from other relevant projects.]
 5. Develop Formative Research Plan (with HEALTHCOM).

Phase One Products: Workshop Paper (consultant); Workshop Report (VBC),
Operational Research Plan (consultant and HEALTHCOM, etc.)

Phase Two: A. Nigeria: Formative Research (October 3-November 7)

1. Hold meetings with organizations in Nigeria who are active in IDP (Lagos, Ilorin, Jos, and Yola), including USAID Mission, Africare, UNICEF, RBF, etc.
2. Conduct brief field review of IDP and health education activities in Kwara and Kogi States.
3. Organize and conduct formative research in Taraba and Adamawa States.
4. Undertake preliminary data analysis.
5. Feedback research results to Africare, SMOHs and researchers.

(The following activity will be executed as part of Phase 2, but consultant time is budgeted under Phase 3)

6. Hold TPM with Africare and SMOH on developing a communication plan for Adamawa and Taraba States.
[Local "Communication Team" gathers communication planning inputs]

B. Washington: Communication Planning (November 8-19)

1. Write final research report
2. Develop communications plan format (with HEALTHCOM)

C. Nigeria: Complete Communication Plan and Initiate Development of Draft Materials (November 24-December 8)

1. Hold communication planning meeting in Yola
2. Identify media specialists
3. Organize and conduct materials development exercise

D. Washington: Complete Final Communication Plan (December 9-11)

Phase Two Products: Practical Guidelines in Operational Research Methods for Developing IDP Materials (consultant); Field Assessment Report (consultant); IDP Health Communication Plan and Planning Materials (consultant).

Scope of Work

Phase Three: Nigeria: Materials Development (January 4-23)

1. Pre-test materials in Field
2. Make materials revisions
3. Arrange for reproduction

Phase Three Products: Final reproduced materials

Phase Four: A. Washington: TOT Planning (in period January 25-February 7)

1. Design TOT Plan and training materials for health educators in Adamawa and Taraba States, including modules on interpersonal communication in relation to materials produced.
2. Plan the Launch event to inaugurate new materials

B. Implementation (February 7-28, exact dates depending on length of time required for materials reproduction in Nigeria. Timely completion essential to allow for materials dissemination prior to onset of rains.)

1. Train MOH/Africare health education personnel, local healthworkers and CBW trainers to use health education materials.
2. Launch health education activities using new materials.

C. Washington: Completion of Final Report (by mid-March)

Phase Four Product: Final Report

Annex A-3
Calendar of Activities

September 1992

IDP Health Education

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
		1	2	3	4	5
Review Materials/Hold Background Discussions						
6	7	8	9	10	11	12
Research Background Review						
13	14	15	16	17	18	19
Begin Workshop Planning						
Media, Communications, Health Education Review						
20	21	22	23	24	25	26
Workshop Planning						
Draft Workshop Papers/Presentations						
27	28	29	30			
Prepare Workshop - Prepare Travel						
Develop Formative Research Plan						

3/4/1993

October 1992

IDP Health Education

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
				1	2	3
				Workshop: 'Future Directions in Health Ed for IDP'		
4	5 Team Planning Meeting	6	7	8	9	10
		Develop Training Materials				
		Complete Research Plan				
11 Depart for Lagos	12	13 7:05pm Arrive in Lagos VIA SWISSAIR 262	14 Meeting with Plateau State OCP Travel to Jos	15 Field Visit Plateau State	16 Meetings at USAID Return to Lagos	17 Travel to Ilorin Visit Kwara IDP
Travel to Lagos						
18 Visit Kwara IDP	19 Meeting with Dr. Ojodu, VOCP	20 Travel to Yola Meetings at UNICEF	21 Meetings with AFRICARE/SMOH in Yola	22 Team 1 Arrives Yola Research Planning AFRICARE and SMOH	23 Train Team 1 (Adamawa)	24 Field Preparation
					IEC Research Workshop: 1	
25	26	27	28 Members: 1 VBC, 1 AID, 2 Kwara, 7 Kogi Team 2 Arrives Yola Data Analysis Team 1	29 Round Table on Communications Planning	30 Train Team 2 (Taraba)	31 Field Preparations Team 2
Field Research - Adamawa					IEC Research Workshop: 2	

3/4/1993

November 1992

IDP Health Education

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
1	2	3	4 Team 2 Debriefing: Data Analysis	5 Trip 2 Planning Debriefing: ATOP-Yola	6 Debrief w/ Africare- Lagos USAID Travel to Lagos	7
Field Research - Taraba			Travel to Washington, D.C.			
8	9	10	11	12	13	14
Africare IDPs Gather Planning Inputs				Complete Research Report		
15	16	17	18	19	20	21
Africare IDPs Gather Planning Inputs			Complete Research Report			
22	23	24 USAID/VBC D- ebriefing on Trip 1	25	26	27 Travel to Lagos	28 7:00pm La Pin Arrives Lagos
VBC/Healthcom Meet		Africare IDPs Gather Planning Inputs				
29 Douglas arrives Lagos	30 Travel to Yola Meeting with Howard Teel (Africare) and USAID					

3/4/1993

December 1992

IDP Health Education

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
		1	2	3 Travel to Yola	4	5
		Prepare Communication Planning Workshop		Communication Planning & Materials Dev. Workshop		
6	7	8	9	10	11 Scheduled mtg on communications plan w/ Govt & ATOP Travel to Lagos	12
		Draft Communications Plan				
13	14	15	16	17	18	19
		Travel to Washington		Hearcom & VBC to Complete Final Comm. Plan		
20	21 Meeting with A.L.D.	22	23	24	25	26
27	28	29	30	31		

3/4/1993

January 1993

IDP Health Education

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22 Debriefing on Trip 2	23 Travel to Lagos
				TPM Healthcom		
24 Travel to Lagos	25 Meetings in Lagos	26 Travel to Yola	27 Meetings in Yola	28	29	30
				Materials Development Workshop		
31						

February 1993

IDP Health Education

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	1 Creative meeting	2	3	4	5 Materials Pre-test	6 Materials Revision
	Materials Development					
7 Materials Revision	8 Travel to Lagos	9	10 Debriefing on Trip 3	11	12	13
	Travel to Washington			Complete information packet		
14	15	16	17	18 Core Planning Meeting	19	20
	Complete information packet					
21	22 Final Report Planning	23	24	25	26	27
					Plan Health Education TOT	
28						

3/4/1993

March 1993

IDP Health Education

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	1	2	3 Submit Final Report	4 Revisions to report	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

3/4/1993

Annex A-4

ATOP Inputs Assessment

1. Inputs for an ATOP Communication Initiative

The IEC process spans a wide array of activities and draws on a range of talents. They include coordination, research, communication planning, materials development and production, training, dissemination, and overall planning, monitoring and evaluation.

Identifying inputs — institutional, human, logistical, and others — is a continuing process within any project. IEC needs are broad and ever-changing. An initial resource assessment for the ATOP project (with emphasis on Adamawa State) offered the team a rapid survey of inputs available for IEC, but these will require constant updating and revision over time.

Categories of inputs discussed below include institutional structures, human resources, training, timing, logistics, financial resources, and resources for materials development, production and dissemination.

1.1 Institutional structures

Four sets of institutional structures may support IEC activities. They are governmental institutions, external cooperating agencies, private sector, local advocacy groups, and traditional and religious structures.

1.1.1 Government

In Nigeria, the National Onchocerciasis Control Program (NOCP), under the Federal Directorate of Disease Control, sets policy and guides implementation by individual states and their external cooperating agencies. State Directors of Disease Control oversee these activities in their localities. Oversight of ATOP — a government project — is in theory divided between the two participating states; however, its ties with Adamawa State are stronger than those with Taraba because its headquarters are located in Yola, Adamawa's capital. In Yola the project is supervised by the Chief of the Epidemiological Unit, with technical guidance provided by two staff members from Africare.

The NOCP foresees the creation of a State Onchocerciasis Control Task Force (SOCTF) in each endemic state of the Federation. In principle, the Task Force — under the guidance of the State Director of Disease Control — coordinates the activities of the state and local onchocerciasis control teams (SOCTs and LOCTs) and fosters linkages with other sections of the State Ministry of Health (SMOH). It also encourages cooperation with other State Ministries such as Information (SMOI), Primary Education (SMOPE) and Post-primary Education (SMOPPE), together with such other institutions as the Women’s Commission, the State Arts Council, the Yola Institute of Technology (Parasitology Units, Medical Schools, Art Departments) and the Government Printing Office.

The absence of an SOCTF in both Adamawa and Taraba States came to light when the team sought to create a structure for coordinating IEC within ATOP. The request catalyzed plans in Adamawa State to institute the Task Force. In addition, the director of disease control proposed that an ATOP Communication Subcommittee be created with members from the SMOH, SMOI, SMOPE, SMOPPE, State Women’s Commission, State Arts Council, Africare and possibly others. It is expected that the subcommittee’s role will be chiefly catalytic and advisory.

Owing to ATOP’s field orientation, *de facto* supervision of ATOP takes place at the LGA level, where the Primary Health Care (PHC) coordinator plays the key role. Project activities are carried out by the head of the LOCT. For administrative and financial support, the coordinator and team leader rely on the Local Health Commissioner, who is a member of the LGA Council that advises the LGA Chairman. Because the council manages the budgeting process and approves allocation of logistical resources, these LGA-level decision makers are critical to the future success of the IDP.

Clinic-based ivermectin distribution is likely in future, but will confront constraints. On the whole, rural health infrastructure is weak, and government health services are concentrated around the main cities and towns. In principle each LGA has a hospital in its administrative center, together with clinics and dispensaries in district centers. Quality and quantity of services vary widely. Though health facilities in remote LGAs often have qualified and dedicated personnel, they are typically ill-fitted with equipment, drugs or supplies.

1.1.2 External cooperating organizations

Africare regional offices in Yola, Biu (Borno State), and a national office in Lagos provide technical support to ivermectin delivery. The agency offers two staff members as technical support to ATOP and one to the BOP. Africare also provides support staff to manage project funds, supplies (including ivermectin) and reporting.

Otherwise, the 121 ATOP workers are composed of State onchocerciasis workers (SOCWs), local onchocerciasis workers (LOCWs), and trained staff from dispensaries and clinics near endemic communities. Multiple tasks of these workers include assessment of endemicity, informing endemic communities about ivermectin delivery, distributing ivermectin house-to-house, ensuring drug supply, and maintaining three to four sets of records. Eventually, distribution in hyperendemic communities will be undertaken by CBDs identified and trained by Africare and ATOP technical staff to manage ivermectin and provide health education. Health clinic staff in meso- and hypoendemic areas may also enter the training program to treat affected individuals in those areas.

Gombi LGA is a pilot center supported by UNICEF for introducing a revolving drug fund scheme to Adamawa State. This scheme, the so-called Bamako Initiative, may in future offer a structure for passive ivermectin distribution that improves upon the existing rural health structure. As seen earlier, mission groups and clinics also provide health services in some endemic areas, but their coverage is very narrow.

1.1.3 Private sector services and support

Given the ban on commercialization of ivermectin, the private sector has played little direct role in ATOP operations. Print and electronic media have published or broadcast general information about the project and its rationale. Local printing presses reproduce forms and household registration cards. With the expanding role of IEC, greater project reliance on local media houses, free-lance artists and presses is likely.

1.1.4. Local advocacy groups

Private advocacy and philanthropy in Nigeria includes such international organizations as the Rotary, which joins business and professional leaders in major ATOP area towns. The State Councils for Women's Societies draw together over 100 women's organizations in northeastern Nigeria. Individual philanthropists such as Chief Abiola have business or personal interests in endemic areas. Because such advocates are often the most influential members of local communities, their political and financial support may be important to project success and especially to an IEC strategy.

1.1.5 Traditional and religious structures

Alongside its modern administrative structures, northeastern Nigeria has maintained a network of traditional rulers stemming from the Fulani occupation of the area and the structures of British indirect rule. Moreover, most indigenous socio-political structures at community level have survived in some form, including chieftaincy institutions and women's organizations and titles. Diverse religious institutions include mosques, churches and traditional cults.

1.2 Human resources for IEC in Local Institutions

Owing to the pilot status of the IDP Communication Initiative, several expatriate consultants were assigned as needed to various phases of the project. Their assistance to ATOP in Nigeria was monitored by Africare in Lagos and Washington, with support from the VBC Project and HEALTHCOM. Few IDPs command the resources needed to engage external consultants. It was expected that their inclusion in the initiative would build the institutional capacity of ATOP, its sister project the KSBPP, and that of other IDPs in Nigeria and elsewhere. Individuals trained by the initiative would become resources for training other IDPs in an IEC methodology.

Midway through the communication planning process, the need for additional IEC staff support was recognized. One health educator in ATOP's parent government institution in Adamawa — the Epidemiological Unit — was assigned half-time to the project. This person will assist

in overseeing the development, printing or replication, and distribution of communication materials. He will also serve as a trainer for SOCT members, CBDs and other health workers in the program.

A second health educator from Taraba State was also drawn into the communication initiative during the materials development phase, and he may serve the same role for that state. Efforts will also need to be made to establish suitable operational mechanisms in Borno State. In addition, Africare has requested that one Peace Corps volunteer be assigned to ATOP by the end of 1993 to train IEC trainers and assist in monitoring health education activities.

Elsewhere, government and private sector personnel in the institutions comprising the ATOP IEC Subcommittee offer potential talent to the initiative. Specific sources of human resources include the following:

- ***Training:***
health educators in the MOH, staff in the College of Technology (Yola), MOPE primary science teachers, MOPPE specialized science teachers, staff of the Better Life Programme (under the State Women's Commission), staff of the Agricultural Development Programme
- ***Research:***
trained personnel in the MOH, staff in the College of Technology
- ***Information dissemination:***
numerous publications of the state and private press, the Nigerian Television Authority Services (NTA) in Adamawa and Taraba States, the Adamawa Television (ATV), the Taraba State Television (TSTV), the Adamawa Broadcasting Corporation (ABC), the Taraba State Broadcasting Corporation (TSBC), local radio transmitting stations at LGA capitals, state-run "viewing centers" for television and video broadcasts, Hausa-language services of the BBC and VOA, and people who own radios, cassette tape recorders or VCRs.

- ***Materials development and production:***
producers, editors and sound recordists from the information sector; illustrators, graphic designers and printers from the Graphics Unit of the MOI and the State Printing Office; performing artists in the modern and traditional sectors; traditional performing groups
- ***Advocacy:***
political and business leaders, traditional rulers, members of the Rotary Club, Association of Women's Societies, the press and electronic media, churches and mosques
- ***Communication initiative management:***
ATOP project manager and at least one IEC specialist full-time or two half-time.

Finally, we discovered that the best talent could be found among the ranks of the LOCT and SOCT members and other workshop participants. For example, two illustrators were identified during the workshop from the doodles in their notebooks. A trained health educator sent from the KSBPP in Kwara State to attend the research and planning workshops quickly assumed the role of co-trainer. The participatory approach of the initiative encouraged such discoveries.

1.3 Training for IEC Planning and Development

Each phases of the communication initiative was a training opportunity for building local capacity. A workshop was held for each phase — research, communication planning and materials development — following the principles of adult learning by actively involving the participants in building the communication strategy for ATOP. Furthermore, the aim of the consultants who facilitated the workshops was to enable participants to conceive and develop a communication strategy that suited their operational and program needs.

Details on the content and methods of each workshop are offered in Annexes B-D. General features include the following:

ATOP Inputs Assessment

- Workshops were grounded in the principle that all trainees were likely to become IEC trainers of future IDP workers, whether in the ATOP area or elsewhere.
- Workshops were designed to compensate for the scarcity of health education personnel in the area and to ensure quality in field-level health education events.
- A key purpose of the training was to enable ATOP to carry out a long-term IEC activity and to respond adequately to shifting needs and course changes in the program.
- Nearly all trainees were members of the ATOP staff or of the Africare-supported KSBPP from Kwara State; therefore, they had a good understanding of how IEC could serve program needs.
- Field exercises in research and materials pretesting were essential components of training.
- Frequent small group exercises were held in the workshop setting to draw upon the trainees' field experience and knowledge of ATOP operations.
- All workshop exercises were structured to produce a product (research report, communication plan, draft materials) that was an integral part of the communication strategy.
- In each workshop participants applied skills learned in previous training events and were given increasing levels of autonomy and responsibility to enable them to gain confidence as future trainers.
- The venue for the first two workshops was a quiet, air-conditioned conference room provided by the ASMOH; teaching equipment was kept simple and consisted of xeroxed handouts, flipcharts and paper, and in one instance a videocassette player and monitor borrowed from the ASMOI.
- The opportunity cost of the training to the participants was recognized and compensation was provided.

The success of the adult learning approach was demonstrated after the first workshop when KSBPP team members applied the focus group techniques they had learned to identify and dispel false rumors concerning fatal outcomes of ivermectin treatment.

1.4 Timing of the Communication Initiative

The original calendar for the IDP Communication Initiative foresaw an activity spanning seven to eight months in four phases. Each phase was characterized by a capacity-building exercise conducted by VBC and HEALTHCOM consultants and alternate periods during which local staff undertook specific tasks in research, planning or materials design. It happened that this ambitious schedule and the calendar period selected were constraints. (See Annex A-3.)

1.5 Logistics

Because ivermectin delivery is an essential feature of IDPs, logistical support for research, field exercises, materials distribution and health education will be made available as a part of regular program operations. While climatic and road conditions will affect field research and pretesting, research sites can if carefully chosen be visited at seasons when other operations are halted. Field training must be organized so that the number of trainees does not exceed vehicle space.

1.6 Materials Development, Production and Dissemination

1.6.1 Materials development

A variety of IEC materials are possible in an IDP IEC program. They range from sophisticated video broadcasts and international radio programming to such print materials as handbills and T-shirts, to storytelling and songs at the community level. Human, institutional and training inputs required for materials development have been mentioned in previous sections. The communication initiative sought additional assistance from a professional graphic designer to train local artists in new methods for illustration, layout and design of print materials. In this

way, an institutional capacity for revising or creating materials was stimulated. Similarly, organization of a proposed festival of the arts would require training support for health workers charged with stimulating community-level dramatic and musical performances on IDP themes.

1.6.2 Materials production

Inputs for materials production vary greatly according to the socio-economic context. Commitment to development of any communication tool should be contingent on local capacity to create the tool proposed.

The advantages of local materials development and production are important to the long-term objectives of an IDP. This approach permits continuing orders and revision of print materials. In addition, a close relationship develops between the producer and project objectives, offering an additional — if indirect — support to the project in the community.

Midway through the communication planning process an inventory of production resources was made for the Yola area. Printing firms, media houses, radio and television stations, newspapers and journals, the State Arts Council and the market were visited. In addition, inquiries were made into the availability and cost of inks, papers and reproduction processes. Ideally such an inquiry would be made earlier in the life of an IEC activity as an aid to planning and budgeting.

1.6.3 Materials dissemination

As is the case for materials production, possibilities for dissemination of IEC products vary with local technical, financial and management capacity. For example, in Adamawa State the MOH's Epidemiological Unit is charged with distributing posters commissioned by the NOCP. Many posters were seen in the Unit's warehouse, but none in health clinics or other public or private buildings in the field. At the same time, posters on other themes often were displayed. In such cases individual projects or private distributing companies had distributed the materials.

Discussions initiated with the MOH and ATOP staff concerning dissemination of ATOP IEC materials suggest that the ATOP project staff, together with health educators assigned to it, will undertake or closely monitor materials dissemination. One concern is to avoid creating inappropriate demand for ivermectin by targeting only intervention areas for health education materials. General information materials carried by mass media about the onchocerciasis may be disseminated more widely.

1.7 Financial Resources

One objective of the communication initiative is to ensure that the materials produced are inexpensive and replicable. Owing to the current economic climate in Nigeria, ATOP enjoys the advantage of stretching its funds; in many other African contexts the products envisaged could be twice as expensive. At the same time, cost-containment has been ensured through comparative pricing and a call for bids. (For sample bids, see Annex E.)

It is expected that ATOP funds will be complemented by IEC expenditures from state governments. A function of the IEC Subcommittee of the State Onchocerciasis Control Task Force will be to promote technical and financial cooperation among participating state ministries. For example, transfers are made frequently by the MOH to the MOI for materials development and media coverage on health education themes. Other potential sources of financial contributions are such local advocacy groups as the Rotary Club or private local philanthropists.

Annex B-1

People Met: Trip 1

The Africare Ivermectin Delivery Program
in Adamawa and Taraba States, Nigeria
Trip No. 1
October 11-November 7, 1992

LIST OF PERSONS MET

Mr. Patrick Adah	KSBPP Project Assistant, Africare-Ilorin
Mr. Tunde Adewale	Kogi State IDP
Mr. Sali Aji	PHC Director, Taraba State
Mr. Desmond Ajoko	Health Education Advisor, Africare-Lagos
Oba Akádi	King (oba) of Idera, Ifèlódùn LGA, Kwara State
Mr. David Ali	Taraba State Onchocerciasis Control Team Leader
Hajiya Maryam A. Bakari	Adamawa State Commissioner for Health
Mr. Mathias Barde	Chairman, Ganye LGA
Mr. Peter Bazza	Community Health Assistant, ATOP-Yola
Ms. Michel Recharb Bongji	Director General, Adamawa SMOH
Mr. Yuhana Chibila	Community Health Assistant, Ganye LGA (LOCW)
Alhaji Dahiru "Bako"	Assistant PHC Coordinator for Disease Control, Taraba State
Mr. Wali Danjumo	Community Health Assistant, Taraba SOCT
Mr. Bukar Galadima	Team Leader, State Onchocerciasis Control Team, Borno State
Alhaji Sa Ali Gombi	Principal Rural Health Superintendent, detached to ATOP Health Education
Dr. Carlos Gonzalez	RBF Advisor, Plateau State OCP
Mr. Hickson Hellendendu	ATOP Project Assistant, Africare
Dr. Inyang	Health Programme Officer, UNICEF-Lagos
Ms. Regina Jediel	Community Health Assistant, Ganye LGA (LOCW)
Dr. Bode Kayode	Senior Lecturer, Health Education, University of Ilorin

People Met: Trip 1

Ms. Susan Kren	JHU/PCS Country Representative, FHS/IEC Div.
Mr. Johana Kura	Member, LCOT, Akwanga LGA, Plateau State
Mr. Jonathan Lawrence	Community Health Assistant, Gombi LGA (LOCW)
Alhaji Maraffa	PHC assistane, ATOP-Yola
Dr. Abdulla Meftuh	Africare ATOP Project Director, Yola
Mr. Timmawus Mathias	Team Charade Communications, Ltd., Yola
Dr. Emmanuel S. Miri	Director, Plateau State OCP, Jos
Mr. Hamidou Mohammed	Executive Secretary of the Health Services Management Board, Taraba State
Mr. Hussein Musa	Community Health Assistant, Africare-Yola
Dr. Ahmed Ibrahim Mustapha	Chief, Epidemiological Unit, Dept. of Communicable Diseases, ASMOH
Ms. Margaret Nyamse	Asst. Programme Communications Officer, UNICEF-Lagos
Dr. Kamurudeen A. Ojodu	Director, NOCP-Lagos
Dr. Isa H. Omar	Director of Primary Health Care, Adamawa SMOH
Dr. Yomi Oshinowo	Director, KSBPP, Ilorin
Dr. Nosa Orobotan	Health Officer, Family Health Services Project
Ms. Vandean Philpott	Deputy Director, Africare-Lagos
Mr. Matthias Robinson	Community Health Assistant, ATOP Yola
Mr. James Sambari Shamaki	Chairman, Akwanga LGA, Plateau State
Mr. Donald Rice	RBF Operations Manager
Ms. Veronica T. Umar	Director General, Taraba SMOH
Dr. Peter G. Warwar	Taraba State Commissioner for Health
Mr. Jeffrey S. Watson	RBF Advisor, Plateau State OCP
Dr. Abel Webimumen	PHC Coordinator, Ganye LGA
Mr. DeWitt Webster	Health Program Officer, Africare-Lagos

Annex B-2

Schedule of Activities: Trip 1

The Africare Ivermectin Delivery Program
in Adamawa and Taraba States, Nigeria
Trip No. 1
October 11-November 7, 1992

SCHEDULE OF ACTIVITIES

- Oct. 11 Depart Dulles Airport, Washington
- Oct. 12 Arrive Geneva
- Oct. 13 Depart Geneva/Arrive Lagos
Meeting with DeWitt Webster, Health Program Officer,
Africare
- Oct. 14 Travel to Jos, Plateau State, by air
Meetings with Jeffrey S. Watson and Dr. Carlos Gonzalez,
Advisors, Plateau State OCP (supported by the River Blind-
ness Foundation)
- Oct. 15 Field Visit to Bayandusi, Akwanga LGA
- Oct. 16 Return to Lagos by air
Meeting with Vandean Philpott, Deputy Country Representa-
tive, Africare-Lagos
Meeting with Eugene Chivarolli, USAID Country Director
Meeting with Dr. Nosa Orobotan, Family Health Services
Project (FHS), USAID
Meeting with Susan Kren, IEC support to FHS, USAID
TGIF Reception at the home of the USAID Country Director
Meeting with Donald Rice, RBF Consultant
- Oct. 17 Travel to Ilorin by road
Meeting with Yomi Oshinowo, Director Kwara State Blind-
ness Prevention Program, Ilorin (supported by Africare, RBF,
IEF) and with Dr. Bode Kayode, Senior Lecturer in Health
Education, University of Ilorin
Field Visits to Alábe and Idera Villages (Ifèlódùn LGA)
- Oct. 18 Field Visit to Apado Village (Ilorin East LGA)
Travel to Lagos by road

- Oct. 19 Meeting with Dr. Ojodu, Acting Director, National Onchocerciasis Control Program (NOCP)
Meeting with Desmond Ajoko, Health Education Intern, Africare
- Oct. 20 Meeting with Dr. Inyang, Health Programme Officer, UNICEF-Lagos
Meeting with Ms. Margaret Nyamse, Asst. Programme Officer, IEC, UNICEF-Lagos
Travel to Yola by air
Meeting with Dr. Abdullah Meftuh, Project Director, Adamawa and Taraba States Onchocerciasis Program (ATOP, supported by Africare, RBF, and USAID)
- Oct. 21 Meeting with Dr. Meftuh, ATOP Project Director and Hickson Hellendendu, Assistant Project Director
Meeting with Dr. Isa Omar, PHC Director, Adamawa SMOH
Meeting with Ms. Mitchel Recharb Bongi, Director General, Adamawa SMOH
Meeting with Chief Timmaius Matthias, Media Consultant
- Oct. 22 Meeting with Dr. Ahmed Ibrahim Mustapha, Chief, Epidemiological Unit, Dept. of Communicable Diseases, ASMOH, ATOP National Project Director
Workshop Preparation with ATOP team
- Oct. 23 Workshop on IEC Research Strategies: Team 1 (Adamawa, Bornu), SMOH Conference Room, Yola
- Oct. 24 Workshop on IEC Research Strategies, cont.
Pilot Field Trial, Vinikula village, Song LGA
Research debriefing, Yola International Hotel
- Oct. 25 Travel to Ganye by road
Reconnaissance visits to research villages
Meeting with Ganye LGA Health Commissioner

Schedule of Activities: Trip 1

- Oct. 26 Research in Taksi (morning) and Nawai (afternoon), Ganye LGA
Meeting with Ganye LGA Chairman, Mr. Bane
- Oct. 27 Research in Mapio (morning) and So'o (afternoon), Jada LGA
Return to Yola by road
- Oct. 28 Data Analysis and Debriefing: Team 1
- Oct. 29 Roundtable on Strategies for Communication Planning: Teams 1 and 2
- Oct. 30 Workshop on IEC Research Strategies: Team 2 (Taraba, Kwara Kogi), MOH Conference Room, Yola
- Oct. 31 Workshop on IEC Research Strategies, cont.
Pilot Field Trial, Vinikula village, Song LGA
Research debriefing, Yola International Hotel
- Nov. 1 Travel to Jalingo, Taraba State
Reconnaissance visits to research villages
Meeting with Mr. Hamidou Mohammed, Executive Secretary of the Health Services Management Board, Taraba State and Mr. Sali Aji, PHC Director
- Nov. 2 Meetings with Veronica T. Umar, Director General, Taraba SMOH and Dr. Peter G. Warwar, Taraba State Commissioner for Health Research in Hawan Mata (morning) and Pamanga (afternoon), Bali LGA
- Nov. 3 Research in Kwanan Dutse (morning) and Sunkani (afternoon), Jalingo LGA
Return by road to Yola
- Nov. 4 Data Analysis and Debriefing: Team 2

- Nov. 5 Planning meeting with Abdulla Meftuh, Hickson Hellendendu,
 and Alhaji Gombi on Trip 2 in December
 Debriefing Meeting with Dr. Omar, Ms. Bongi, and the
 Adamawa State Commissioner for Health
 Debriefing with Dr. Mustapha, Chief, EPI Unit, SMOH

- Nov. 6 Travel from Yola to Lagos by air
 Meeting with Vandean Philpott, Africare
 Meeting with Eugene Chiavaroli, USAID Director
 Depart Lagos by air

- Nov. 7 Arrive Dulles via Frankfurt

Annex B-3

**Workshop on Qualitative Research
Agenda: Team 1**

Workshop on Information, Education, and Communication
Research Strategies for Ivermectin Delivery Programs

State Ministry of Health Conference Room
Yola, Adamawa State

Purpose

To introduce Africare and Government Staff to qualitative research techniques useful in developing informational and educational materials to promote the sustainability of Ivermectin Delivery Programs (IDPs).

Main Topics

- * Overview of the IDP: issues of demand and sustainability
- * The IEC approach to Social Marketing
- * Developing Research Questions
- * Qualitative vs. Quantitative Research
- * Focus Groups
- * In-depth Interviewing
- * Community Profiles
- * Qualitative Data Analysis

Participants: Core Research Team 1

Mr. Peter Bazza	Community Health Assistant, Africare-Yola
Mr. Yuhana Chibila	Community Health Assistant, Ganye LGA (LOCW)
Dr. Adrienne Ertl	IDP Programme Officer, USAID Washington
Mr. Bukar Galadima	Team Leader, State Onchocerciasis Control Team, Borno State

Workshop on Qualitative Research: Team 1

Mr. Hickson Hellendendu	ATOP Project Assistant, Africare
Mr. Alhaji Gombi	Principal Rural Health Superintendent, detached to ATOP Health Education
Ms. Regina Jediel	Community Health Assistant, Ganye LGA (LOCW)
Mr. Jonathan Lawrence	Community Health Assistant, Gombi LGA (LOCW)
Dr. Deirdre LaPin	VBC Health Research and Communica- tions Consultant, Workshop Facilitator
Dr. Abdulla Meftuh	ATOP Project Director, Africare-Yola

Workshop Only Participants:

Mr. Hussein Musa	Community Health Assistant, Africare- Yola
Dr. Ahmed Ibrahim Mustapha	Chief, Epidemiological Unit, Dept. Communicable Diseases, Adamawa SMOH
Mr. Abel Webimumen	PHC Coordinator, Ganye LGA

**Workshop on Information, Education, and Communication
Research Strategies for Ivermectin Delivery Programs
State Ministry of Health Conference Room
Yola, Adamawa State**

AGENDA

Day 1: October 23

- 9:00 Pre-test
- 9:15 Presentation of the IEC Research Exercise within the ATOP strategy
- 10:00 Introduction to Health Education and Social Marketing
- 10:30 Break and Decision Making Exercise
- 11:30 Developing IDP/IEC research questions
- 12:30 Working Lunch
- 2:00 Key features of qualitative research
- 3:00 Introduction to Focus Groups and Exercise
- 4:30 Debriefing
- 5:00 Close

Day 2: October 24

- 9:00 Review of the Research Plan for Days 3-6
- 9:30 In-depth Interviewing
- 10:00 Break and In-depth Interviewing Exercise
- 11:00 Review of Questionnaires

Workshop on Qualitative Research: Team 1

12:15 Working Lunch

1:00 Pilot research activity in a semi-urban community

4:30 Research debriefing and data analysis

5:00 Close

Days 3-5: October 25-28

Field Research in Adamawa State intervention villages (Nawai, Taksi) and non-intervention villages (Mapio, So'o)

Day 6: October 29

Data Analysis, Yola

Annex B-4

**Workshop on Qualitative Research
Agenda: Team 2**

Workshop on Information, Education, and Communication
Research Strategies for Ivermectin Delivery Programs

State Ministry of Health Conference Room

Yola, Adamawa State

Purpose

To introduce Africare and Government Staff to qualitative research techniques useful in developing informational and educational materials to promote the sustainability of Ivermectin Delivery Programs (IDPs).

Main Topics

- * Overview of the IDP: issues of demand and sustainability
- * The IEC approach to Social Marketing
- * Developing Research Questions
- * Qualitative vs. Quantitative Research
- * Focus Groups
- * In-depth Interviewing
- * Community Profiles
- * Qualitative Data Analysis

Participants: Core Team 2

Mr. Patrick Adah	KSBPP Project Assistant, Africare
Mr. Tunde Adewale	Kogi State IDP
Dr. Bode Kayode	Senior Lecturer, Health Education, University of Ilorin
Mr. David Ali	Taraba SCOT Leader
Mr. Haruna Dauda	Health Educator for Gashaka LGA
Mr. Ahlahi Dahiru	Assistant PHC Coordinator for Disease Control, Taraba State
Mr. Alhaji Gombi	Principal Rural Health Superintendant, detached to ATOP Health Educatio
Dr. Adrienne Ertl	IDP Programme Officer, USAID Washington
Dr. Deirdre LaPin	USAID Health Research and Communications Consultant, Workshop Facilitator
Dr. Abdulla Meftuh	ATOP Project Director, Africare
Mr. Hickson Hellendendu	ATOP Project Assistant, Africare

**Workshop on Information, Education, and Communication
Research Strategies for Ivermectin Delivery Programs**

**Yola, Adamawa State
Team 2**

AGENDA

Day 1: October 30

- 9:00 Pre-test
- 9:15 Presentation of the IEC Research Exercise within the ATOP strategy
- 10:00 Introduction to Health Education and Social Marketing
- 10:30 Break and Decision Making Exercise
- 11:30 Developing IDP/IEC research questions
- 12:30 Working Lunch
- 2:00 Key features of qualitative research
- 3:00 Introduction to Focus Groups and Exercise
- 4:30 Debriefing
- 5:00 Close

Day 2: October 31

- 9:00 Review of the Research Plan for Days 3-6
- 9:30 In-depth Interviewing
- 10:00 Break and In-depth Interviewing Exercise
- 11:00 Review of Questionnaires
- 12:15 Working Lunch
- 1:00 Pilot research activity in a semi-urban community
- 4:30 Research debriefing and data analysis
- 5:00 Close

Days 3-5: November 1-3

Field Research in intervention/non-intervention villages

Day 6: November 4

Data Analysis, Yola

Annex B-5

**In-depth Interview or Small Group
Discussion Questionnaire**

ATOP IDP/IEC Research 1992

IN-DEPTH INTERVIEW OR SMALL GROUP DISCUSSION QUESTIONNAIRE

Purpose

This brief questionnaire is designed to be used with an individual expert or a small group of 2-3 experts in the health field. This person or persons may be male or female. They may be traditional birth attendants, traditional healers, clinic-based health workers, or other health experts. Ideally, they should share the same culture and language as the community; however, this criterion may be difficult to meet in a group of 2-3 persons.

The purpose of the questionnaire is to explore the perceptions of serious diseases in the community, the health services available to community members, the management of health care at the household level, and the channels of communication for health advice and health education.

Name, Age, and Title of Interviewee(s):

1. Ranking of serious diseases

- 1.1 What are the most serious diseases affecting children in this community? [List up to four. Then ask the group to rank them and assign a number 1, 2, 3, 4 to indicate their order of priority.] In what way do you consider them "serious" (e.g. severity, high prevalence, an epidemic, etc.)

1.2 What are the most serious diseases affecting adult men and women?
[List up to four and rank in order of priority.] In what way?

1.3 Do many people in this community suffer from intense itching?

1.4 If so, what is the cause? [Probe, but do not suggest an answer.]

1.5 Have you noticed this condition leading to any skin discoloration?

1.6 Can itching and skin discoloration lead to any other health problems?
[Probe, but do not suggest an answer. Some answers may include
nodules, inflammations, blindness.]

1.7 What treatment do most people in this community use for this
disease? [Try to learn the local name for the disease] Why is this
treatment preferred?

1.8 Do you know other treatments that are used in other communities or
by other people? If "yes" what are they?

1.9 Is malaria a problem disease in this community?

What is its cause?

Can malaria be transmitted from one person to another? If so, how?

2. Health Services

2.1 Where is the nearest health center? What kind is it? How far away is it and how long does it take you to reach there?

2.2 For what sort of illnesses or health services do you go to a health center?

2.3 How would you evaluate the quality of service? [Probe: Are drugs available there? Do you pay for services? for drugs? Is a competent and interested health worker present? How long do you wait before being seen by a health worker?]

2.4 We know that in Africa traditional healers can offer cures that are very helpful for some illnesses. Do you have traditional healers in this community? What sorts of diseases do they treat?

2.5 Are the treatments of traditional healers helpful? Why?

3. Health Prevention

3.1 What actions do you believe are most important to avoid illness in the family or the community?

4. Channels of Health Communication

4.1 At the present time who or what is the best source of information about health for the people in this community?

[Encourage the respondent to give his or her own answer. After that answer Probe: Do you listen to radio? What programs? How often? (If literate) Do you read newspapers or magazines or books? Do you ask an imam or someone whose opinion you respect?]

4.2 Have you ever seen or heard any health education materials? If so, what types (videos, posters, flyers, songs, etc.)?

4.3 What is your opinion of them? [Probe: Did you learn any new ideas from them? If so, what did you learn?]

Annex B-6

**Focus Group Discussions:
Description and Checklist**

FOCUS GROUP DISCUSSIONS

1. Introduction

Definition of focus groups

A group discussion that is guided by a moderator and focussed on specific topics i.e. the feelings of the group towards the talks given by Imams.

2. What types of groups?

- a) Representative of specific types of people
e.g. old/young
male/female
i.p. users/nonusers
- b) Similar types of people in each group.
- c) Avoid groups of friends or other groups that meet together frequently.

3. How many?

- a) Have more than one group representing each type of people.
- b) Have 8 - 10 people in each group.

4. Planning the Discussions

- a) Select people because of their characteristics so that each group has similar people.
- b) Tell people that it will be fun and that they will be meeting others informally.
- c) Make sure that those invited to participate are asked in advance and that the time/date is suitable for all participants.

- d) Unless you are sure that all people invited will definitely be able to attend, invite an extra 3 - 4 people initially.
- e) Contact the village leader before arranging the meeting to get their permission and to organize a suitable date, time and site.

5. Holding the Discussion

- a) Choose a neutral and private site so that participants feel comfortable and there will not be distractions.
- b) It is often useful to have a "hostess/host", meet and greet participants, to keep other people away during the discussions, to serve refreshments and to look after babies etc.
- c) Use a tape recorder and have some keeping notes of the discussions; it is better to keep too much information than not enough.
- d) The not-taker can either be slightly separate from the group to prevent distractions or can act as an assistant moderator and join in occasionally.
- e) The discussions must follow a certain structure that is guided by a discussion guide. This guide contains a list of the topics to be covered and the order in which they should be discussed.
- f) Each discussion should last for 1 - 2 hours at the most. The discussion guide should be pre-tested to ensure that the topics to be discussed flow naturally and that they can be covered comfortably within the time allowed.

6. Skills for Guiding the Discussions

- a) Start the discussion by describing briefly what you will be discussing and explain how you would like the discussion be undertaken i.e. everyone join in, only one person speaking at a time, feel free

to agree or disagree with the others, etc. To make people feel comfortable, begin with either some general questions that everyone can answer easily or ask each person to say something about themselves.

- b) Try to follow the topics listed on the discussion guide but do not be too rigid; allow the discussions to continue if they are producing useful and relevant information.
- c) Use open-end questions and address them to the group as a whole; try to avoid discussion only with one or two people and encourage the quieter ones to talk (but without embarrassing them);

Avoid asking questions that can be answered yes/no;

Avoid asking simply 'why?'; try to be more specific by asking what influenced their feelings or what it is they like or dislike.

- d) Try to memorize the sequence of topics so that you do not have to keep looking at the guide and it does not seem as if you are asking a series of questions. Be flexible and try to think ahead as to how to raise the next topic after finishing this one.
- c) Remember that you are only guiding the discussion, not leading it. Try not to speak too much or dominate the discussion and do not express your own views, even if you strongly disagree with what people are saying.
- d) Try to notice the way in which people express themselves through their facial expressions and body language as they can often indicate how strongly they feel.
- e) Keep the discussions as informal as possible by using small talk, being friendly and avoiding becoming too serious; it should be enjoyable and informative for all involved. Serve refreshments either before the discussions begin, as a chance for people to mix, or during the discussions. If served during the discussions do not take a break but ask the "server" to quietly serve them while the discussions continue.

- f) Anticipate in advance when you feel that the discussion is coming to an end. Make sure that you have covered all the topics on the guide; the assistant can help with this by keeping track of the topics covered (perhaps by ticking them off on a list as they are covered). Try to make the end of the discussion as natural as possible so that it does not just end suddenly.
- g) Thank everyone for coming and talking and tell them that the discussion has been very useful and that you hope they have enjoyed it. You may like to ask them if they have any suggestions for improving the next discussions.
- h) At this point you may give each person a small gift if this is appropriate. Collect together all of the papers, tapes, etc., make sure that the meeting place is tidy and thank the village leader or whoever gave you permission to hold the meeting.

7. After the Discussion

- a) On the same day, if possible, go through the notes with the assistant and make sure that they are clear and easily understandable. Follow through the discussion guide to make sure that the responses and discussions for each topic are obvious to the person who has to do the final analysis. This may mean reorganizing the notes slightly so that they follow the sequence of topics in the guide.
- b) As soon as possible after the meeting take the notes and tapes to the researcher and go through them with him/her to explain any problems you may have had or any points that need to be explained more fully.
- c) Start the next meeting.

Checklist for Focus Group Discussions

Discussion Guide

Personnel:

**Moderator
Assistant
Hostess/Host**

Permission from Village Leader

Meeting Site

Meeting Date and Time

Tape Recorder and Blank Tapes

Notepads, pencils, erasers, sharpeners, etc.

Refreshments

Gifts

Participants

Transportation

Annex B-7

Rapid Community Profile Questionnaire

ATOP IDP/IEC Research 1992

RAPID COMMUNITY PROFILE QUESTIONNAIRE

Purpose

This brief questionnaire may be used to gather information about a community in which IDP or other health programs are planned. The information sought is very selective and may be administered to a community head and/or senior leaders (male or female) in less than 40 minutes. For additional socio-economic information, questions may be added or a different research instrument may be more appropriate. Some of these questions ask "how many?" The answer depends on the knowledge of the person(s) interviewed. Because his or her knowledge may not be wholly accurate, the answers should be regarded as indicative, not factual. For many program purposes, indicative answers are adequate. Where they are not, a quantitative survey should be carried out.

Questionnaire

Explain to the respondent: We are conducting research to improve our understanding of the health services in your community. We expect that this information which you have been so kind to agree to share with us will be used by health planners. There are no right or wrong answers to these questions, and they will be kept confidential to our project. Thank you for agreeing to talk to us.

0. RESPONDENT INFORMATION

0.1 Names and titles of respondents (Usually Jauro and Councillors)

0.2 Date and Time

1. COMMUNITY IDENTIFICATION

1.1 Name

1.2 District

1.3 LGA

1.4 Type (town quarter, single village, satellite village, etc.)

1.5 Name of village chief

1.6 Name of women's head

2. POPULATION SECTORS

2.1 How many people live here in all seasons?

2.2 How many others pass through during migration?

2.3 What are the main migration months?

2.4 What ethnic groups live in the community? (List in order of size)

2.5 What is[are] the main language[s] spoken?

2.6 What is the most prominent religion?

What is the second most prominent?

2.7 In what month of the year are the largest number of people present?

Why?

Would this month be a good time to deliver a health intervention (Mectizan) to the community?

Why or why not?

If this is not a good time can you suggest an alternative month in the year when people are likely to be around?

3. HOUSEHOLD INCOME

- 3.1 What is[are] the main source[s] of livelihood for men in this community? (Do not suggest an answer. Responses can include farming, herding, trading, salaried employment, or other). Please list in order of priority.
- 3.2 What is[are] the main source[s] of livelihood for women in this community? (e.g. farming, herding, crafts, trading, salaried employment, specify other, no income earning activity). Please list in order of priority.

3.3 Are there any households not earning enough to feed their families properly? How many?

3.3a [Interviewer's impression of validity of above response based on observation]

3.4 In the past year about how many people have left the community to look for work outside?

3.5 To what age group and sex do they belong?

4. SOCIAL SERVICES

The following questions ask about the distance to certain services or facilities. If they do not know the answer, write an interrogation mark, "?"

Where is the nearest...

4.1 primary school

4.2 church

4.3 mosque

4.4 health center

4.5 dispensary

4.6 active health worker

- 4.7 pharmacy
- 4.8 active traditional healer
- 4.9 community health committee

5. HEALTH SEEKING BEHAVIOR

- 5.1 What is the nearest health facility?
- 5.2 Is the service run by the government? By another organization?
- 5.3 How many miles away is it?
- 5.4 How long does it take to reach it? By what means?
- 5.5 Are drugs available there?
- 5.6 Does one pay for drugs? For health service?
- 5.7 When someone in the family falls ill, who is the person who decides what treatment to use?
- 5.8 Who looks after the person and carries out decisions?

5.9 Where is the first place most people go for health care? (e.g. traditional healer, health worker, etc.)

6. COMMUNICATION CHANNELS

6.1 To whom does a woman go first for advice when illness strikes a family?

6.2 To whom does a man go first?

6.3 What radio channels do you receive here?

6.4 How many households in this community have radios that are working now?

6.5 How many people have working tape recorders?

6.6 Does anyone have a television set in this community? If so, about how many sets are there?

6.7 Where is the nearest television viewing center?

6.8 What do people do for entertainment in this community?

6.9 Has this community formed any performing groups for the traditional arts (e.g. singers, dance groups, storytellers, other entertainments)?

6.10 Would the community be interested in creating small theatre groups or participating in a song contest?

7. OTHER

Is there any other important information about the health of your community you would wish to share with us?

Thank you very much for talking with us. Your responses to these questions have been very helpful.

Annex B-8

Topic Guide for Focus Groups

ATOP IDP/IEC Research Topic Guide for Focus Groups

Purpose: This Topic Guide is to be used in a focus group of either men or women, Mectazin users or non-users, totalling no more than 10 persons. You should allow up to two hours to complete the focus group discussion. The questions below are intended to help you make sure all aspects of the topic is covered. **IT IS NOT NECESSARY TO ASK ALL QUESTIONS** if the group touches on these topics naturally in the course of the discussion. You need ask the question only in cases where the group has not answered it to your satisfaction. It is not necessary that answers follow the order given here.

1. WARM-UP AND EXPLANATION (10 minutes)

A. Introduction

1. Good Morning/Afternoon. My name is X and I am here to guide your discussion. I wish to listen to your own ideas, not to give you any new information or teach you anything new.
1. Thank you for coming to talk with us about health conditions that exist in your community.
2. Your presence is important to the planning health services in this locality and in other parts of X state.
3. Some of you may have heard of or participated in survey research. Your group will also be answering some questions. In this type of research, however, we are more interested in listening to your ideas and opinions in response to a few general questions. My questions will be very few. Mostly, we will be having a conversation among us.

B. Purpose

1. Today I will be talking with you about your community and the health of the people who live here.
2. I am interested in all your ideas, comments, and suggestions.

3. There are no right or wrong answers
4. All comments, positive and negative, are welcome.
5. Please feel free to disagree with one another. We want to have as many observations and points of view as possible.

C. Procedure

1. You will see that we have brought a tape recorder to help us record this discussion. Please be assured that all information is confidential and will be used only by the researchers. The tapes will not be copied and will remain with us. Also, my colleague X who is here will be taking notes. They are also confidential.
2. Please feel free to speak out. You do not have to ask my permission before saying something. Try to speak one at a time so that we can all hear what you have to say.

D. Self-Introductions

1. Let us go around the group and introduce ourselves. You may give your name and tell us how long you have lived in this community and what your type of work is. [If the group is female, ask how many children they have.]

II. General Perceptions about Community Health

A. Management of Health and Illness at the Household Level

1. When someone falls ill in your family, what is the first step you take?
2. What do you do next?
3. Then what?

4. Who in your family makes decisions about appropriate treatment?
5. Who advises the person in making these decisions?
6. Who carries out those decisions? (Who actually cares for the sick person at home?)

[Probe: why? why? why? Encourage everyone to speak.]

B. Perception of Main Health Problems in the Community

1. What do you consider the most significant health problem in this community?
2. What would you say is the next most significant?
3. Are there other illnesses that have a serious effect on the community? If so, what are they?

[Probe: in what way are they significant? e.g. because of severity and risk involved? high prevalence? length of treatment? persistence?]

C. Health Services

1. Where is the nearest health center? What kind is it? How far away is it and how long does it take you to reach there?
2. For what sort of illnesses or health services do you go to a health center?
3. If you are the sick person, or if you are taking your child there, would you go alone or would someone go with you?

4. How would you evaluate the quality of service? [Probe: Are drugs available there? Do you pay for services? for drugs? Is a competent and interested health worker present? How long do you wait before being seen by a health worker?]
5. We know that in Africa traditional healers can offer cures that are very helpful for some illnesses. Do you have traditional healers in this community? What sorts of diseases do they treat?
6. Are the treatments of traditional healers helpful? Why?

D. Health Prevention

1. What actions do you believe are most important to avoid illness in the family?
2. Would everyone in this community agree with you? If not, why not?

III. Channels of Health Communication

A. Sources of information

1. At the present time who or what is the best source of information for you about health?

[Encourage the respondent to give his or her own answer. After that answer Probe: Do you listen to radio? What programs? How often? (If literate) Do you read newspapers or magazines or books? Do you ask an imam or someone whose opinion you respect?]

2. Have you ever seen or heard any health education materials (videos, posters, flyers, songs, etc.)?

3. What is your opinion of them?

[Probe: Did you learn any new ideas from them? If so, what did you learn?

4. What kinds of entertainment do you enjoy most in this community?

IV. Treatment of Onchocerciasis

A. Knowledge of the disease entity

1. Do people in this community ever suffer from intense itching?

2. What is the cause?

[Probe, but do not suggest an answer.]

3. Does this [name cause] bring about any other health problems?

B. Treatment of the "itching" disease [Try to learn the local name for this disease.]

1. What treatment do most people in this community use for this disease? Why is it preferred?

2. Do you know other treatments?

C. Analogous diseases and concepts

1. Is malaria a problem disease in this community?

2. What is its cause?

3. Can malaria be got from other people?.

4. [If the questioning about onchocerciasis has not yielded any information, ask the following question]

Do you know a disease called filaria? What is it called in your language here?

V. (INTERVENTION AREAS ONLY) Experience with Mectizan Delivery

A. Participation in IDP

1. Were you present when Mectizan was delivered to your village? Did you take the drug? Why or Why not?
2. What was your experience with the drug. [Probe: ask each person present to tell his/her story. Cover topics of positive benefits, side reactions, etc.]
3. Will you take the drug again next year?
4. What do you understand its benefits to be?

B. Perception of Program

1. Was the drug brought at a convenient time? [Why/Why not?]
2. What time do you feel would be the very best possible?
3. Are you satisfied with the way the drug is being made available to you? [Probe: would you like to be able to obtain it a different way?]
4. Mectizan is free. Is this drug something you would pay for? How much would you pay for it?

VI. (ALL FOCUS GROUPS) Closing

- A. [Summarize the main points of what has been said]**

- B. Does anyone have anything more s/he would like to add?**

- C Thank you so much for coming to this meeting. Your comments have been very useful to us.**

Annex C-1

Preliminary Considerations

.....

DEVELOPING A COMMUNICATION PLAN FOR IDP IN NIGERIA

Preliminary Considerations

Purpose

Public health communication represents a strategy for planning and implementing long-term programs to produce specific, sustained behavior change in target populations.

Broadly viewed, this strategy consists of three stages:

1. **Planning**
2. **Intervention**
3. **Monitoring**

These three stages in the planning process work in a cyclical pattern. Continuous feedback through monitoring feeds into an ongoing revision of planning. In other words, the communication planning never ends, but rather grows and expands as our knowledge of the effect and impact of our communication strategies improves.

The individual steps of the public health communication process are:

1. **Planning**
 - 1.1 Health problem analysis
 - 1.2 Developmental research
 - 1.3 Strategy development
 - 1.4 Testing materials and strategies
 - 1.5 Writing an operational plan
2. **Intervention**
 - 2.1 Production
 - 2.2 Training
 - 2.3 Distribution

3. Monitoring and Evaluation

- 3.1 Baseline measures
- 3.2 Regular Benchmarks
- 3.3 Summative evaluation

These preliminary notes will focus on PLANNING, which serves as the first stage in the process. Specifically, they will consider the planning step "strategy development." The purpose is to assist IDP planners identify the kinds of information we need in order to write an operational Communications Plan for IDP health education.

Strategy Development

Results from health problem assessment (skin-snipping/rapid assessment) and developmental research (KAP surveys, qualitative research) suggest answers to the following questions, which comprise the total IDP health education planning strategy.

1. What is the objective of the strategy?
2. What is the target audience?
3. What is the product strategy?
4. What behaviors do we wish to encourage?
5. What distribution strategy is to be used?
6. What health education messages are suited to the audience?
7. What channels are most appropriate?
8. What materials will be developed?
9. Who will be trained to use them?
10. What specific behaviors will the materials encourage?

The objective of the health education strategy is related to the overarching program objective.

Target audience (or audiences) is determined by observing the various groups that comprise the potential user or decision making population. We refer to this analysis as **audience segmentation**. It is possible to have primary, secondary, and tertiary audiences.

The principal health education messages are related to the **product strategy** which is adopted. How do we want to promote the product? What aspects of the product are most important to its sustained use? How do we want to position the product with the audience? Some methods for positioning a product include the creation of a logo and development of a tag line.

Behavior strategy will depend on the following criteria:

- health impact of the behavior
- perceptible positive consequences of the behavior
- cost of engaging in the behavior
- compatibility with existing practices
- frequency of the behavior
- complexity of the behavior
- persistence of the behavior

The distribution strategy for the product will have an important impact on its availability, i.e. its supply.

The messages will relate to the following considerations: appeal, benefits, frequency of use, source, price, side-reactions, depth of educational information. Possible messages can be developed with brainstorming.

Channels selected will depend on the audience, the media available to them, and the messages to be conveyed. Channels may include inter-personal communication, folk traditions, print, and such sophisticated media as newspapers, radio, TV, tape recordings, and Video.

Educational materials will be developed to suit the target audience, the channels, and the messages to be conveyed.

Preliminary Considerations

Educators to be trained will be drawn from the program workers available. The level of training will depend on their education and responsibility. In many health education strategies, training occurs on two levels: training of trainers, and the training of front-line health workers.

Further Research

Developmental research has been undertaken in Adamawa (KAP, qualitative research), Taraba, and Kwara States. This effort offers answers to many of the above questions. However, further information will be needed to complete the research plan. Some topics for research will include the following:

1. The PHC structure in intervention areas; capacity for delivery and for health education
2. Population segments (social groups) in the endemic communities
3. Names and titles of opinion leaders and decision makers who are critical to program sustainability.
4. Principal languages intelligible to the target population. Proportion able to understand a lingua franca, e.g. Hausa.
5. Existing communication channels accessible to the target population; their reach; their health programming schedule; most popular programs of any kind and most popular listening periods of the day.
6. The "stories" of disease entities related to oncho, from first symptoms to endpoints. What is the cause of the disease? Common treatments?
7. Festivals or traditional events that may suit the symbolism or calendar time for tablet distribution.

8. Existing artists in graphic arts, song, drama, dance, etc.
9. Structures and capacities of state ministries of health and ministries of information for the development of health education materials.
10. Existing plans for IDP materials development or training.

Specific Preparations for the Development of the Communications Plan

Each state onchocerciasis control team is requested to develop a draft document addressing the ten elements described in "Strategy Development" above. In addition, accurate information relating to the research questions should also be gathered. This material will be refined in late November-early December at a Communication Planning Workshop.

Annex C-2

Results of an Exercise in Media and Channels

IDP Health Education

"PRINT"

1. Examples of Channels:
 - a. Posters
 - b. Pictures
 - c. T-Shirts
 - d. Face caps
 - e. Cups and plates
 - f. Bags
 - g. Flip Charts
 - h. Sign boards or bill boards

2. List of target groups
 - a. Health workers
 - b. School teachers
 - c. Community leaders
 - d. Religious leaders

3. Messages
 - a. Have you taken ivermectin
 - b. Treat yourself with ivermectin
 - c. Make sure you take ivermectin
 - d. For River Blindness or Oncho - Take Ivermectin

4. Cost effective
 - a. Posters (most cost effective because of availability of materials)
 - b. Bill boards

IDP Health Education

"Traditional Media"

A. Drama

1. Target Group - Rural dwellers

- a. literate or illiterate
- b. Objective: Make community members aware of the disease
- c. Drama cuts across age groups and sexes
- d. Drama will educate recipients about the dosage, duration, side reactions and overdoses of the drug.

2. Cost

- a. Cost effective by using CBD, children and teachers.
- b. The receiver could be literate or illiterate.
- c. The message will be in their language and culture.
- d. Events can be seasonal or during distribution.
- e. Places of presentations:
 1. schools
 2. village centers
- f. Dramas should be simple
- g. Potential Title: Prevent Blindness Take Mectizan

B. Song/Dance

1. Target Group - Rural dwellers including:

Community health workers
Adults within the community
School children

- a. Song/Dance cut across age groups and sexes
- b. Literates and illiterate people can participate in song/dance
- c. Songs are simple and in local languages

2. Cost

- a. cost effective - materials are locally available
- b. time - all year especially during harvest when people are generally on their farms

IDP Health Education

"INTERPERSONAL"

A. Existing Channels

1. Peer Group; e.g. friends normally adolescents between 15-18 years
2. Family Interpersonal; e.g.
husband to wife
(wives)/wives to wives
husband to children
wife to children
children to parents
3. Leaders; e.g.
community to community
group to group

B. Target Groups

1. Adult males
2. Adult females
3. Parents
4. Community leaders e.g.
farmers group
fisherman association
family heads
head of households
5. Religious leaders
6. Health workers e.g.
CBD's
VBHW
TBA
Nurses/Midwives

C. Cost

1. Materials:
 - a. equipment: drug and scleral punches
 - b. transport/money
 - c. information
2. Manpower
 - a. identify individuals/leadership
 - b. health educator (who is the source)
3. Time
 - a. to suit target audience
 - b. to suit health educator

D. Examples

1. Where the awareness is low

"Causes of Oncho"

Appropriate:

"Beware of black fly bite."

Inappropriate:

"Black flies live near rivers. They cause oncho."

2. For distribution of ivermectin

Appropriate:

"Ivermectin treats oncho: it prevents blindness and can save your life"

Inappropriate:

"Ivermectin is good for your health"

IDP Health Education
"MASS MEDIA"

Channel	Costs	Target Group	Accessiblilty/ Familiarity	Message
Newspapers, Journals, etc.	**	Literature urban economically advantaged	High	Policy issues/ Feature articles
Radio	*	Can target wide range of interest groups, e.g. chil- dren, women, rural, urban, policy mak- ers, etc.	Medium for rural: Higher for urban	Convey specific messag- es; teach children through songs and jingles; most direct
TV	****	Economically advantaged, mainly urban, e.g. policy makers, influential groups	High with limited audi- ence	In-depth program; visual demonstrations; combined audio and visual effects
Telecom telex fax	*****	National elite policy makers	Low	Emergency messages (disease outbreaks)
Cinema, Video, Slides, Viewing centers	*****	Where available: 1. specific groups can be targeted 2. potentially wide audience	Low	Entertainment/ Educational

Annex C-3

**Results of an Exercise on
Elements in Communication Planning**

*Results of an Exercise on Elements
in Communication Planning*

Elements of Communication Planning: Group 1

TARGET GROUP	BEHAVIOR	MESSAGE	CHANNELS
Community: persons school-aged and above	After applying diagnostic techniques, to comply with annual treatment	Causative agents, signs, complications - blindness, itching, etc. Drugs: the safety, is free, also treats helminths.	Songs Face-to-face Drama Story-telling Public address
Community leaders	Annual meetings with community leaders, press, LGA, For fund generation. Community leader to comply with treatment, mobilize communities for treatment.	Create awareness about the disease and the drug; The drug is free	As above. In house evaluation. Participatory planning.
Health workers, (CBD's)	To update knowledge, able to diagnose and treat reactions, mobilize community for treatment, diagnosis, etc.	Create awareness of the disease, dangers and treatment. Exclusion criteria	Train and retraining. Use of manuals Posters
Policy Makers	Financial and political commitments with 3 tiers with the government and also NGO's, eg. Missionaries, Rotary Clubs, etc.	Oncho is a disease with significant economic and public health importance	Meetings Evaluation Reports Progress reports Radio on the level of endemicity Print media Mass media

Elements of Communication Planning: Group 2

TARGET GROUP	OBJECTIVE	BEHAVIOR CHANGES	MESSAGE	CHANNELS
Primary target: Community 1. Adult males & females 2. School aged children	To increase awareness about oncho prevalence in the community. etiology & pathogenesis	Identify oncho as a disease. To be able to associate the disease with the black fly.	Oncho is a disease that is transmitted by a tiny black fly. Black flies introduce worms into the body. The worms grow and produce more tiny worms. The tiny worms live under the skin and cause itching, leopard skin and blindness.	Interpersonal: health talks Posters Microscope Traditional: Song, Drama, Dance Institutional: school teachers Media: radio, TV, town crier.
Community	Sustain annual demand and participation in ivermectin treatment activity	To promote maximum use of ivermectin.	Oncho can be treated with Mectizan. Mectizan should be taken once a year over period of 15 years. Mectizan can prevent blindness. Mectizan is free.	Mass mobilization
Secondary Target: Community leaders 1. traditional and religious leaders 2. health workers 3. school teachers	Secure their support and endorsements (S). Active participation in IDP activities	Active participation of community leaders in IDP: special role, community mobilization Physical presence during IDP activities Practical interaction with community during IDP activities Coordinate community inputs in IDP activities	The success of IDP depends on your cooperation and active participation. Take ivermectin in the presence of your people to encourage them to take theirs. Inform your community about days of IDP activities.	Face-to-face Community Meetings Workshop Curricula for teachers

*Results of an Exercise on Elements
in Communication Planning*

Elements of Communication Planning: Group 2, cont.

Tertiary Target	Demonstrate severity of oncho as health problem.	Accept oncho as priority health problem.	60% of LG endemic LG losses N5 million annually	Council on Health meeting.
Policy Makers	Obtain political support for IDP activities	Provide human, material, logistic & financial resources.	Provide resources for sustained IDP delivery.	Publication of survey results.
1. LGA chairman				Radio/TV programs.
2. State Govt: directors & commissioners		Active participation in IDP		Pressure groups.

Elements of Communication Planning: Group 3

TARGET GROUP	BEHAVIOR	MESSAGE	CHANNELS
Primary Group:	<ol style="list-style-type: none"> 1. Create awareness 2. Demand cure 3. Education (facts, drug, cure, effects) 4. Compliance 5. Behavior modification (long term) 6. Spread message 	<ol style="list-style-type: none"> 1. Explain signs and symptoms and mode of infection 2. Intervention (drug) 3. General Enlightenment: side effects, benefits, dose, who takes 4. Take Mectizan on the spot with CBD/HW and exclusion Parameters 5. Sustained Behavior explain improved health and increased productivity 6. Tell your family, neighbors, community 	<ol style="list-style-type: none"> 1. Pictures Small Groups Microscopes 2. Posters Drama/Songs 3. Posters Pictures Drama/Songs Radio 4. Face to Face 5. Handbills Drama/Songs 6. Face-to-face
Secondary Group:	<ol style="list-style-type: none"> 1. Role Model 	<ol style="list-style-type: none"> 1. Effects of disease on his people <ol style="list-style-type: none"> a. Community is infected b. Benefits to community c. Improved health d. Increased productivity 	<ol style="list-style-type: none"> 1. Face-to-face Pictures

2. Health workers	2. Deliver a. Drug b. Message c. Care	2. General manifestations of disease a. blindness prevention b. explain disease c. effects, itching, etc d. drug capability e. educate recipients (materials)	2. Face to face Materials Posters Pictures Radio
Tertiary Group:			
1. LGA: Councilors and chairman	1. Create awareness of oncho, allocate funds, mobilize LGA residents, inclusion in 5 year dev. plan	1. Oncho exists in their LGA, economic losses, transmission mode, benefits.	1. Face to face Video/TV Posters Journals
2. State/ Governor	2. Commitment and allocation of funds, promote oncho education	2. Same as above	2. Face to face Video/TV Slides Radio Journals
3. National	3. Same as above	3. Oncho awareness, economic losses, overview of transmission, benefits	3. TV Radio Journal

Elements of Communication Planning: Group 4

TARGET GROUP	BEHAVIOR	MESSAGE	CHANNELS
A. Community	Take the drug once a year every year	1. Disease a. cause b. transmission c. manifestations d. progression of illness 2. Direct benefit of drug a. stops itching b. prevents blindness c. smoothes skin d. gives more energy 3. Side benefits a. deworming b. better appetite 4. Side effects (short term) 5. Exclusions 6. Take the drug every year once a year 7. How and where to get it 8. It is free	1. Interpersonal communication through community leaders and health workers (CBDs) 2. Print Materials a. pictures of the effects b. T-Shirts for health workers and CBDs
B. Community leaders and health workers	Encourage and motivate the community to take the drug once a year every year	Health effect of the disease (blindness) 2. Socio-economic effect 3. Financially contribute to support the delivery and management of the drug (budget yearly for the program)	1. Television 2. Radio 3. Newspapers 4. Information Packets
C. Policy Makers	Support the delivery of the drug once a year		

Annex C-4

Materials Pretest: Topic Guide for Focus Groups

ATOP IDP/IEC Research

MATERIALS PRE-TEST

Topic Guide for Focus Groups

Purpose: This Topic Guide is to be used in a focus group of either men or women totalling around 7 persons. It is designed for pre-testing materials developed for IDP health education. It may also be used as a 30-minute warm-up to a focus group discussion on other topics. You should allow up to two hours to complete the focus group discussion, whether devoted only to the materials pre-test or to a mixed format. The questions below are intended to help you make sure all aspects of the topic is covered. **IT IS NOT NECESSARY TO ASK ALL QUESTIONS** if the group touches on these topics naturally in the course of the discussion. You need ask the question only in cases where the group has not answered it to your satisfaction. It is not necessary that answers follow the order given here.

INSTRUCTIONS TO THE MODERATOR

Be sure the group is sitting so that they can all see the image you display. If necessary, rotate print materials among the group once before you begin so that everyone has a close look. Then begin asking the questions on the schedule below. Use your best judgement when asking the questions. Be sure that everyone responds. If the members of the group hesitate to answer initially, rotate the materials from person-to-person or call on each person in turn. Discuss one image at a time. If any group member wishes to see an image again or more closely, allow him/her to do so. When using several focus groups, present the materials in a different order each time. Respondents warm up to the task at different rates and this fact may affect their expression of opinion.

1. WARM-UP AND EXPLANATION (10 minutes)

A. Introduction

1. Good Morning/Afternoon. My name is X and I am here to guide your discussion. I wish to listen to your own ideas, not to give you any new information or teach you anything new.
2. Today I have brought some materials (say: drawings, pictures, video, etc.) for your comment. [Do NOT say they will be used for health education or oncho-related activities. This fact will need to be discovered by the group, assuming it is aware of onchocerciasis.] Thank you for coming to talk with us.
3. Your group will also be answering some questions. I am interested in listening to your ideas and opinions in response to a few general questions. My questions will be very few. Mostly, we will be having a conversation among us.

B. Purpose

1. Today I will be talking with you about these [materials; hold them up or demonstrate]. We are interested in your opinions about these materials.
2. I am interested in ALL your ideas, comments, and suggestions.
3. There are no right or wrong answers. This is not a test of your knowledge.
4. All comments, positive and negative, are welcome.
5. Please feel free to disagree with one another. We want to have as many observations and points of view as possible.

C. Procedure

1. You will see that we have brought a tape recorder to help us record this discussion. Please be assured that all information is confidential and will be used only by the researchers. The tapes will not be copied and will remain with us. Also, my colleague X who is here will be taking notes. They are also confidential.
2. Please feel free to speak out. You do not have to ask my permission before saying something. Try to speak one at a time so that we can all hear what you have to say.

D. Self-Introductions

1. Let us go around the group and introduce ourselves. You may give your name and tell us whether you have been involved in health education activities before.

INSTRUCTIONS TO THE NOTE-TAKER

Use this form to indicate the responses of each respondent separately to the questions asked below. Record any additional responses or comments and indicate the number of the respondent who made it. Record the following information here:

1. What type of group is it (young female, older male, etc.)
2. List and NUMBER the names of all participants. Do not take the names down if you are also moderating the group. You may get this information from the tape after the session is over but we sure to mentally assign each person a number in the same order in which they introduce themselves on the tape.

Names and number of respondents:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.

QUESTIONS (Use a separate sheet for each material)

Name of Image:

II. General Perceptions about the material.

- A. Ask a very general question such as: What is happening in this picture?

[Record summary responses below. Be sure to include opinions.]

1.

2.

3.

4.

5.

Materials Pretest:
Topic Guide for Focus Groups

6.

7.

8.

III. Follow with more specific questions:

- A. What is this (man/woman) doing?
- B. Does this person look like anyone who might live in your community?
- C. [If you want to elicit some specific information about the image, e.g. the person is blind, has nodules on his body, had rough skin, etc.] What do you notice about this person?
- D. Add other specific questions as required.

1.

2.

3.

4.

5.

6.

7.

8.

IV. Assessment of the Image

- A. Do you like this picture? Why or why not?
- B. Solicit additional information about specifics: Do you think the image is well drawn? Do you like this color? Would you suggest any changes in the picture to make it more clear?

1.

2.

*Materials Pretest:
Topic Guide for Focus Groups*

3. _____

4.

5.

6.

7.

8.

V. Closing

A. Does anyone have anything more s/he would like to add?

B. Thank you so much for coming to this meeting. Your comments have been very useful to us.

Annex C-5

Results of Materials Pretest Exercise

RESULTS OF MATERIALS PRE-TEST EXERCISE

Purpose

ATOP wished to pre-test provisional sketches commissioned from a local artist. The chief intention of the sketches was to illustrate the ATOP Training Manual for community-based Distributors. A secondary purpose was to use the drawings as educational tools with members of endemic communities.

The exercise also served as a training opportunity for ATOP staff in materials pre-testing. It was assumed that the sketches would be revised or redrawn altogether. Therefore, the point of the exercise was to gain general insights into how well community members understood the sketches.

Method

Eight Focus Group Discussions (FGDs) were organized among 8-12 persons of the same sex and similar age grade. In some instances the FGDs were organized exclusively for the pre-test. In others the main motive of the FGD was to conduct communication research on River Blindness Disease. Here, the materials pre-test served as an ice-breaker at the start of the group.

Using the "Materials Pre-test: Topic Guide for Focus Groups" the moderator showed from 1 to 3 sketches to respondents. Eight different sketches were tested in all. Many of the drawings bore words written in either English or Hausa. The drawings were photocopied and the words were covered so that only the illustrations could be seen. Because the ATOP population is not more than 30% literate, eventual print materials would need to convey most information through images, not written words. Comments of each respondent were noted by the recorder.

General Observations

While responses to individual sketches varied with their content, some general trends in the effectiveness of the illustrations were observed:

1. *Relation to personal experience.* Men and women respond to illustrations in terms of their personal experience and immediate surroundings. Sketches that do not accurately reflect what people see every day are often misinterpreted. For example, a "river" was misread as a road in one community because it did not have a bridge over it. The community was located near a bridge on the Benue River.
2. *Abstract conventions or symbols.* Such conventions as pointers ("Nodules"), magnification within a circle ("Female Black Fly Feeding on a Man"), or enlargements ("Female and Male Black Flies," "Black Fly," and "A Man Scratching"), are not understood by persons who have not learned them in an educational setting. An illiterate viewer will interpret a pointer literally as an "arrow"; a magnifying circle is a "plate"; enlargements become monstrous natural aberrations or things other than intended (e.g. snakes instead of filarial worms).
3. *Proportion.* An illustration that is not in correct proportion or clumsily drawn is often misunderstood. A person may be interpreted as "sick," "handicapped," or suffering some physical abnormality. Facial expressions are studied attentively for signs of mood.
4. *Ideographs.* Some images have become so standardized, whether in picture or in thought, that they are readily understood irrespective of the illustrator's skill. Such an ideograph is the blind person being led by a child. Certain expectations surround these ideographs, however. For example, the persons depicted should normally be male, and a profile presentation is preferred by most viewers.
5. *Color.* Black and white images are often understood, but color greatly enhances comprehension and requires less skill from the illustrator. Moreover, color is much appreciated for its own sake. Colors or shading must correspond to colors of real life. An illus-

tration of ivermectin tablets in palms, for example, was understood to depict wounded hands because the medicine was darker than the hands themselves. Respondents suggested that the shading be reversed.

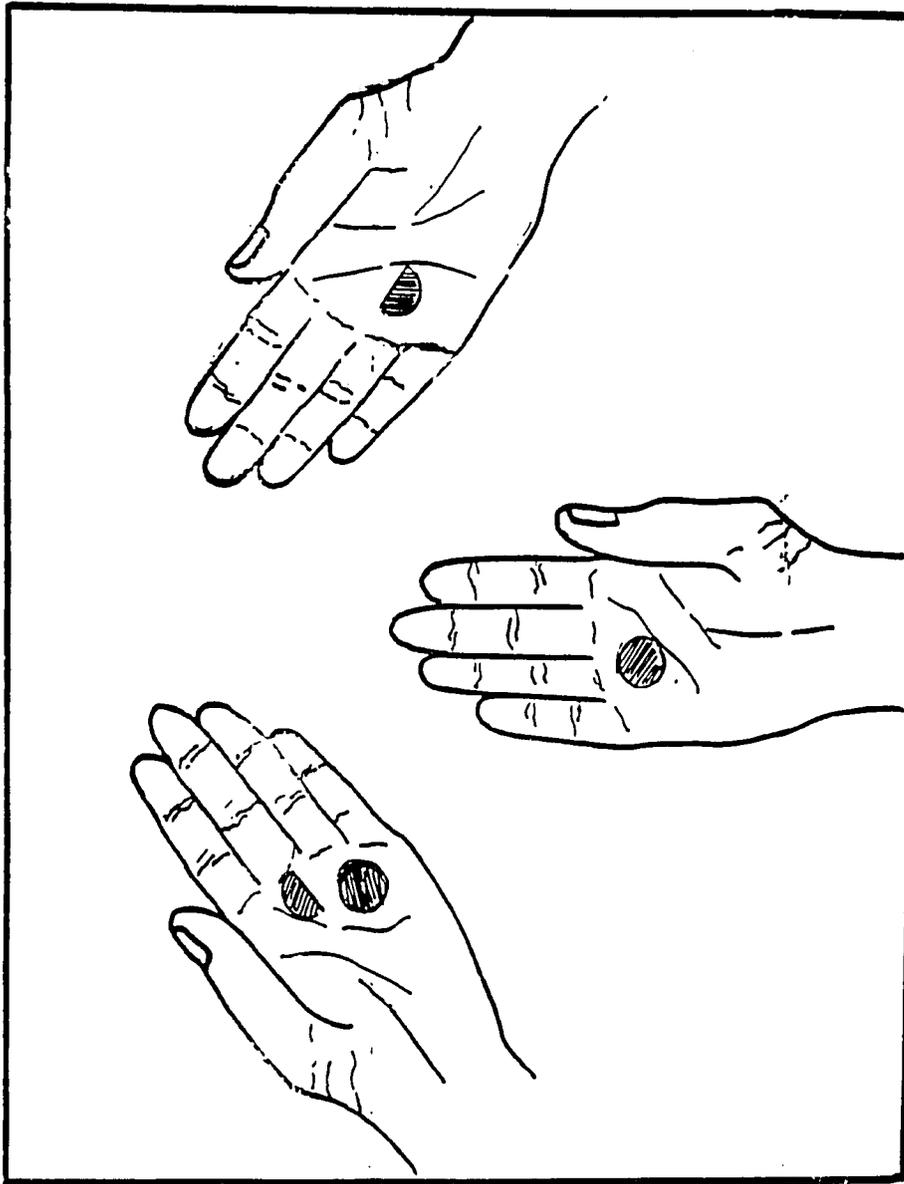
6. *Photographs.* Good photographs are often preferable to poor drawings. Photographs may also serve as models for drawings.
7. *Aesthetic judgements.* While some educated viewers were able to make aesthetic judgements or offer artistic criticisms of the drawings, most respondents recognized a "good" drawing as one having proper or morally desirable content. The question, "Is this a good picture?" may yield the response, "No, because it shows a sick man."
8. *Literacy.* Children or adults who have attended school understood illustrations more readily and accurately than persons lacking formal education.
9. *Endemic areas.* Persons in endemic areas were more likely to understand depictions related to the River Blindness experience than others. For example, images of scratching or nodules are recognized quickly by people who suffers from these signs of the disease.
10. *Emotional, direct responses.* In many instances, body language disclosed strong, emotional responses to the sketches. In some cases the responses support the educational objective, while others do not. For many persons in the ATOP area, a picture is not only an illustration of representation, but rather a re-presentation of some reality. It does not merely display a large fly, but IS one. We noted one woman respondent become quite shaken and upset by a black fly in one picture; eventually, she withdrew from the focus group. On another occasion several viewers began to scratch themselves, almost unconsciously, in response to images of scratching people.

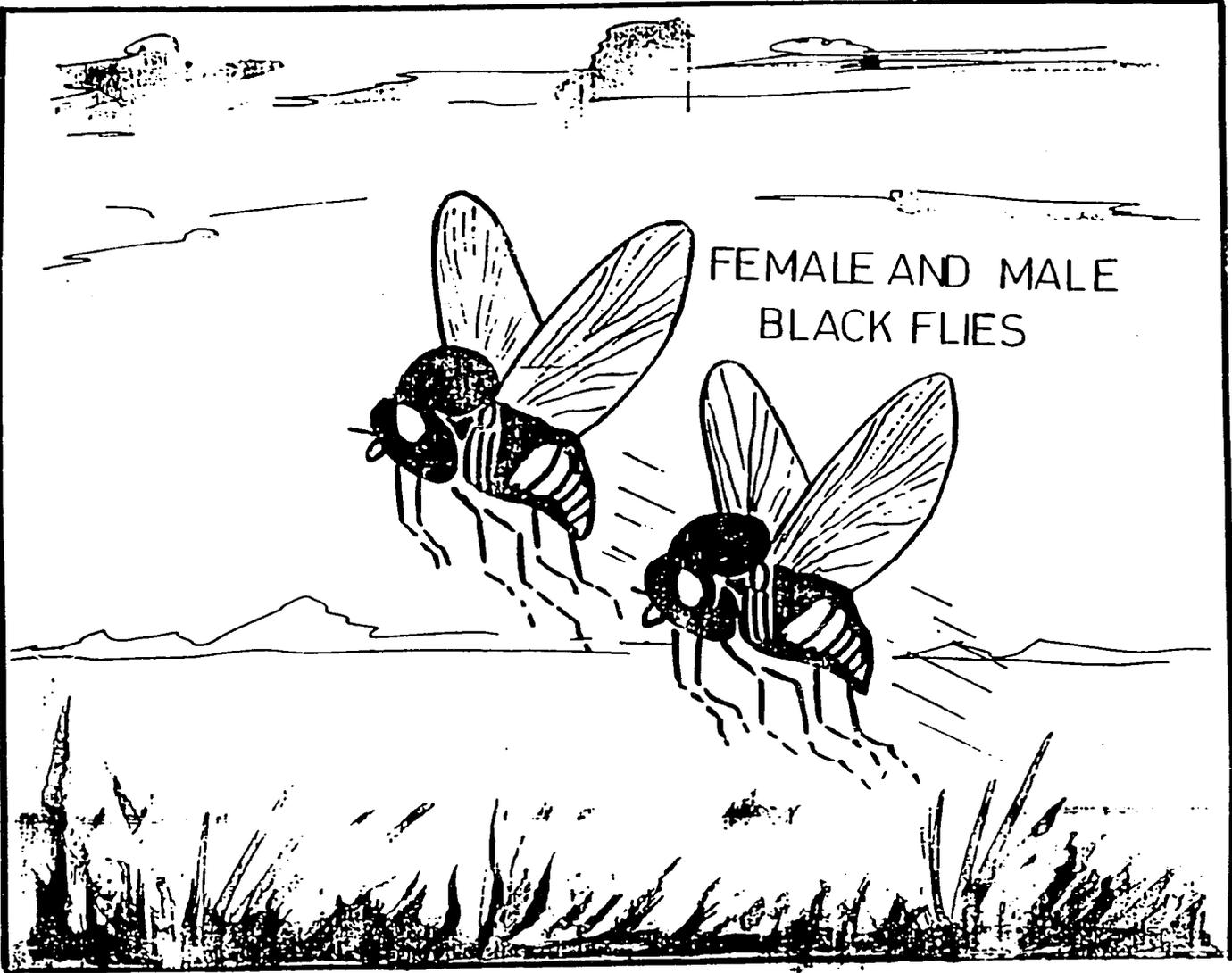
Conclusion

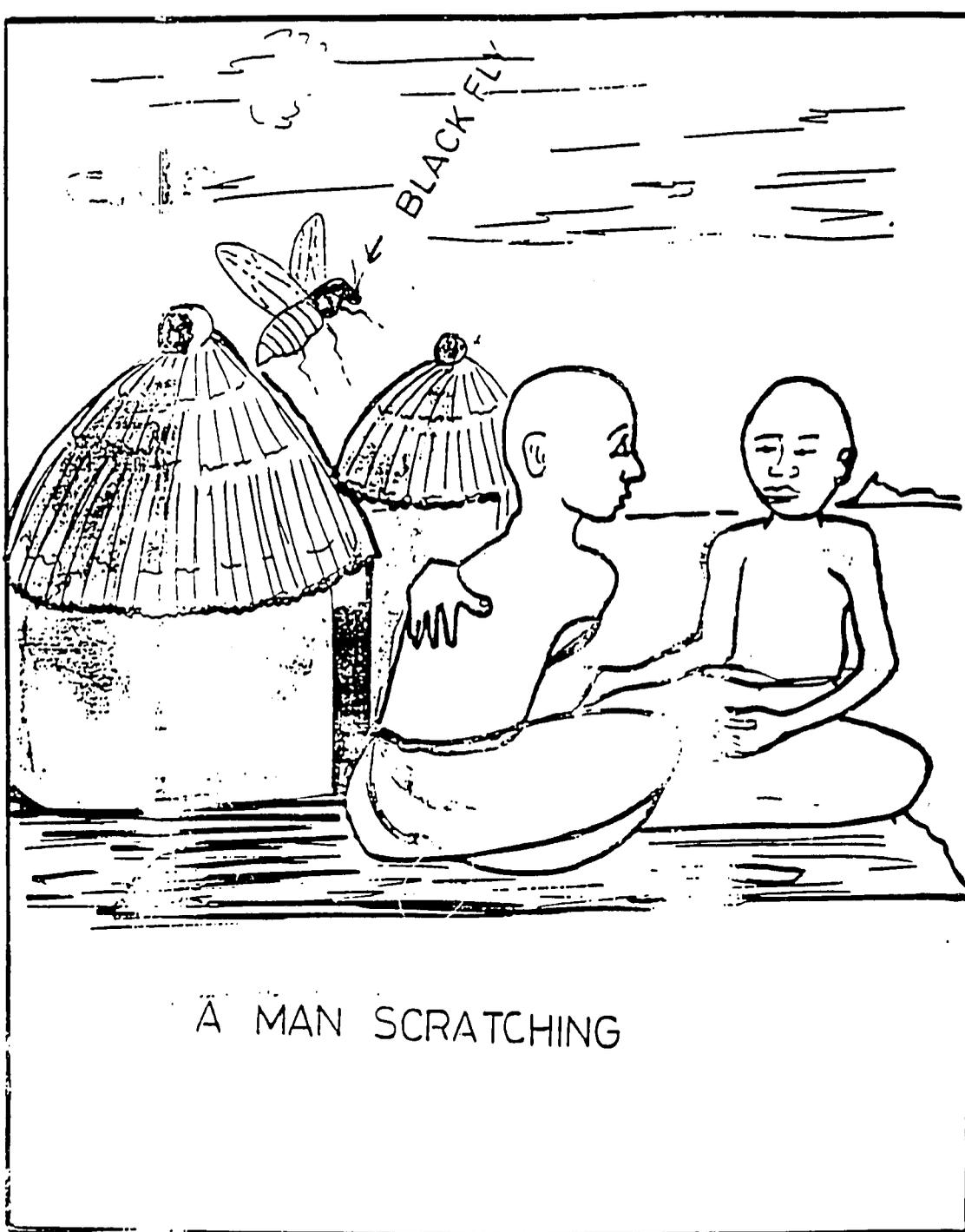
Graphic design needs to be planned and carefully executed by skilled artists. Frequent pre-testing is recommended throughout the process in order to correct errors early on.

Conclusion

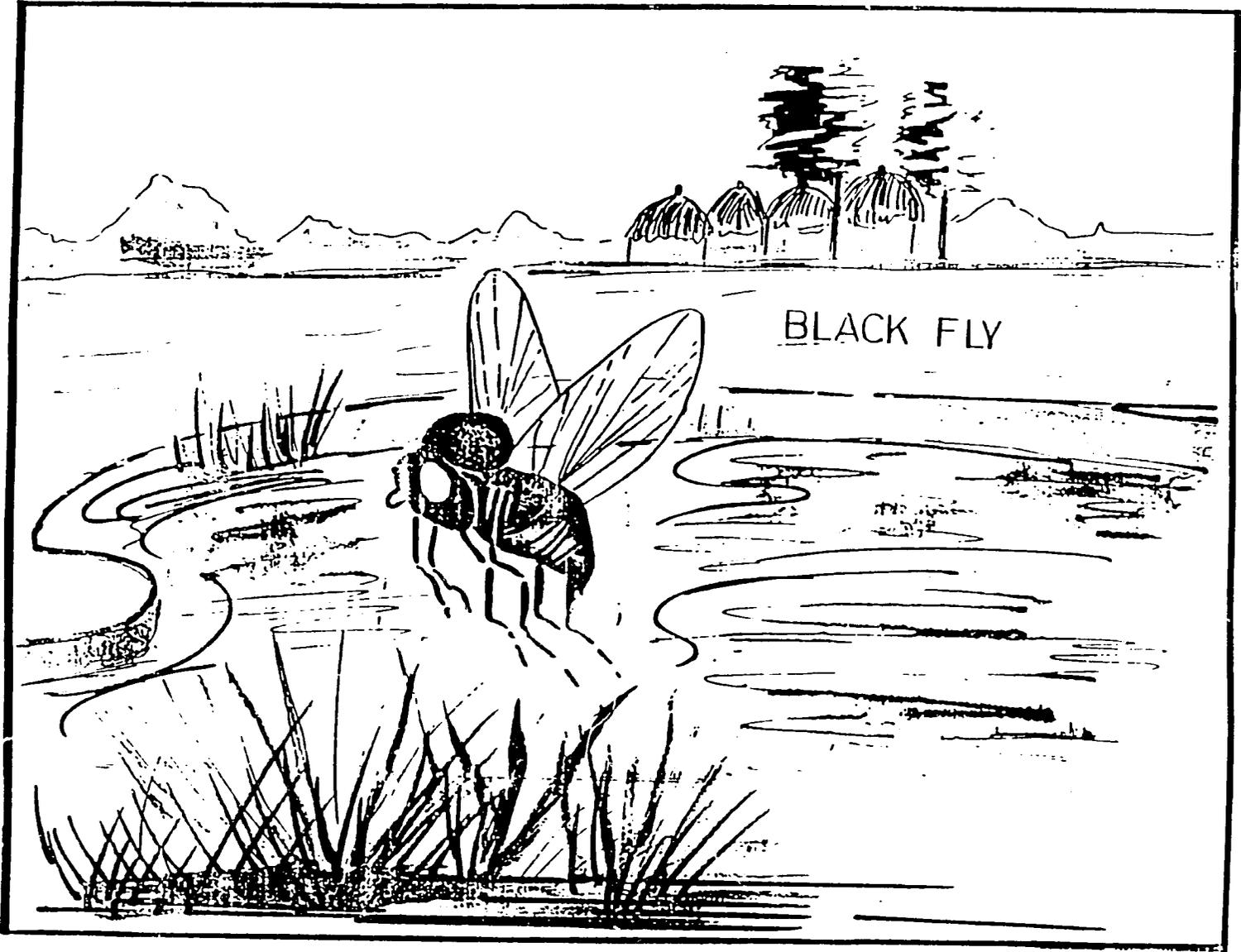
Graphic design needs to be planned and carefully executed by skilled artists. Frequent pre-testing is recommended throughout the process in order to correct errors early on.

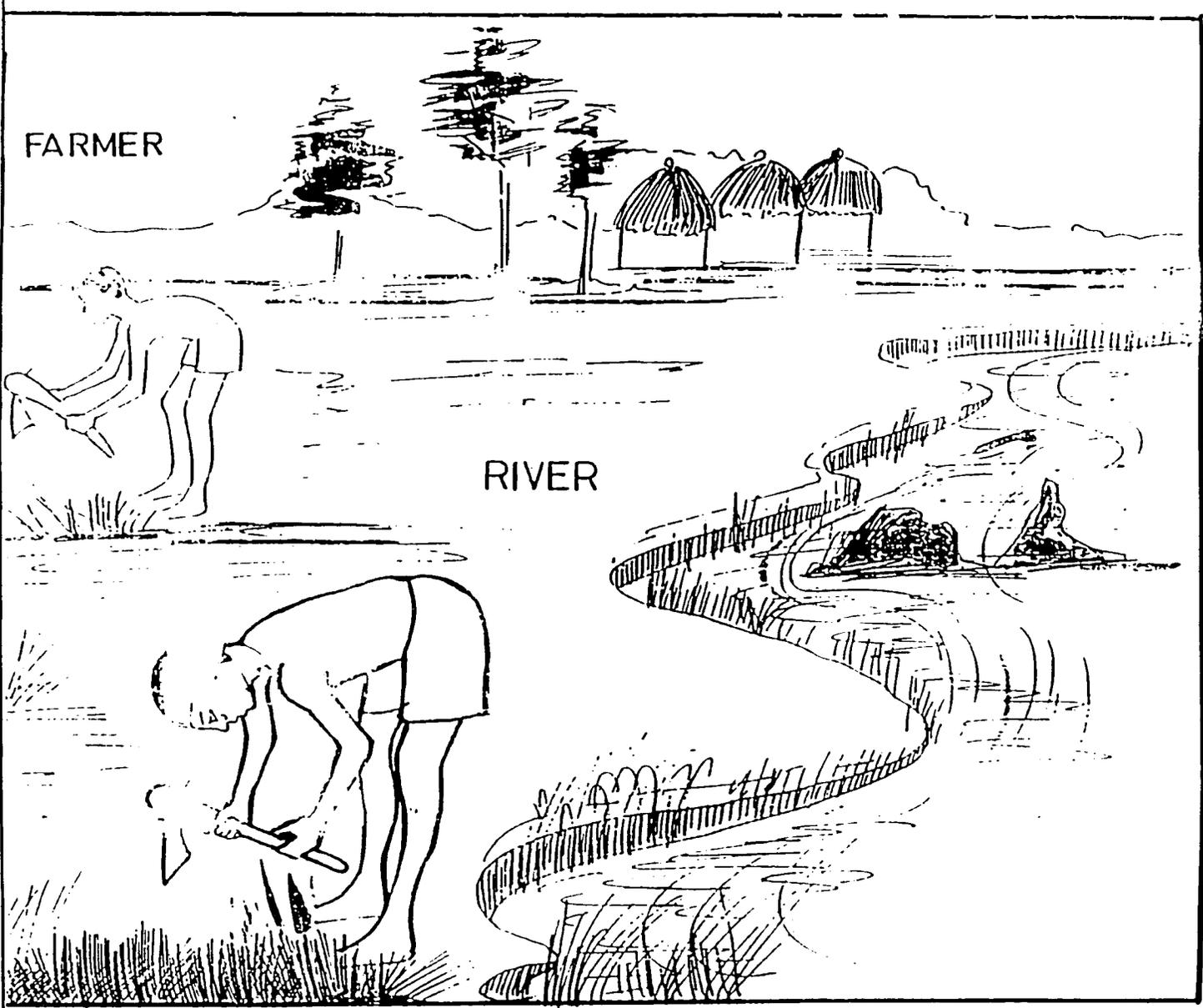


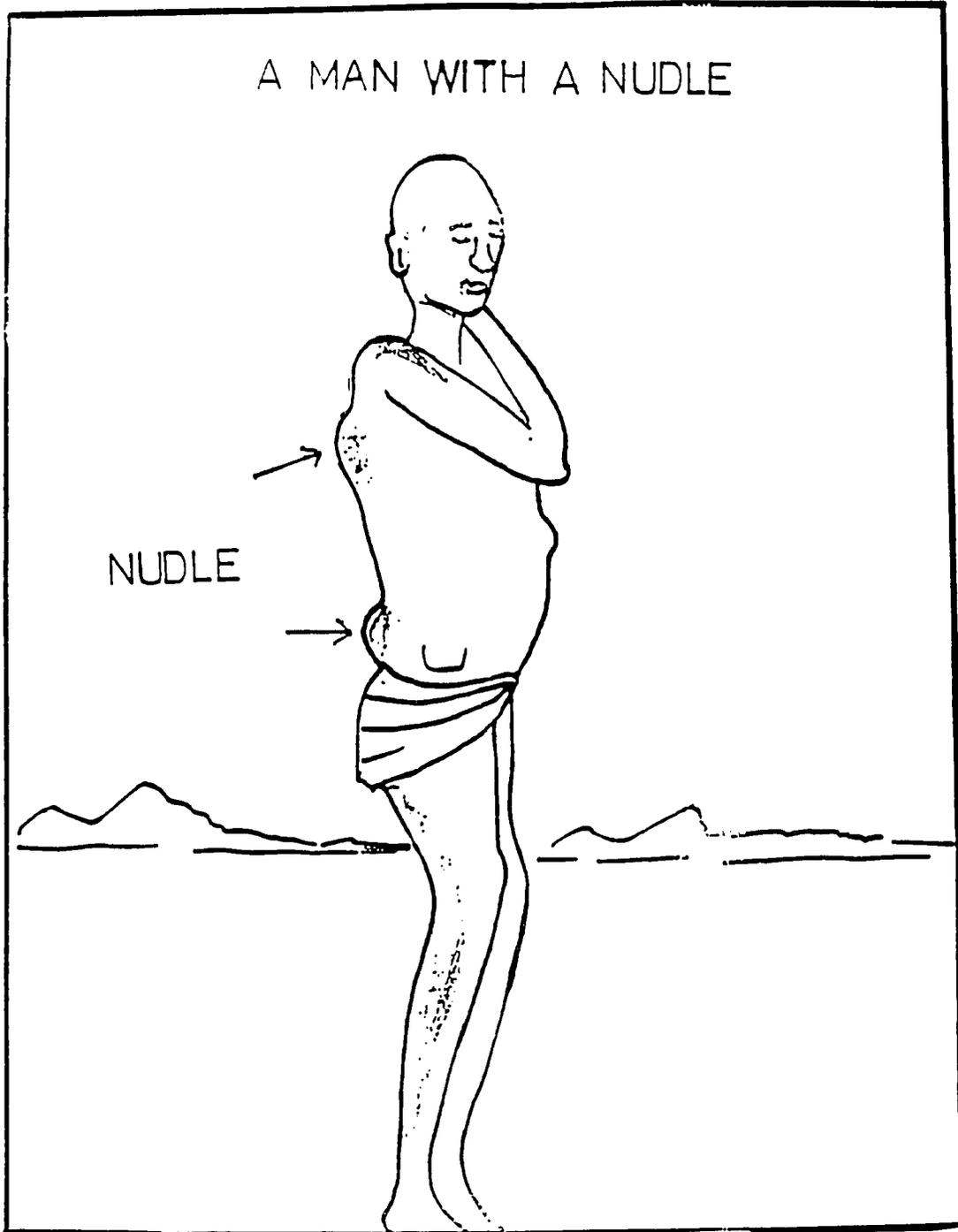


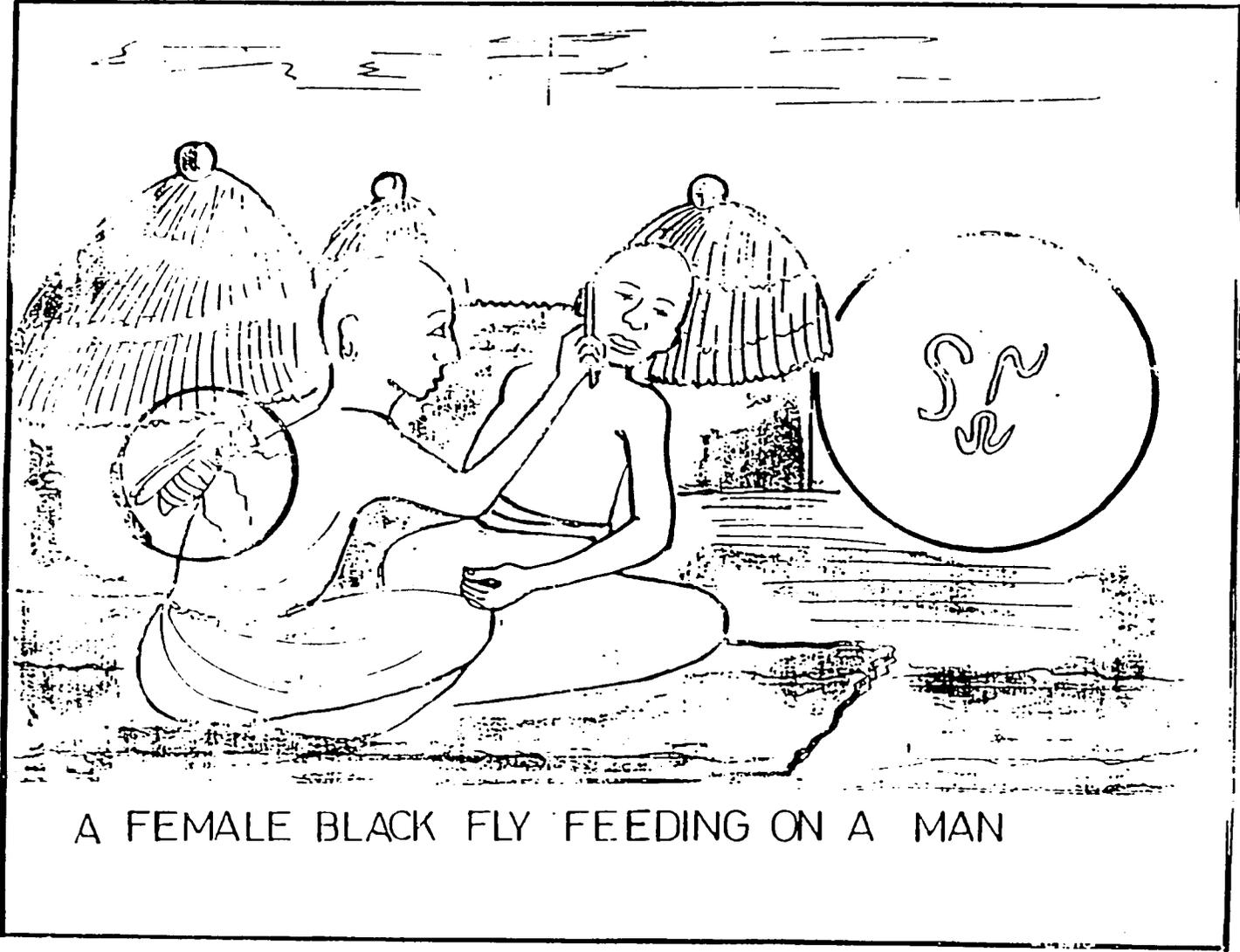


A MAN SCRATCHING

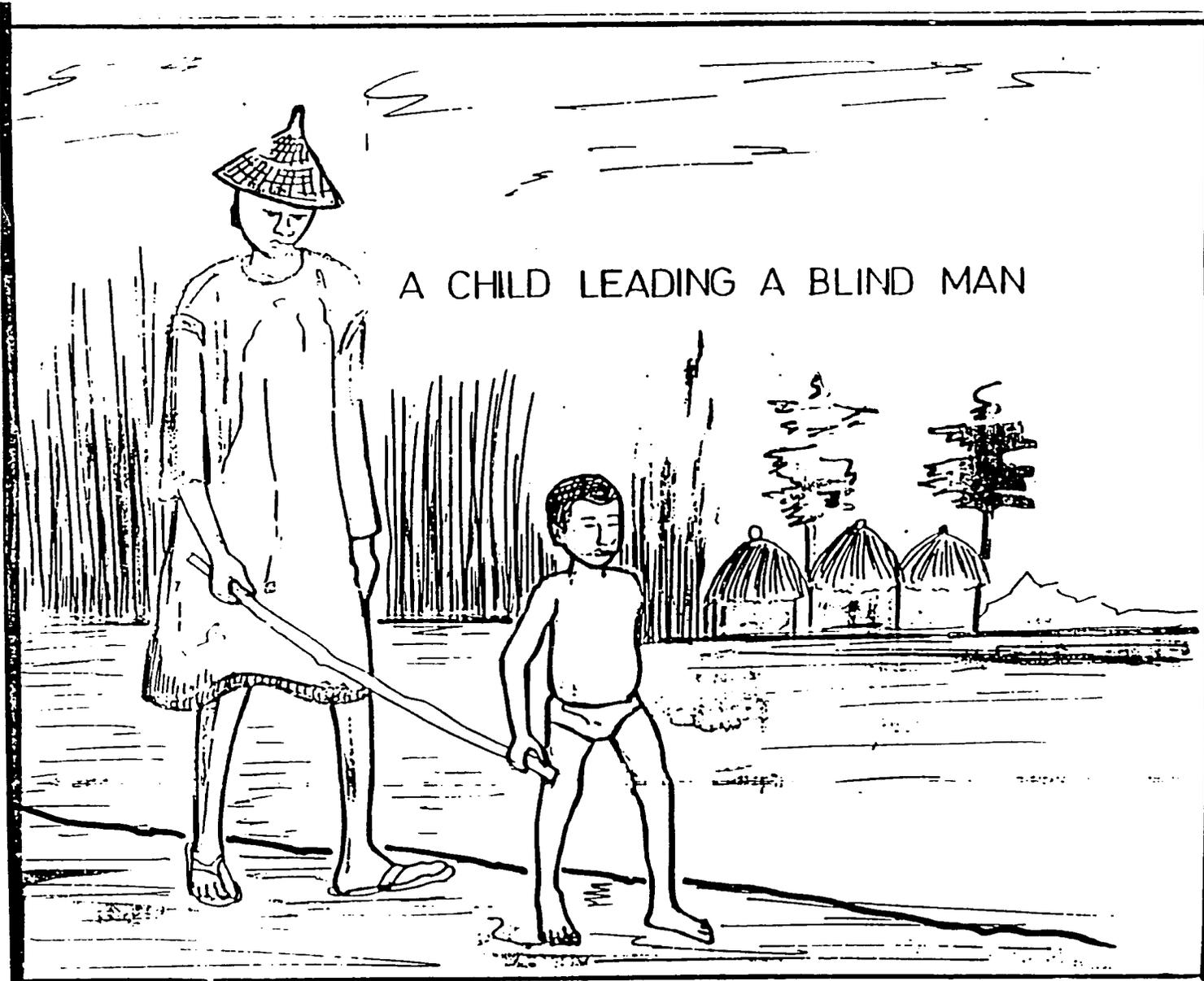








A FEMALE BLACK FLY FEEDING ON A MAN



A CHILD LEADING A BLIND MAN

Annex C-6

List of People Met: Trip 2

List of People Met: Trip 2

The Africare Ivermectin Delivery Program
in Adamawa and Taraba States, Nigeria
Trip No. 2
November 27 - December 15, 1992

LIST OF PERSONS MET

Mr. Aoudou Aba	Media Officer, ASMOI detached as media education advisor, Agricultural Development Prog.
Mr. Patrick Adah	KSBPP Project Assistant, Africare-Ilorin
Mr. Tunde Adewale	Kogi State IDP
Mr. Bakari S. Ahmed	Director of Post-Primary Education, ASMOE
Mr. David Ali	Taraba State Onchocerciasis Control Team Leader
Ms. Michel Recharb Bongri	Director General, Adamawa SMOH
Mr. Yuhana Chibila	Community Health Assistant, Ganye LGA (LOCW)
Hajiya Maryam A. Bakari	Adamawa State Commissioner for Health
Alhaji Dahuru "Bako"	Assistant PHC Coordinator for Disease Control, Taraba State
Mr. Gene Chiavaroli	Director, A.I.D.
Mr. E. M. Dah	Deputy Director, Adamawa State Post-Primary Schools Board
Mr. Wali Danyumo	Community Health Assistant, Taraba SOCT
Mr. Bukar Galadima	Team Leader, State Onchocerciasis Control Team, Borno State
Mr. Francis N. Gobara	Secretary and Acting Director, Yola State Arts Council
Alhaji Saadir Ali Gombi	Principal Rural Health Superintendent, detached to ATOP Health Education
Mr. Hickson Hellendendu	ATOP Project Assistant, Africare
Musa Hono Hussani	Health Educationist, PHC Department, Serti, Gahaka LGA
Ms. Regina Jediel	Community Health Assistant, Ganye LGA (LOCW)
Dr. Bode Kayode	Senior Lecturer, Health Education, University of Ilorin
Mr. Joseph T. Kwaj	Assistant Director of Information Services, ASMOI, Yola
Mr. Jonathan Lawrence	Garkida Hospital, EPI Clinic, Gombi LGA
Dr. Abdulla Mefruh	Africare ATOP Project Director, Yola
Mr. Timawus Mathias	Team Charade Communications, Ltd., Yola
Mr. Abubakar Mitchika	Director, Graphics Unit, ASMOI
Mr. Hussein Musa	Community Health Assistant, Africare-Yola
Dr. Ahmed Ibrahim Mustapha	Chief, Epidemiological Unit, Dept. of Communicable Diseases, ASMOH
Mrs. Fibi Nancy Nadah	President, National Council of Women's Societies, Adamawa State Branch
Dr. Isa H. Omar	Director of Communicable Diseases, Adamawa SMOH
Ms. Vandean Philpott	Deputy Country Representative, Africare-Lagos
Mr. Mark Smith	Administrative Officer, Africare-Lagos
Mr. Mohamed J. Sule	SMOE Director of Primary Education

Christopner Sulle

Mr. Jarvin Taboroso
Dr. J. Howard Teel
Mr. Maxwell Tillo
Mr. Rudi Thomas
Mr. DeWitt Webster

PHC Department, Sertu, Gashaka LGA, Taraba
State

Producer, Adamawa State Television
Country Representative, Africare-Lagos
Director of Information Services, ASMOI-Yola
Deputy Director, A.I.D.-Lagos
Health Program Officer, Africare-Lagos

Annex C-7

Schedule of Activities: Trip 2

Schedule of Activities: Trip 2

The Africare Ivermectin Delivery Program
in Adamawa and Taraba States, Nigeria
Trip No. 2
November 27 - December 15, 1992

SCHEDULE OF ACTIVITIES

- Nov. 27 Depart Dulles Airport, Washington
- Nov. 28 Arrive Lagos via Brussels
- Nov. 29 Arrival Ed Douglass, second team member (HEALTHCOM),
in Lagos Evening TPM
- Nov. 30 Meeting with J. Howard Teel, Country Representative,
Africare
Meeting with Vandean Philpott, Deputy Country Representa-
tive
Meeting with DeWitt Webster, Health Program Officer,
Africare
- Visit to A.I.D.-Lagos/arrival cable sent to A.I.D.-Washington
- Travel to Yola by air
- Dec. 1 Communications Planning Workshop preparation with Dr.
Abdalla Meftuh, Project Director, ATOP, and Hickson
Hellendendu, Africare Program Assistant
- Meeting with Dr. Ahmed Ibrahim Mustapha, Chief, Epidemi-
ological Unit, ASMOH and Workshop preparation continues
- Dec. 2 Meeting with Dr. Meftuh and Mr. Hellendendu
Meeting at SMOI with Joseph T. Kwaji, Assistant Director of
Information Services
Visit to Health Education Section, Epi Unit
Selection of Workshop site
Look at the Graphics Unit, SMOI

- Workshop preparation completed
- Dec. 3 Meeting with Dr. Isa H. Omar, Director of Communicable Diseases, ASMOH
- ATOP IDP Communications Planning Workshop, Day 1
- Dec. 4 ATOP IDP Communications Planning Workshop, Day 2
- Evening Video Presentation
- Dec. 5 ATOP IDP Communications Planning Workshop, Day 3
- Meeting of Select Planning Committee and Working Dinner
- Dec. 6 Breakfast Meeting with KSBPP team from Kwara and Kogi States on their Program Communication Plan
- Writing of ATOP Communications Plan
- Dinner with Dr. Meftuh and Hickson Hellendendu
- Dec. 7 Meeting with Chief Timawus Mathias, Team Charade Communications
- Meeting with Francis N. Gobara, Secretary and Acting Director, Yola State Arts Council
- Meeting with Mrs. Amina Kabir, Director, Better Life Programme, Adamawa State Women's Commission, Yola
- Meeting with Mrs. Fibi Nancy Nadah, President, Adamawa State Branch of National Council of Women's Societies
- Working session with Jonathan Lawrence, graphic artist
- Writing of Communications Plan
- Dec. 8 Meeting with Ms. Michel Recharb Bongi, Director General, Adamawa SMOH
- Meeting with Hajiya Maryam A. Bakari, Adamawa State Commissioner for Health
- Meeting with Dr. Isa H. Omar, Director of Communicable

Schedule of Activities: Trip 2

Diseases

Meeting with Dr. Ahmed Ibrahim Mustapha, Chief, Epidemiological Unit

Pre-test in Yola market of drawings by Jonathan Lawrence, graphic artist

Writing of Draft Communication Plan

- Dec. 9 Meeting with E. M. Dah, Deputy Director, Post-Primary Schools Board
Meeting with Joseph T. Kwaji, Acting Director, Information Services
Meeting with Mohamed J. Sule, Director of Primary Education
- Screening of IDP Video with Chief Mathias, Dr. Meftuh, Mr. Hellendendu
- Evening meetings with media and graphic artists: Idris, Charade Team Communications; Aoudou Aba, ASMOI and ADP, and Jarvin Taboroso, Adamawa State Television
- Writing of Draft Communication Plan
- Dec. 10 Follow-up meeting with Joseph T. Kwaji, ASMOI
Meeting and tour with Abubakar Mitchika, Director, Graphics Unit, ASMOI
Meeting with Bakari S. Ahmed, Director of Post-primary Education
- Completion of Draft Communication Plan
- Dec. 11 Submission of Draft Communication Plan
Travel from Yola to Lagos by air
Meeting with Mr. Mark Smith, Administrative Officer, Africare-Lagos
Meeting with J. Howard Teel, Country Representative, Africare

- Dec. 12 Meeting with Rudi Thomas, Deputy Country Director,
USAID-Lagos
Visit to British Airways to arrange travel for team members to
USA
USAID Christmas Party
- Dec. 13 Expansion of Draft Communication Plan
- Dec. 14 Meeting at US Embassy with Administrative Personnel
Meeting and lunch with J. Howard Teel
Debriefing at USAID with Dr. Teel, Rudi Thomas, Gene
Chiavaroli and submission of expanded Draft Communication
Plan
- Depart Lagos by air
- Dec. 15 Arrive Dulles via London

Annex C-8

Workshop on IDP Communication Planning - Agenda

Workshop on IDP Communication Planning - Agenda

ADAMAWA AND TARABA ONCHOCERCIASIS PROGRAMME

Workshop on IDP Communications Planning
Yola, Adamawa State, Nigeria
December 3 - 5, 1992

Purpose and Objectives

Purpose

The purpose of the workshop is to develop a communications plan. This plan will direct a set of communications activities to support the goals of the Ivermectin Distribution Programs of the Adamawa and Taraba States of Nigeria.

Objectives

1. To identify the target audiences who should receive information and persuasive messages about Mectizan and its ability to control the development of River Blindness, including the preceding stages of itching, leopard skin, lizard skin, and nodules.
2. To list and describe the desired behaviors which members of each target audience must perform in order to be free of River Blindness and all of its stages.
3. To create messages which will motivate members of the target audiences to engage in the desired behaviors.
4. To identify the channels of communication which can deliver the messages to the target audiences. These channels should be effective, affordable, available in the target area.

ADAMAWA AND TARABA ONCHOCERCIASIS PROGRAMME

Workshop on IDP Communications Planning
 Yola, Adamawa State, Nigeria
 December 3 - 5, 1992

Participants

Patrick Adah	Assistant Program Officer, Africare, Kwara State
Tunde Adewale	Project Assistant, Africare, Kogi State
David B. S. Ali	SOCT Officer, Bali LGA, Taraba State
Alhaji Dahuru Bako	Asst. PHC Coordinator, Bali LGA, Taraba State
Yuhana Chibula	PHC Department, Ganye LGA, Adamawa State
Wali Danjuma	SOCT, Taraba State
Bukar Galadima	Leader, SOCT, Borno State
Dāūda Hassan	PHC Department, Serti, Gashaka LGA, Taraba State
Hickson Hellendendu	Assistant Project Officer, ATOP, Yola
Musa Hono Hussani	Health Educationist, PHC Department, Serti, Gashaka
Regina Jediel	LOCT, Ganye LGA, Adamawa State
Sode Kayode	Senior Lecturer, Health Education, Univ. of Ilorin
Jonathan Lawrence	Garkida Hospital, EPI Clinic, Gombi LGA, Adamawa
Abdalla Meftuh	Africare ATOP Project Director
Christopher Sulle	PHC Department, Serti, Gashaka LGA, Taraba State
Edward Douglass	Workshop Facilitator, HEALTHCOM
Deirdre LaPin	Workshop Facilitator, VBC

Workshop on IDP Communication Planning - Agenda

ADAMAWA AND TARABA ONCHOCERCIASIS PROGRAMME

Workshop on IDP Communications Planning
Yola, Adamawa State, Nigeria
December 3 - 5, 1992

Agenda

3 December (Thursday)

- 0900 Welcome and Introductions
- 0930 Communications Support for the IDP (with video presentation)
- 1100 Coffee Break
- 1115 Lessons Learned from Previous Workshop on IEC Research Methods
- 1145 Review of Research Results to Support Communications Planning
- 1230 Lunch at Verayo Restaurant
- 1400 Identifying and Defining the Target Audiences
- 1500 Listing Desired Behaviors for Each Target Group (Group Work)
- 1600 Presentations of Group Work
- 1700 Close

4 December (Friday)

- 0900 Developing Messages for the Selected Target Audiences
- 1000 Developing Messages (in Three Groups, one for each Target Audience)
- 1100 Coffee Break
- 1115 Development of Messages, continued
- 1230 Lunch at Verayo Restaurant
- 1400 Presentation and Critique of Messages
- 1530 Choosing and Justifying Communication Channels
- 1600 Getting Messages to the Target Audience (Group Work)
- 1700 Group Presentations
- 1800 Screening of Dakka IDP video; rescreening of "Partnership for Child Survival"

ADAMAWA AND TARABA ONCHOCERCIASIS PROGRAMME

Workshop on IDP Communications Planning
Yola, Adamawa State, Nigeria
December 3 - 5, 1992

Agenda, cont.

5 December (Saturday)

- 0900 Rounding Out the Communications Strategy: Adding Tools, Tone, and Timing
- 1000 Refining the Communications Strategy for Three Target Audiences (Group Work)
- 1100 Coffee Break
- 1115 Refining the Communications Strategy, continued
- 1200 Lunch
- 1330 Prepare Group Presentations
- 1430 Presentations of the IDP Strategies for each Target Audience
- 1600 Close

Annex C-9

**Five Essential Steps to
Effective Public Health Communication**

Five Essential Steps to Effective Public Health Communication

ADAMAWA AND TARABA ONCHOCERCIASIS PROGRAMME WORKSHOP ON ICP COMMUNICATIONS PLANNING

Five Essential Steps to Effective Public Health Communications

Definition: Public health communications provides a strategy for planning and conducting long-term programmes to produce specific, sustained behaviour change in large target populations.

Proven Effectiveness: A five-step process has been used world-wide, including Nigeria, with great success. The process is not a linear one, but a cyclical one - the results of experience are fed back into and shape subsequent action.

Partnership: The process must be a collaborative, cooperative activity between programme people concerned with the treatment of at-risk and infected individuals and the people who communicate to the people so that they all come for treatment, for the first time and every year thereafter.

Sustainability: The process must be institutionalized. USAID, VBC, HEALTHCOM, and Africare must leave behind staff in the ministries and the private sector who have the ability to develop and deliver a continuous public health communications programme.

The Five Steps

Assess - The essential components of the Assessment step:

Health Problem Analysis

- Epidemiological analysis
- Behaviour analysis: What are people doing now? Which behaviours are useful? Which ones not?
- What is the local behaviour pattern which would lessen the health problem?

Developmental Research

The Research Agenda - set in order to understand the

target audience (orientation to the consumer), the capacity of the health providers, the capacity of service delivery systems, and potential communication channels. Also, developmental research aids health communication planners to establish measurable objectives and realistic strategies for the communication programme.

- Collecting Data: Techniques typically used (quantitative and qualitative methods):
- Setting Program Objectives - realistic and measurable (that is, quantifiable)

Plan

The plan for any health communication strategy is based on the findings of the preceding step, Assessment. The plan can be made up of the following components.

- Audience segmentation - which are the primary, secondary, and tertiary target audiences?
- Product strategy - The "product" can be a commodity, an idea, or a health practice.
- Behaviour strategy - Developing an "ideal" behaviour pattern for target audience(s).
- Distribution and Training strategy
- Message and Creative strategy
 - Content: What is to be said to each target audience?
 - Appeals: Emotional, rational, educational, motivational, hard sell, soft sell, scientific, traditional
 - "Image:" Rural, urban, modern, traditional, sophisticated, folksy
 - "Tone:" Humorous, serious, family-oriented, scientific, etc.
 - Source of Information: Credible sponsor
 - Message integration (consistency)
- Media channels strategy
- Structure for institutional delivery

Five Essential Steps to Effective Public Health Communication

Pretest

Pretesting is done to find out if the communication is understood by the audience in the way you intended. Materials are tested on the target audience (NOT on health professionals)

- Product testing.
- Market testing.
- Behaviour trials.
- Materials pretesting

Writing the Operational Plan.

Deliver

Production

Distribution

Media activities

- Delivery of messages
- To target audiences
- With planned repetition
- With planned, coordinated use of the various media
- Using face-to-face, print, and mass media.

Products and services

Interpersonal support

Training

Monitor

Monitoring

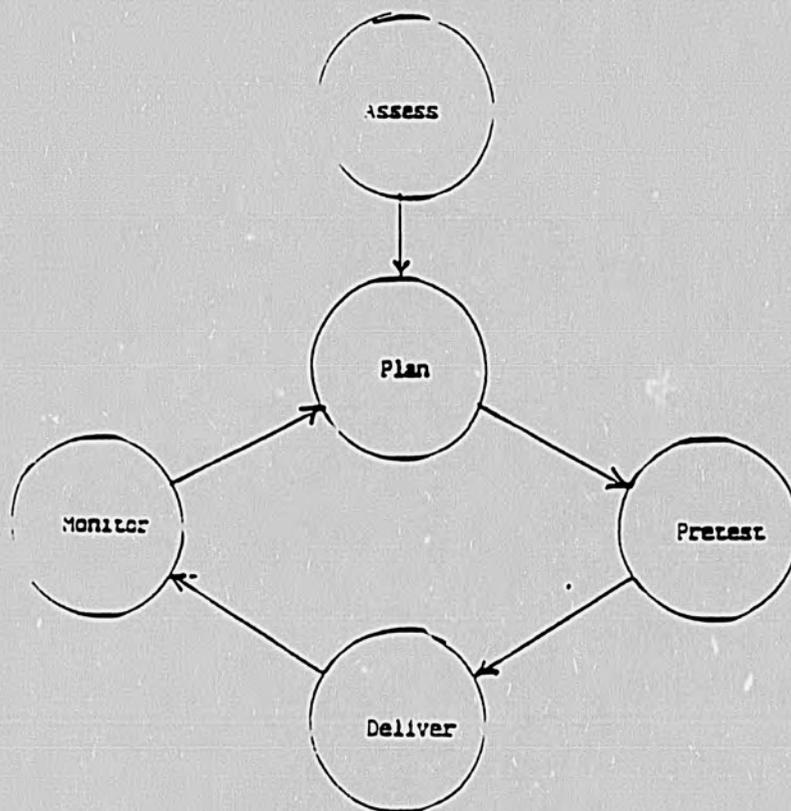
Mid-course corrections

Evaluation

DAMAWA AND TERABA UNCHOCEREBRALS PROGRAMME
WORKSHOP ON TOP COMMUNICATIONS PLANNING

The Four-Step Method to Effective Communication

Health communication is a two-way process that investigates audience perceptions, values, and needs and uses these to design programmes which in turn inform and motivate positive changes in behaviour."



Annex C-10

**"Pros and Cons of Different Media, Materials
and Techniques for Communication Projects"**

"Pros and Cons of Different Media, Materials
and Techniques for Communication Projects"

PROS AND CONS OF DIFFERENT

MEDIA, MATERIALS AND TECHNIQUES FOR COMMUNICATION PROJECTS

- A. People Based
- B. Mass Media
- C. Other Media and Materials

A. PEOPLE BASED	MAIN ADVANTAGES	MAIN DISADVANTAGES	COMMENTS
1. Public meetings and lectures	Easy to arrange. Reach many people. Can have more than one speaker. Create public interest and awareness. Stimulate follow-up discussion.	Audience is usually passive. Speakers may not understand audience's needs. Difficult to assess success. Audience might not learn the main points.	Handouts should be used. Presentation should be clear. Use visual aids when possible. Audience should be encouraged to raise questions and to participate. Speaker should establish two-way communication.
2. Group discussion.	Build group consciousness. Individual members of the group can understand where each member stands in regard to the discussed issue. Provide chances for exchanging opinions and increase tolerance and understanding.	Some members may dominate. Sometimes difficult to control or to keep focusing on the main issue. Requires trained leaders.	Should be used with an interested audience to discuss a definite problem. Procedure should be flexible and informal. Summary of discussion should be presented at the end of discussion. Decision should be made by group members regarding its stand on the issue discussed. Requires the selection of good chairman.

Source: This is largely based on Shavki M. Barghouti, Reaching Rural Families in East Africa, Nairobi: FAD Programme for Better Family Living in East Africa, 1973. Other specialists have developed similar tables. Differences in opinion exist on such matters: this Annex should therefore not be viewed as prescriptive or 100 percent accurate in all project situations. Some additions have been made.

(Prepared by Phyllis T. Piotrow)

A. PEOPLE BASED	MAIN ADVANTAGES	MAIN DISADVANTAGES	COMMENTS
3. Role playing	Facts and opinions can be presented from different viewpoints especially on controversial issues. Can encourage people to reevaluate their stand on issues and can invite audience participation. Deepens group insight into personal relations.	Cannot be used in community meetings. Some role-players may feel upset by playing a role they do not agree with. Requires careful preparation for the selection of the issue and actors. Careful preparation is essential.	Can only be used in training courses. Follow-up discussion should focus on the issue rather than on actors' performances. Source material about the issue should be provided to the actors to prepare their arguments.
4. Drama	Groups can be active "learning by doing". Can attract attention and stimulate thinking if situations are effectively dramatized.	Actors require attention in training and preparing script. Preparations might be too difficult for the field worker. Difficult to organize because it requires considerable skills and careful guidance by the field worker.	Should be restricted to one issue. Can only be used during training courses. Can be used as entertainment before a public meeting if well prepared.
5. Case study	Can illustrate a situation where audience can provide suggestions. Can elicit local initiative if the case corresponds to local problems.	Difficult to organize. Rewording of events and personalities might reduce the effectiveness of the case. Some audiences may not identify themselves with the case.	Should be clearly prepared. Can be used in training course. Questions and discussions should lead to recommendations for audience action. Audience should be encouraged to prepare case studies relevant to its experience.

"Pros and Cons of Different Media, Materials and Techniques for Communication Projects"

A. PEOPLE BASED	MAIN ADVANTAGES	MAIN DISADVANTAGES	COMMENTS
6. Home visits	Establish good personal relationships between field workers and families. Can provide information about families that cannot be collected otherwise. Encourages families to participate in public functions, demonstrations and group work.	Field worker usually cannot visit every family in the community. Only families in accessible localities can be visited.	Records should be kept for families visited. Schedule of home visits should be developed to assure allocation of time for field work activities. Hand-outs should be given to the families visited.
7. Demonstration (with a small group)	Participants can be active and learn by doing. Convinces the audience that things can easily be done. Establishes confidence in field worker's ability.	Requires preparation and careful selection of demonstration topic and place. Outside factors can affect demonstration results and consequently might affect confidence in field worker.	Demonstration processes should be rehearsed in advance. Audience should participate in the demonstration. Educational materials should be distributed to the participants at the end of the demonstration.

3. MASS MEDIA	MAIN ADVANTAGES	MAIN DISADVANTAGES	COMMENTS
1. Radio	<p>Radio technology available in all countries and can reach mass audiences cheaply. Receivers are inexpensive and available in the remotest communities. Messages can be repeated at low cost. Easy to reach illiterate audience. Can be used to support other channels of communication. Efficient to announce events and development activities, and, if properly used, can mobilize audience to participate in public events and projects of value to the community. It is flexible, and style can include drama, lectures, folklore songs, interviews and variety shows. Excellent in regular teaching and out-of-school correspondence courses. Radio is effective in creating awareness and setting agenda of priorities for people's attention.</p>	<p>One-way channel. Complicated technical issues are difficult to illustrate. Audience reaction, participation or interest in messages delivered, difficult to assess. Requires special skills and continuous training of radio personnel. Content may not be tailored to small communities and tends to be general in nature and is usually prepared for national audience, or special ethnic or language group thus reducing relevance to local problems. Difficult to use material broadcast as a reference without investment in radio documentation. Texts of radio programs are usually needed for effective follow-up. This is not always possible. Gatekeepers control content on controversial issues.</p>	<p>Radio messages should often be supported by personal follow-up. Radio effectiveness increases if messages used in group discussions (e.g., farm forums) or regular training courses. Desirable for radio to cover local events. assist in explaining and promoting local projects and development efforts. Programming should maintain balance between national and local coverage, interviews and lectures, news and profile coverage of development issues. Entertainment value of songs, dramas. variety shows can be potent in changing KAP. For behavior change, specific messages are needed.</p>

"Pros and Cons of Different Media, Materials and Techniques for Communication Projects"

B. MASS MEDIA	MAIN ADVANTAGES	MAIN DISADVANTAGES	COMMENTS
2. Television	<p>Its novelty attracts audience and can be the main attraction in rural communities. Can be used to explain complicated messages because of its combination of sound and picture. Programs can be repeated at reduced cost. It is suitable for mix presentation of issues. Suitable for motivation through utilization of folklore art and music, community events, and animated public speeches and debates. Efficient in bringing issues to public attention, and powerful in setting public agenda for action and participation in development effort. Successful in creating awareness. Suitable for illiterate audiences if they have access to receivers or to TV clubs. Enter-Educate approach provides role models and stimulates interest, emotions, commitment to change attitudes and behavior.</p>	<p>Expensive to operate. Receivers not available in many rural areas and among poorest population groups. Has traditionally been used for entertainment and politics more than for development and educational purposes. Programming skills were likely to be available for entertainment. Educational programs may face severe competition from entertainment. No audience participation. Present state of technology in many developing countries does not allow immediate coverage or timely relay of local community actions and events. Requires more planning and preparation, and technical, creative, and communication skills than other media. Difficult to use material televised as a reference without investment in television documentation. Texts of television programs are needed for follow-up. This is not always possible.</p>	<p>Local television stations can play important role in development. More educational training is required for staff. Easy to exchange information and programs are scheduled in advance, well-documented, with heavy involvement of and focus on local problems. Very effective for activating group learning when used in viewing centers or as part of multi-media campaign for education-information and motivation. Combining entertainment - education enhances impact. Gatekeepers and policy-makers must be persuaded to include controversial issues.</p>

B. MASS MEDIA	MAIN ADVANTAGES	MAIN DISADVANTAGES	COMMENTS
3. Newspapers	<p>Can provide detailed information. Easy to present technical data in clearly designed text. Important topics can be covered in a series of articles. Can influence the attention of audience by where they place information and on what page. Influential in creating awareness and mobilizing public opinion. Material published can be shared and used as reference. Can be used to support radio and television for education purposes and follow-up on lessons, issues and topics discussed by the other two media.</p>	<p>It can be used by literates only. Difficult to reach isolated communities. Can be expensive for poor families. Requires special writing and editing skills, which are not always available. Like all other mass media, it is one-way communication channel. Feedback is difficult because of audience reluctance or inability to contact the editor. Difficult to publish at regional level. Small communities can not afford to publish their own newspapers without continuous support from national government.</p>	<p>Best source of information if topics of development are covered on regular basis. Can be used to establish community local papers and bulletin boards. Can be circulated to community members to reduce cost per individual family. Could be used to support literacy classes: sections could be prepared especially for poor readers and semi-literates.</p>
4. Cinema	<p>Captures attention well. Reaches big audiences in selected countries and can be very cheap (particularly with semi-permanent and traveling cinemas). Can reach lowest strata in certain countries and even have large rural audience.</p>	<p>Is expensive in some countries and may only reach certain sub-groups in the target audience (such as the rich, youth, females). Distribution can be a problem. May be distracting setting for educational messages. Audience feedback difficult.</p>	<p>Great care must be taken in preparing the film clips.</p>

"Pros and Cons of Different Media, Materials and Techniques for Communication Projects"

8. MASS MEDIA	MAIN ADVANTAGES	MAIN DISADVANTAGES	COMMENTS
5. Folk theater	Culturally relevant. In some countries is easily available and inexpensive. Often more credible to the traditional elements of society than the modern media.	Can lose control of the message. Format can distract from content. Difficult to monitor.	Flexibility of the form can vary from country to country. One of the best uses is often a combination with a modern medium such as television, radio, or supported by loudspeakers.
6. Wall paintings Billboards	Potentially available to large audience. Low costs per person reached if well located.	Can be easily ignored. Limited to simple messages.	Message must be extremely well designed and pre-tested. Siting is critical to be able to reach the kinds of people intended.
7. Mass media group listening	Combines mass media and personal channels. Can be prepared and used for many audiences over a period of time. Encourages group participation.	Requires preparation for recruiting groups, training group leaders, and preparation of educational material. Can be expensive. Dropout can be a problem if special efforts are not made.	Should be regularly held. Participants should be provided with educational material. Can be effective in enforcing literacy and adult education. Programs selected should be about local problems. Tape recorders can be used. They are flexible. Can be used to tape role-playing, group discussion and interviews with local personalities.

C. OTHER MEDIA AND MATERIALS	MAIN ADVANTAGES	MAIN DISADVANTAGES	COMMENTS
1. Publications and Loose Leaflets	Excellent for in-depth presentation of issues and technical information. Can cover more than one topic. Easy reference and can be directed to specific audiences. Can be illustrated and made attractive. Can support other media for education purposes.	Expensive. Can only be effective if well designed and produced. Poorly printed publications may be less expensive but not be read. Require special editing, design and production skills. Distribution can be difficult and expensive.	Should be used to support special campaigns, such as literacy and adult education. Most useful if topics are covered in series of publications. Could be used successfully in group discussions and as back up for public meetings. Can also be used for in-service training of field staff and to keep up morale particularly if field staff are widely dispersed.

"Pros and Cons of Different Media, Materials and Techniques for Communication Projects"

C. OTHER MEDIA AND MATERIALS	MAIN ADVANTAGES	MAIN DISADVANTAGES	COMMENTS
2. Video (Forum)	<p>Can be used to introduce new ideas to selected audiences. Excellent tool for micro-teaching. Can introduce complicated concepts and technical issues in a series of presentations; can record field operations and activities and use them on numerous occasions; can be used to teach skills and change attitudes. Feedback to the broadcaster can be immediate and relatively accurate. Can be handled by model farmers and community leaders; can build useful libraries for teaching in the case of literacy and adult education classes.</p>	<p>Is expensive. Forum members tend to drop out. Breakdown in hardware is common, and batteries are exhausted. Forum requires highly skilled personnel and extensive hardware. Restricted to communities where trained field agents are available. Requires continuous servicing and maintenance and updating. Can become negative tool for development if fails to attract different sub-groups in the community (such as the poorest and religious or racial minorities). Sometimes because of difficulty in finding needed materials or training manpower, many events in the community go by without being recorded or utilized.</p>	<p>Forums require continuing attention from professional organizers. Most successful in small group learning. Group discussion leaders must be carefully selected and trained. Training materials and programs must be carefully organized and kept in order. Its efficiency increases if used in combination with booklets and handouts at the end of the discussion. Should be used to teach special skills, for structured instruction and where possible, as a tool to generate participation among a rural community or one that is for other reasons isolated from ongoing programs or slow to cooperate.</p>

C. OTHER MEDIA AND MATERIALS	MAIN ADVANTAGES	MAIN DISADVANTAGES	COMMENTS
3. Films	Use of sight and sound can attract audience's attention. Can make great emotional appeal to large audiences.	Good films are rare. Equipment costly to buy and maintain. Is one-way communication unless special measures are taken. Requires skill in running film projectors.	Best if combined with discussion groups. Much work to be done regarding getting good films made. Attention should be given in getting audience to evaluate the film. Films should be used for stimulating discussion rather than for teaching alone.
4. Filmstrips	Much cheaper and easier to work than films. Easily made from local photographs. Encourage discussion.	Usually sight only. Not so dramatic as motion pictures. Could be expensive.	Can have recorded commentary. Strip can be cut up and individual pictures mounted as 2" slides; then can be selected and re-arranged.
5. Slides	Have all the advantages of film strips plus more flexibility and can be more topical. They can be used in a series to illustrate a concept.	Could be expensive. Difficult to have them on all subjects of teaching.	They should be used after careful preparation of logical sequence and a good commentary.
6. Flannelboard	Can be portable and mobile. Can be prepared by expert in advance. Little skill required in actual operation. Could be used to make presentation more dynamic.	Can only be used for what it is prepared. Cannot adapt to changing interest of group. More elaborate than ordinary blackboard. Difficult to keep up-to-date.	Very useful but only for the prepared talks. Audience can participate. It should be used step-by-step. Flannel materials should be stored properly for future use. Flannelgraphs should be numbered according to their order in the presentation.

"Pros and Cons of Different Media, Materials
and Techniques for Communication Projects"

C. OTHER MEDIA AND MATERIALS	MAIN ADVANTAGES	MAIN DISADVANTAGES	COMMENTS
7. Bulletin board	Striking, graphic, informative, flexible, replaces local newspapers. Keeps community up-to-date with information.	Requires preparation and attention to community needs	Should be combined with maps, talks and photographs. Very suitable for posting articles, announcements and news of development in the community.
8. Flip charts (turnover charts)	Cheap and simple. Can be stopped at will for analysis. Can be prepared locally. Ideas could be illustrated in sequence. Illustrations on flip chart could be used many times for different audiences in different sessions.	Soon torn. Can only be seen by a few at a time. Can be difficult to illustrate complicated ideas.	Should not be overlooked for illustration of simple sequences - especially with small groups. Lectures should be prepared in advance for use on several occasions.
9. Models, exhibitions and displays	Appeal to several senses. Can be used in various occasions and situations. Can illustrate ideas in detail.	Not many workers can build them or use them properly.	Useful models and exhibitions could be built up locally. Should be used in familiar places - centers.
10. Maps, charts, diagrams	Visual appeal. Should simplify details. Permit leisurely study: Can develop sequence on display boards.	May mislead by over-simplicity. Create transport and storage problems.	Should be made especially for groups. May need careful explanation at first. Could be used as summary of information. Symbols and layout should be familiar to the audience.

C. OTHER MEDIA AND MATERIALS	MAIN ADVANTAGES	MAIN DISADVANTAGES	COMMENTS
11. Blackboard	A flexible tool. Easy to make and to use. Can be very attractive if used properly. Use of colored chalks can add to its visual appeal. Can be portable.	Requires some manipulation skill (though quickly acquired). Requires teaching skills to make best use.	Should be essential in every group. Very useful for schematic summaries or talk or discussion. Audience can participate. Small blackboards can be portable. Writing should be clear and organized.

Annex C-11

**Final Workshop Products:
Communication Planning Schemes**

Final Workshop Products:
Communication Planning Schemes

COMMUNICATIONS PLANNING SCHEMA
TARGET AUDIENCE: COMMUNITY

TARGET AUDIENCES	MESSAGES	BEHAVIORS	CHANNELS	TOOLS
(1) All community members	<p>(1) Ivermectin Prevents Blindness due to River Blindness and controls other signs of the disease such as:</p> <ul style="list-style-type: none"> * prolonged intensive itching * leopard skin * lizard skin * nodules <p>(2) Take ivermectin once a year every year</p> <p>(3) Additional benefits of ivermectin include:</p> <ul style="list-style-type: none"> * deworming * end to deterioration of vision * increased energy and productivity * promotion of appetite * improved appearance and texture of the skin 	<p>(1.1) Recognize onchocerciasis as a disease entity and associate it with ivermectin treatment</p> <p>(1.2) Take ivermectin and demand annual re-treatment</p>	<p>Print media</p> <p>Inter-personal</p> <p>Traditional</p> <p>(Mass electron. media)</p>	<p>Handbills Posters</p> <p>Talks</p> <p>Dance Drama Song Stories</p> <p>(Radio Video)</p>
<p>(2) Community leaders</p> <ul style="list-style-type: none"> * council * religious leaders * teachers * health workers 	<p>(4) Ivermectin is an improved drug:</p> <ul style="list-style-type: none"> * it requires only one dose from 1/2 to 2 tablets once a year according to body weight * it has fewer side effects (than Banocide), which last for a short period of time (2-3 days) * not everyone experiences the side effects, and they diminish from year to year as the worm load in the body decreases * people should not take ivermectin if they weigh <15 kilos, are very ill, are pregnant, or have given birth <8 days previously; such people should take ivermectin the next time it is available. 	<p>(2.1) Mobilize members of the community for IDP activities</p> <p>(2.2) Sustain high levels of awareness and demand (80% of community members eligible)</p>		

COMMUNICATIONS PLANNING SCHEMA
TARGET AUDIENCE: POLICY MAKERS

TARGET AUDIENCES	MESSAGES	BEHAVIORS	CHANNELS AND TOOLS																									
<p>All policy makers, especially</p> <ul style="list-style-type: none"> * PHC coordinators * LGA chairmen * Members of LGA council * State level decision makers, e.g. commissioners and ministers of social services and key decision makers in the health ministries * Leaders and members of NGOs (e.g. Rotary) * Key advocates and philanthropists * Traditional rulers, including emir, seriki, etc. * Religious leaders at state and regional levels 	<p>(1) All basic messages given to the community of beneficiaries, especially the key messages:</p> <p>(a) Ivermectin Prevents Blindness due to River Blindness and controls other signs of the disease such as:</p> <ul style="list-style-type: none"> * prolonged intensive itching * leopard skin * lizard skin * nodules <p>(b) Take ivermectin once a year every year</p> <p>(2) Additional messages include:</p> <p>(a) River Blindness is a significant public health problem in your area and reduces the general health and welfare of your people;</p> <p>(b) blindness and other signs of R.B. are preventable through the IDP;</p> <p>(c) R.B. affects the economy of your LGA(s) and is a worthy investment for the state and local government;</p> <p>(d) the IDP requires an annual budget commitment for at least 15 years</p>	<p>(1) Participatory planning and promotion</p> <ul style="list-style-type: none"> * Project accords * Memoranda of understanding <p>(2) Provide</p> <ul style="list-style-type: none"> * funds * health staff * logistics <p>(3) Monitor NGO, gvt. staff</p>	<p>(1) Interpersonal communication:</p> <ul style="list-style-type: none"> * Visits to LGA chairman, PHC coordinator, LGA Council, etc.; * presentations of printed materials and proposals; * participation in in-house evaluations of the ATOP program. <p>(2) Print materials:</p> <ul style="list-style-type: none"> * copies of reports; * handbills, flyers, other health education materials; * information packet, containing such information as - - value of collaboration - financial contribution, e.g. <table border="1"> <thead> <tr> <th></th> <th colspan="4">Year</th> </tr> <tr> <th></th> <th>1</th> <th>2</th> <th>3</th> <th>4</th> </tr> </thead> <tbody> <tr> <td>NGO</td> <td>75%</td> <td>50%</td> <td>30%</td> <td>-</td> </tr> <tr> <td>LGA</td> <td>15%</td> <td>25%</td> <td>35%</td> <td>75%</td> </tr> <tr> <td>State</td> <td>10%</td> <td>25%</td> <td>35%</td> <td>25%</td> </tr> </tbody> </table> <ul style="list-style-type: none"> - cost/benefit analysis - assistance with fund raising from NGO sources and individuals <p>(3) Video</p> <p>To show at time of visit to DMS: themes stress the impact of R.B. on the area</p>		Year					1	2	3	4	NGO	75%	50%	30%	-	LGA	15%	25%	35%	75%	State	10%	25%	35%	25%
	Year																											
	1	2	3	4																								
NGO	75%	50%	30%	-																								
LGA	15%	25%	35%	75%																								
State	10%	25%	35%	25%																								

Final Workshop Products:
Communication Planning Schemes

COMMUNICATIONS PLANNING SCHEMA
TARGET AUDIENCE: HEALTH PROMOTERS (Health Worker s)

TARGET AUDIENCES/ OBJECTIVES	BEHAVIORS	MESSAGES	CHANNELS AND TOOLS
(1) Training of health workers and other health promoters: * Increase knowledge of the benefits of ivermectin	Inform and educate users of ivermectin at every opportunity Inform and educate the policy makers about ivermectin	Ivermectin prevents blindness due to RB and controls other signs of the disease such as intensive and prolonged itching, leopard skin, lizard skin, nodules.	Interpersonal channels: * 2-way discussion using training manuals designed for IDP health education (including information on strategies for interpersonal communication and delivering health education talks) * scientific information on RB: * communications tools developed for the other target audiences (community policymakers) * samples or illustrations of the drug
(2) Training HWs and other HPs: * to encourage HWs to promote and sustain IDP activities at community level * to increase HWs' communications and mobilization skills.	Motivate HWs in order to ensure the use of ivermectin by the people Ensure commitment of the policy makers to IDP	(For trainee HWs) Promote and sustain demand for ivermectin in your area Use health education and communication materials at every opportunity (To Policy Makers) Promote and sustain supply of ivermectin for IDP.	* (if possible) samples of the blackfly and a microscopic demonstration of microfilariae in a skin snip * (for talks to policy makers) role plays and sample social marketing strategies * sample dramas, skits, or songs that communities may learn to promote IDP and positive knowledge of and attitudes toward RB control.

Annex C-12

**Meeting Invitation:
Presentation of Community Plan
for Ivermectin Delivery**

Meeting Invitation: Presentation of Communication
Plan for Ivermectin Delivery



"Improving the quality of life in rural Africa through the development of
water resources, increased food production and the delivery of health services"

Africare

Washington
Headquarters:-
440 R. ST N. W.
Washington D. C. 20001
Tel: 202-482-3614
Telex: No 64232

Nigeria Headquarters:-
45, Ademola Street,
Ikoyi S. W. Lagos
P. O. Box 62833,
Festac.
Tel: 685400.

ADAMAWA AND TARABA STATES ONCHOCERCLASIS
CONTROL PROGRAM
PRESENTATION OF HEALTH COMMUNICATION PLAN
FOR IVERMECTIN DELIVERY

To: _____

Ministry of health and Africare cordially invites you to attend a
session on presentation of Health Communication Plan for Ivermectin
Delivery Program (River Blindness Control) in Adamawa and Taraba
States by USA based consultants: Dr. Deirdre LaPin and Dr. Edward
Douglass.

Venue: State Ministry of Health
Conference Hall.

Date: December 11, 1992

Time: 10:00am

Please endeavor to attend.

Dr. Abdalla Meftuh
Project Adviser,
Africare/Adamaw and Taraba
River Blindness Control Project.

FM:COMM-27.2
December 1992

Annex C-13
Test Sketches

Test Sketches





Test Sketches





Test Sketches





Test Sketches



Annex D-1

List of People Met: Trip 3

The Africare Ivermectin Delivery Program
in Adamawa and Taraba States, Nigeria
Trip No. 3
January 23 - February 9, 1993

LIST OF PERSONS MET

Mr. Thomas Abbia	Information Systems Specialist, Africare-Lagos
Chief Bashorun Abiola	Philanthropist, businessman, Presidential hopeful
Mr. Oladele Benjamin Akogun	Africare BOP Project Director, Biu, Borno State
Mr. David Ali	Taraba State Onchocerciasis Control Team Leader
Mr. Gene Chiavaroli	Director, A.I.D.
Mr. J. P. Dangoji	Health Educator, State Epidemiological Unit, TSMOH
Dr. Bode Kayode	Senior Lecturer, Health Education, University of Ilorin
Mr. Maxwell Kekene	Health Educator, State Epidemiology Unit, ASMOH
Ms. Susan Kren	Representative, PCS Project, Lagos
Mr. Jonathan Lawrence	Garkida Hospital, EPI Clinic, Gombi LGA
Dr. Abdalla Meftuh	Africare ATOP Project Director, Yola
Mr. Abubakar Mitchika	Director, Graphics Unit, ASMOI
Dr. Ahmed Ibrahim Mustapha	Chief, Epidemiological Unit, Dept. of Communicable Diseases, ASMOH
Chief D. S. Nyapuru	Chairman/Managing Director, Nyapuru Printing and Packaging Industries, Ltd.
Mr. Joseph Okome	Lecturer, University of Port Harcourt and contributing journalist, <u>Taraba Insight</u>

Dr. Isa H. Omar

Dr. J. Howard Teel
Mr. Michael Timbulu
Mr. Rudi Thomas
Mr. DeWitt Webster

Director of Communicable Diseases,
Adamawa SMOH
Country Representative, Africare-Lagos
Graphic Designer, ASMOI, Yola
Deputy Director, A.I.D.-Lagos
Health Program Officer, Africare-
Lagos

Annex D-2

Schedule of Activities: Trip 3

The Africare Ivermectin Delivery Program
in Adamawa and Taraba States, Nigeria
Trip No. 3
January 23 - February 9, 1993

SCHEDULE OF ACTIVITIES

- Jan. 23 Depart Dulles Airport, Washington
- Jan. 25 Arrive Lagos via London [12 hour delay owing to engine malfunction]
Meet Howard Teel, Africare re: Preparations for Yola visit
Meet Susan Kren, PCS project re: printing and contract guidelines for Nigeria
- Jan. 26 Meet Gene Chiavaroli, USAID Director
Afternoon TFiM
Travel to Yola by air
- Jan. 27 Meeting with Abdalla Meftuh
Meetings with Dr. Ahmed Ibrahim Mustapha, Chief, Epidemiological Unit, ASMOH and Dr. Isa H. Omar, Director of Communicable Diseases
Visit to Team Communications, Ltd., Yola (Chief Mathias away)
Visit to the Graphics Unit, Ministry of Information
Working Session with Abdalla Meftuh on portions of the Information Packet for Decision Makers (DLP)
- Jan. 28 Graphic Design Training I: Introduction and Assessment (MCDV)
Meetings with Abdalla Meftuh and Dr. Benjamin Akogun, Africare director of the BOP (DLP)
Research for Information Packet (DLP)
Preparation of Specifications for Estimates on Printed Materials (MCDV/DLP)

Schedule of Activities: Trip 3

- Jan. 29 Graphic Design Training I, cont. (MCDV)
Visit to 5 area printers and presentation of Invitations to Bid (DLP)
Research for Information Packet, cont. (DLP)
- Jan. 30 Graphic Design Training I, cont. (MCDV)
Discussions with area printers, cont. (DLP)
Visit to Nyapuru Packaging and Printing (MCDV/DLP/design trainees)
- Jan. 31 Preparation of Creative Meeting
SOW for IEC Section of ATOP Training Manual developed
- Feb. 1 Creative Meeting
Compilation of printing bids submitted
SOW for Training Manual approved by AM
- Feb. 2 Graphic Design Workshop 2: Materials Preparation (MCDV)
Travel by air for one day to Lagos for meeting with Bode Kayode, Submission of SOW to Africare-Lagos, and Faxing Bids to VBC (DLP)
- Feb. 3 Graphic Design Workshop 2, cont. (MCDV)
Development of Drama Component for ATOP Communications Plan (DLP)
- [Strike of All State Government Civil Servants Begins]
- Feb. 4 Graphic Design Workshop 2, cont. (MCDV)
Development of Drama and Festival Component, cont. (DLP)
Arrangements for Pre-testing mock-ups of 2 flyers and Logo (MCDV/DLP)
Writing of Drama and Festival Component (DLP)

- Feb. 5 Visit to Federal Surveys Office in search of recent maps (DLP)
Pre-testing mock-ups of flyers (MCDV/DLP)
Debriefing following pre-testing and revisions planned
Evening meeting with Joe Okomo on portions of Information Packet (DLP)
- Feb. 6 Revisions of flyers and logo (MCDV)
Design of Information Packet (DLP)
Informal Debriefing with Dr. Isa H. Omar (DLP)
- Feb. 7 Revisions of flyers, cont. (MCDV)
Breakfast meeting with Joe Okome (DLP)
Final research for Information Packet and review of materials drafted in preliminary form (DLP)
Debriefing with Abdalla Meftuh
- Feb. 8 Travel to Lagos by Air
Visit to Federal Surveys Headquarters for maps
Debriefing with Rudi Thomas, USAID
Debriefing materials left with Africare-Lagos
Planning Trip Report
Travel to London
- Feb. 9 Arrival in Dulles Airport, Washington, D.C.

Annex D-3

**ATOP/BOP IEC Materials Development:
Creative Meeting Participants and Agenda**

ATOP/BOP IEC Materials Development
Creative Meeting
February 1, 1993

Participants:

Dr. Ahmed Ibrahim Mustapha	Chief, Epidemiological Unit, Department of Communicable Diseases, ASMOH
Mr. David Ali	OCT Leader, TSMOH (asst. materials developer)
Mr. Lawrence Jonathan	Health Asst., EPI Clinic, Garkida District, Gombi LGA, ASMOH (graphic artist)
Mr. Maxwell Kekene	Onchocerciasis Health Educator, Epidemiological Unit, ASMOH (asst. materials developer)
Mr. Michael Timbulu	Graphic Designer, Graphics Unit, ASMOI
Dr. Abdalla Meftuh	Africare ATOP Project Director, Yola (Adamawa State)
Dr. Oladele "Benjamin" Akogun	Africare BOP Project Director, Biu (Borno State)
Mr. J. P. Dangoje	Health Educator MOH Epidemi- ological Unit, Jalingo
Ms. Claudia De Valdenebro	Graphic Designer, HEALTHCOM consultant

Dr. Deirdre LaPin

Communications Planner, VBC
consultant

Program

9:00 - 10:00 Introduction and Distribution of Handouts

- (a) Brief Background: Stage 1: Research; Stage 2: Communications Planning; Presently Stage 3: Materials Development
- (b) What is a Creative Meeting? On the basis of education needs which emerged from our assessment in Stage 1, we have developed the content of possible messages to be conveyed to the target audiences, together with possible channels and some communications tools. Today, we shall have an open discussion on the best ways to transmit these messages to each of the target audiences. We shall be translating the message content into clear images and words.
- (c) Tools: The following tools are proposed for immediate implementation, using a mixed media strategy:
 - (i) 2-3 flyer/posters
 - (ii) stickers
 - (iii) T-shirts
 - (iv) Drama
 - (v) Songs
 - (vi) Stories
 - (vii) Video recordings of the presentations in iv-vi
 - (viii) Information Packet for Decision Makers
 - (ix) IEC section for ATOP training manual

(d) Agenda: By end of the day we hope to accomplish the following:

- (i) make a final selection of core messages
- (ii) frame verbal portion of messages in English and (provisionally) in Hausa, including narrative presentations where appropriate
- (iii) develop image concepts likely to be successful with target audiences (recall that images must transmit 80% of the message to community-level beneficiaries)
- (iv) propose narrative and poetic concepts for developing stories, song, and drama
- (v) identify institutional frameworks for developing performances using materials in (iv) above, e.g. through existing institutions or projects, holding an Arts for River Blindness competition, etc.
- (vi) select key subjects, tone, and themes for the decision makers information packet
- (vii) discuss dissemination issues.

10:00-10:30	Review of messages
10:30-12:30	Putting messages into words, pictures, and performances
12:30- 2:00	Group Working Lunch
2:00 - 4:00	Discussion of Institutional Strategies

Annex D-4

Creative Meeting Accomplishments

CREATIVE MEETING ACCOMPLISHMENTS

Date: February 1st, 1993
Venue: Adamwa State Ministry of Health
Conference Room

Members: Dr. Abdulla Meftuh, AFRICARE ATOP Project Director
Mr. David Ali, Taraba State Onchocerciasis Control Team
Leader
Mr. J. P. Dangoje, Health Educator MOH Epidemiological
Unit, Jalingo
Dr. Oladele "Benjamin" Akogun, Africare BOP Project
Director, Biu Borno State
Mr. Jonathan Lawrence, Garkida Hospital, EPI Clinic,
Gombi LGA
Mr. Maxwell Kekene, Health Educator, State Epidemiology
Unit, ASMOH
Mr. Michael Timbulu, Graphic Designer, ASMOI Yola
Dr. Deirdre LaPin, VBC Communications consultant
M. Claudia De Valdenebro, Graphic Designer, HealthCom
consultant

Accomplishments: We developed the messages to be included in print materials and in dramas, stories, and songs. We also agreed that all printed text will be in the Hausa language. Traditional arts materials may be in any local language or in Hausa.

Logo:

Illustration: A child guiding an adult who holds a stick. In the background a river and mountains.

Text Hausa: Yaki makanta sabili da ciwon dundumi.
Sha Avamatin sau daya a shekara, kowace shekara.

Text English: Prevent Blindness due to river blindness disease.
Take Ivermectin once a year, every year.

T-shirt

Front:

Illustration: See logo

Text Hausa: See logo

Text English: See logo

Back:

Text Hausa: Yaki makanta sabili da ciwon dundumi.
Sha Avamatin sau daya a shekara, kowace shekara.

Text English: Prevent Blindness due to river blindness disease.
Take Ivermectin once a year, every year.

Sleeve:

Illustration: Logos of contributing organizations?

Sticker:

Illustration: See logo

Text Hausa: See logo. (Additional text as follows)
Sake shan naka Avamatin shekara maizuwa

Text English: See logo. (Additional text as follows)
Take your Ivermectin again next year

HAND BILL (flyer) no. 1: General Message/Audience

Final size: 21 x 29.7 cm Divided in three panels each side

Outside:

Panel No. 3: Cover:

Illustration: Small illustrations of the main signs of the disease.

Text Hausa: Kana da wadan nan alamun a jiki?

Text English: Are you suffering from these signs?

Panel No. 2: Backcover:

Illustration: See logo.

Text Hausa: See logo.

Text English: See logo.

"Dundumi" is used in northeastern Nigeria as the Hausa language equivalent for river blindness disease.

This handbill was developed in collaboration with Africare, USAID, ASMOH, TSMOH, MSCl, AED

Panel No. 1: Folded

Illustration: Health worker in uniform with a group of people. He is giving Ivermectin to a woman. In the background there is a nurse in uniform.

Text Hausa: Mai yiwuwa wadannan alamomi na faruwa ne sabili da ciwon dundumi.

Tambayi wani ma'aikacin kiwon lafiya game da jinyar sa.
Sha avamatin sau daya a shekara kowace shekara.

Creative Meeting Accomplishments

Text English: These may be due to river blindness disease.
Ask a health worker about treatment.
Take Ivermectin once a year, every year.

Inside:

Panel No. 1: Panel divided in half.

Frame No. 1:

Illustration: A woman carrying her baby and cooking. She is scratching her leg (day time).

Frame No. 2:

Illustration: Same woman in bed with her baby. She is scratching her arm (night time).

Text Hausa: KAIKAYI:
Na dukkan jiki mai tsanani kuma na tsawon lokaci?

Text English: ITCHING:
Generalized, intensive and prolonged itching?

Panel No. 2: Panel divided in half.

Frame No. 1:

Illustration: A man showing nodules on his upper body (back and waist).

Text Hausa: KULU: Marasa zafi wanda ke fitowa yawanci a kwankwaso ko a kirji?

Text English: NODULES: Painless lumps often in the waist or the chest?

Frame No. 2:

Illustration: A woman showing her legs with spotted skin. The skin does not look normal.

Text Hausa: DABBARE-DABBARE.
Fata mai kaushi da dabbare-dabbare?

Text English: SPOTTED SKIN:
Rough and spotted skin?

Panel No. 3: Panel divided in half.

Frame No. 1:

Illustration: Close-up of a male face showing the eyes with clouds.

Frame No. 2:

Illustration: Same man now he is blind, walking with a stick and being guided by a child.

Text Hausa: GANI DUHU-DUHU:
Rashin gani sosai da kuma ruwa-ruwan ido?

Text English: IMPAIRED VISION:
Blurred vision and watery eyes?

HAND BILL (flyer) no. 2: Prevent blindness.

Final size: 21 x 29.7 cm Divided in three panels each side

Outside:

Creative Meeting Accomplishments

Panel No. 3: Cover:

Illustration: A happy boy and girl (Adamu and Hauwa). They live in Ruwa Village, a very beautiful place with a river, mountains and bushes.

Text Hausa: "Ido shi ne madubin jiki"
Tatsuniya ican Adamu da Hauwa a Kayen Ruwa.

Text English: "The eye is the mirror of the body"
The story of Adamu and Hauwa in Ruwa Village.

Panel No. 2: Backcover:

Illustration: See logo

Text Hausa: Wane misali za ka bi?
Na Hauwa ko Adamu?
Tambayi wani ma'aikacin kiwon lafiya game da jinyar sa.
See logo for the rest of the text.

Text English: Which example will you follow?
Hauwa's or Adamu's?
Ask a health worker about treatment.
See logo for the rest of the text.
"Dundumi" is used in northeastern Nigeria as the Hausa language equivalent for river blindness disease.
This handbill was developed in collaboration with:
Africare, USAID, ASMOH, TSMOH, MSCIAED.

Panel No. 1: Folded

Illustration: Health worker in uniform with a group of people. He is giving Ivermectin to a woman. In the background there is a nurse who is showing the handbill with the illustrations of the signs of the RBD.

Text Hausa: Kasance kamar Hauwa. Kare kanka daga makanta sabili da ciwon dundumi.
Tambayi wani ma'aikacin kiwon lafiya game da jinyar sa.
Sha avamatin sau daya a shekara kowace shekara.

Text English: Be like Hauwa. Avoid blindness due to river blindness disease
Ask a health worker about treatment.
Take Ivermectin once a year, every year.

Inside:

Panel No. 1: Panel divided in two.

Frame No. 1:

Illustration: Adamu and Hauwa in uniforms going to school. They are walking by the river.

Text Hausa: Adamu da Hauwa dukansu na makaranta a kauyen Ruwa omda suke da zama da iyayensu.

Text English: Adamu and Hauwa both go to school in Ruwa Village where they live with their parents.

Frame No. 2: Divided in two:

Illustration: Hauwa is guiding her parents while Adamu is playing and running around.
Hauwa is doing the laundry in the river, while Adamu is playing soccer.

Text Hausa: "Ba na samun lokacin wasa kamar Adamu".

Text English: "I never have time to play like Adamu".

Panel No. 2: Panel divided in half.

Creative Meeting Accomplishments

Frame No. 1:

Illustration: A health worker giving Ivermectin to Hauwa. Adamu walks away rejecting the medicine.

Text Hausa: "Kwayerki na fama da ciwon dundumi. Wannan Avamatin ne. Zai kare ka daga makanta sabili da ciwon dundumi".

Text English: Health worker: "Your village is suffering from River Blindness. This is Ivermectin. It will protect you from blindness due to this disease".

Frame No. 2:

Illustration: Hauwa is taking the medicine.

Text Hausa: "Idan na sha Avamatin, ba zan makanta kamar iyaye na ba!"

Text English: "I take Ivermectin because I do not want to be blind like my parents"

Panel No. 3: Panel divided in half.

Frame No. 1: (Divided in half)

Illustration: Adamu drops out of school because he is blind. He is sitting under a tree.
Hauwa is still going to school.

Text Hausa: Bayan wasu shekaru...
Aiya Adamu! Gashi be ya iya gani sosai domin ya ki shan Avamatin.

Text English: Years later...
Pity on Adamu. He cannot see well because he did not take ivermectin.

Frame No.2

Illustration: Hauwa completes school and graduates. The village is celebrating. Adamu is blind. He is walking with a stick and he is guided by a child.

Text Hausa: Bayan wasu lokatai suka wuche...
Hauwa ta samu zuwa Univasiti, ta gama.
Kwazo!!

Text English: Some time later...
Hauwa went to University and graduated soon after.
Congratulations!! (lit: "How hard you have worked!")

INFORMATION PACKET

Target Audience: Policy makers, advocates, donors

Concept: An "executive" press kit is intended to promote understanding and resource support to ATOP and eventually the Borno Onchocerciasis Program. A social marketing approach toward the packet will be employed, appealing to the interests of decision makers in Nigeria.

Cover: A pocket folder will have a cover printed with a beautiful wrap-around photograph in full color highlighting the magnificent riverain scenery of the ATOP area. In the foreground a rapid stream lurching over a rocky mountain riverbed is shown. In the background a cluster of hills broods over the scene.

Text in English: "Beautiful,
but ..."

The words invite the reader to consider the contrast between the fine scenery of riverain valleys and the debilitating disease fostered by its streams and rocks.

Inside Pages: 8 - 10 loose sheets in A-4 size, printed in black ink on executive stationery in a variety of pale colors. Each sheet treats a different topic related to project activities. The pages will be laid out using WordPerfect 5.1 and/or PageMaker programs. Texts will be supplied on diskette for updating or modification by locality. Although the initial printing will be done on press, subsequent versions may be reproduced on a good quality PC printer. The visual character of the pages will vary sufficiently so that re-edited updates and additions will not appear misplaced.

The subjects of the pages are as follows:

- (1) A one-page personalized cover letter will introduce the decision maker to the prevalence of River Blindness in his area, its impact on health and welfare, and the ATOP Ivermectin Delivery Program (IDP). The letter will stress briefly the collective responsibilities of state government, local government, NGOs, and the community in ensuring success of the IDP. A few sentences will list the topics to be treated in subsequent pages.

The reader of the cover letter will be invited to consider control of River Blindness with ivermectin as a validation of the well-known Hausa proverb: "The eye is the mirror of the body." [The meaning of the proverb is that without the eye, the body cannot navigate or protect itself from harm; without a healthy body to support it, the eye will weaken and grow dim.]

- (2) "River Blindness: One Disease, Many Signs." The second page will present a brief description of the manifestations and symptoms of onchocerciasis. The beautiful scene on the cover of the folder will be invoked as an example of environments in which the disease is transmitted. Black and white photographs will illustrate the most common signs of the disease (intensive and prolonged itching, nodules, discoloration of the skin, blurred vision, and blindness). The text describes the signs and symptoms briefly and their effects on individual health and wellbeing.
- (3) "Locations of River Blindness Disease in Adamawa, Taraba, and Borno States of Nigeria." A map will show new LGAS overlain with endemic areas of Adamawa, Taraba, and Borno States. If possible, levels of endemicity will be shown. [This map does not yet exist and will need to be created. New LGA maps may not be available for all states; in addition,

endemicity levels in areas not yet skin-snipped will be estimates only.] The purpose of the map is to present in graphic terms, early in the information packet, the LGAs targetted for assistance and the reason for their selection.

- (4) "What Causes River Blindness Disease?" A medical information sheet discusses the filarial parasite, breeding sites, and the pathology of the disease. It answers the questions "How do people get the disease?" "How does the disease spread?" "What are the consequences of River Blindness Disease?" and "How can the disease be controlled?" Simple illustrations of the black fly, transmission cycle, and people working by a riverside are suggested.
- (5) "River Blindness: A Preventable Human Tragedy." The fifth information sheet will present three vignettes of communities severely damaged by River Blindness Disease. The personal and economic price of the affliction will be stressed. The tone leans intentionally toward the dramatic. This style in Nigerian journalism is suitable to a human interest story targeting an educated, but not intellectual, readership.

If available, a strong, good quality black and white photograph of at least one community should be included.
- (6) "Beyond River Blindness: The Socio-economics of Disease Control." The sixth page will focus on the socio-economic benefits of controlling River Blindness Disease. Its arguments are designed to appeal to local decision makers who set policy or those who allocate government resources for health programs.
- (7) "Ivermectin: A New and Safe Drug for Treating River Blindness Disease." This page briefly describes the history of ivermectin for the treatment of River Blindness Disease, the rationale of the Mectizan Donation Program, and the imple-

mentation of the Program in northeastern Nigeria. The page opens with a praise song composed by health educators in the ATOP area in honor of ivermectin.. An opening paragraph answers the question: What is Ivermectin? Next: What are the benefits of the new drug? Finally: How does ivermectin reach people who need it?

- (8) "A Partnership for Delivering Ivermectin in Northwestern Nigeria." This page will introduce the reader to the partnership that has been created in northeastern Nigeria in order to support delivery of ivermectin. The members of the partnership will be presented, namely, Merck & Co.; Africare; Donors; National, State and -- especially -- LGA governments in Nigeria; Local NGOs; and Advocates.

The discussion will briefly summarize the history of the ivermectin delivery in northeastern Nigeria, with an emphasis on the Adamawa and Taraba Onchocerciasis Program (ATOP) and its expansion into the Borno Onchocerciasis Program (BOP).

Relevant goals, activities, and key accomplishments will be mentioned. Finally, the current and expected contributions of local governments to the SUPPLY component will be stressed.

- (9) "River Blindness and the People." How is the disease which is medically known as River Blindness understood by the population in the project area? What attitudes do they display toward its signs and symptoms? What do they say about treatment with ivermectin? How can we ensure acceptance by the community to create a rational demand appropriate to available supply?
- (10) "Health Education and Rational Demand." This page will present the rationale and strategy for the ATOP information, education, and communications activities.

Creative Meeting Accomplishments

First, the importance of rational DEMAND in ensuring a sustained treatment program in Nigeria will be explained. Then the cultural milieu with respect to ethnic diversity, KAP, and the key messages selected will be described. The media environment of the area and the channels chosen to convey IDP messages to the target communities will be presented.

(Black and white photographs of planning, pre-testing, materials development, and/or health education sessions are suggested.)

- (11) "How You Can Control River Blindness in Your LGA." This page provides an opportunity to focus on each LGA in greater detail. Its purpose will be to lay out a detailed argument for the specific contributions to the program which are requested from the LGA government.

(A variant of this page could focus on each state and the role of the state government to the program; alternatively, an NGO or an individual philanthropist or donor might be targeted.)

A suggested outline of contents may include, but need not be limited to, the following: (1) program plans in the area, past, present, and future; (2) resource requirements to meet expected targets; (3) a timetable for allocation of needed resources; (4) a reminder of benefits gained from the allocation, supported with examples of gains already realized.

Specific, targeted information is more effective with decision makers than is generalized commentary. Moreover, this page is the best opportunity offered in the Information Packet to make a personalized and direct appeal to a recipient.³²⁹

Annex D-5

**Information Packet:
Inside Pages Description and Text**

INFORMATION PACKET: INSIDE PAGES DESCRIPTION AND TEXT

Page 1: Personalized Cover Letter

Description

The cover letter to the information packet will be designed to introduce the reader to the rationale of the ATOP project and to the contents of the information packet. Typically, the packet will be presented to the addressee during a personal visit made by an ATOP staff member. Its message will be supported by a brief verbal presentation and possibly in conjunction with such other media as a video, sound tapes, or photo illustrations.

The text of the cover letter will be made available to ATOP on either WordPerfect 5.1 or PageMaker software programs. Each letter should be composed, printed, and signed individually. The letter will ideally be printed on ATOP stationery or on paper that carries an accessible return address and contact telephone number for the project.

While 95% of the text is likely to remain unchanged, minor variations will personalize the following:

- name and address of the addressee;
- addressee's title and/or responsibilities relevant to the project;
- name(s) of person(s) to be contacted for further information (usually the individual presenting the packet, his/her superior, a local representative, etc.);
- any additions or changes to the packet contents (e.g. detailed information on project activities in the addressee's locality, recent press articles, new health education materials, copies of project reports that may interest the addressee, etc.);

- mention in closing of significant events which the addressee should know about, areas of support which s/he may lend to the project, or actions which s/he may be invited to take, etc. (Here, the writer must be careful to avoid a tone of demand or expectation, but rather invite the reader to recognize that his or her support to the project is in the best interest of the region or organization of which s/he is a part.)

Date: Month, year [Day optional]

Name of Addressee
Title
Organization
Address

Dear [Title, e.g. Alhaji/a, Chief, Honourable, Chairman, Dr., Professor, Mrs., Mr.] [Family name],

A Special Invitation:

Join a Partnership to End the Tragedy of River Blindness Disease

The beauty and bounty of our region are exceptional in the Nigerian Federation. But few who witness our lofty mountains and watered valleys are aware that this Paradise harbours a debilitating disease. River Blindness Disease, sometimes called onchocerciasis or filaria, has reduced the sight and productivity of countless men and women in our area. Moreover, it threatens the vision and future prosperity of our children.

Fortunately, we can now challenge River Blindness Disease with a new, safe drug called "ivermectin". Treatment is simple: the drug must be taken by eligible persons once a year, every year. Elders tell us: "The eye is the mirror of the body". Indeed, River Blindness begins in the body and progresses toward permanent visual loss.

To ensure that ivermectin reaches the victims of River Blindness Disease, the federal, state, and local governments of Nigeria have joined in a partnership with the drug's manufacturer, Merck and Co. Merck makes ivermectin available free of charge through approved organizations. In Adamawa, Taraba, and Borno States, the U.S.-based organization Africare is working with LGA and state governments to bring the drug to communities that need it. Since 1991 over 60,000 persons have received ivermectin, but many more remain. Because Africare's financial contribution to the project will end in 1994, state and local governments must continue to play an increasingly important part in helping drive this enemy from our Paradise.

This information packet will help you learn more about River Blindness Disease. It also suggests ways for you to help in this important effort.

We (I) take this opportunity to welcome you as a partner in ending the tragedy of River Blindness Disease in your locality. Please take a few moments to read through your information packet. Should you have any comments or require further information, do not hesitate to call on X, who may be reached at X.

With very best wishes,

INFORMATION PACKET: Page 2

River Blindness: One Disease, Many Signs

Description

This page will focus on one aspect of River Blindness Disease, namely, the variety of signs and symptoms that are manifestations of *Onchocerca volvulus*. The purpose is to introduce the disease to a lay audience. Details of habitat, transmission, and parasitic infection will be described in page 5.

The text could be supplemented with 5 black and white photographs, one showing each of 5 main signs: itchy and roughened skin, nodules, skin depigmentation, blurred vision, and blindness.

The text may be laid out in double columns, which permits presentation of the photographs in the same order of appearance as signs in the body. This order will serve as a mnemonic for the reader.

Suggested Text for Page 2: River Blindness: One Disease, Many Signs

Blindness is the tragic endpoint of River Blindness Disease. Fortunately, blindness is preceded by less severe signs and symptoms. Recognition of these earlier signs could encourage timely treatment of the disease.

- **Blurred vision.** In the northern part of Nigeria, the Hausa word for River Blindness — *dundumi* — describes the "hazy vision" and gradual visual loss that precede blindness.
- **Intense and prolonged itching.** In Yoruba the disease is known as *ina'run*. The name means "unearthly itching", a sign that appears in early stages of the illness. Chamba call the same intense and prolonged itching *pensosen*. Victims are sometimes unable at times to sleep at night because of constant irritation of the skin.
- **Nodules.** A painless soft lump called *kulu* in Hausa may appear just under the skin, most often in the waist or back.
- **Skin depigmentation.** Sometimes called "leopard skin" or in Hausa, *dabbare dabbare* this condition leaves light-coloured spots or patches on the skin, most often on the lower legs.

Not everyone suffering from River Blindness Disease will exhibit all of these signs. Even if they do, the signs may not occur at the same time. The progress of River Blindness Disease in the body is slow, and signs usually appear in the following order: intense and prolonged itching, nodules, skin depigmentation, hazy vision, and finally blindness.

On the other hand, not everyone who shows one or two of these signs is suffering from River Blindness Disease. Scabies or *kraw kraw* may also cause itching; vitiligo may cause skin discoloration. Many disorders lead to blindness. Only in River Blindness Disease, however, can all of these signs appear as manifestations of a single illness.

INFORMATION PACKET: Page 3

Locations of River Blindness Disease in Adamawa, Taraba, and Borno States of Nigeria

Description

This page presents an administrative map of Adamawa, Taraba, and southern Borno states. Areas endemic for River Blindness Disease will be shaded. Rivers serving as breeding sites for the black fly will be shown prominently.

The LGA will be the most important administrative unit to be shown, as the audience for the information packet are officials at LGA-level and above. District-level government staff have little authority over the resources required for the project. It is suggested that a note be included which explains that hyperendemic areas will be served first. Otherwise, the project may be pressured to meet a high demand prematurely.

Elements required for the map would consist of (1) a list of known or very likely hyper-endemic LGAs and Districts and (2) current maps of LGA and (if possible) district divisions.

Lists of known hyperendemic areas are available but may be refined periodically.

Up-to-date administrative maps of Adamawa and Taraba States may be available at the Federal Surveys Office in Lagos, but they had not been issued by November 1992. A planned visit to that office was cancelled owing to the civil service strike in early February 1993. In addition, the Adamawa State survey office was closed for the same reason.

Once current LGA maps are obtained, drafting and printing of new maps including the hyperendemic areas may be arranged in Yola.

Suggested Text for Page 3: Locations of River Blindness Disease in Adamawa, Taraba, and Borno States of Nigeria

[A box to the side of the map will contain the text below]

LGAs MOST SEVERELY ENDEMIC

	Est. pop. at risk
ADAMAWA	
Ganye	85,575
Gombi	22,106
Jada	62,093
Fufore	76,889
TARABA	
Bali	156,408
Gashaka	44,638
Sardauna	107,668
Takum	74,125
Wukari	45,188
Donga	44,613
Zing	54,075
BORNU	
Biu	79,932
Hawul	91,112
Kwaya Kusar	40,000
Shani	60,000
Dambo	50,000
Askira Uba	158,873

[Note at the top or bottom of the page]

*Information Packet:
Inside Pages Description and Text*

Please note that the project gives priority to areas medical surveys show to be hyperendemic. Criteria for classification define "hyperendemic" areas as those having an estimated 60% of community residents infected with the disease. "Mesoendemic" areas have between 40% and 60% estimated to be infected. In "hypoendemic" areas infection is present but estimated at under 40%.

INFORMATION PACKET: Page 4

What Causes River Blindness Disease?

Description

The information in this page will build on the knowledge gained from pages 2 and 3. It will discuss the filarial parasite, vector, breeding sites, and the pathology of the disease. Stress is laid on the connection between riverain valleys and the risk of infection to resident populations.

Simple illustrations of the black fly, transmission cycle, and people working by a riverside are suggested.

Suggested Text for Page 4: What Causes River Blindness Disease?

River Blindness Disease, also known as onchocerciasis or filaria, threatens nearly 1 million persons living in northeastern Nigeria.

How do people get it?

Onchocerciasis is transmitted through the stinging bite of tiny black flies infected with parasitic worms (*Onchocerca volvulus*). The worms mature inside the human body, where female adult worms may produce thousands of offspring a day. These offspring invade the tissue under the skin, causing irritating itching and loss of skin pigment. They may also travel to the tissue around the eye, leading to eye lesions or blindness. As more adult worms mature, they join to form a nodule under the skin, which appears as a painless swelling or lump.

How does the disease spread?

Black flies (*Simulium*), which carry the parasitic worms, typically breed in the tumbling waters of rushing mountain streams or dams. The larval flies attach themselves to rocks or other hard surfaces until they mature. Once airborne, the female black flies may bite fishermen, women fetching water or washing clothes, farmers working nearby, and children or infants left by the waterside. When a black fly bites an infected person, it may ingest the tiny filarial worms and eventually transmit them to another person. In this way black flies carry the infection from one person to another.

What are the consequences of River Blindness Disease?

Onchocerciasis may cause widespread discomfort and blindness. A community loses an average of 22 productive years for each blind person. Fear of these consequences has caused people to abandon some of Nigeria's most fertile river valleys. Reduced food production affects the economy and welfare of the region and the Federation.

How can the disease be controlled?

In 1975 the World Health Organization mounted an Onchocerciasis Control Program (OCP) to control River Blindness Disease in West Africa. The first efforts used biodegradable chemicals and biological agents to kill the black fly larvae. Nigeria was not included in this program of vector control. However, since 1987 the drug ivermectin has been introduced to treat infected people. This approach limits the effects of the disease on the infected individual and prevents blindness. With continued treatment, the welfare and productivity of men and women in northeastern Nigeria will be improved.

INFORMATION PACKET: Page 5

River Blindness Disease: A Preventable Human Tragedy

Description

This page will present three vignettes of communities severely damaged by River Blindness Disease. The personal and economic price of the affliction will be stressed. The tone leans intentionally toward the dramatic. This style in Nigerian journalism is suitable to a human interest story targeting an educated readership.

If available, a strong, good quality black and white photograph of at least one community should be included.

Suggested Text for Page 5: River Blindness Disease: A Preventable Human Tragedy

*Before I could see.
Now I cannot see.
Who can give me something?
Only God has done this to me.*

*Now I am blind.
Now I am a beggar.
It is how I get my food.
A beggar cannot work.*

*Who can give me something?
Only God has done this to me.*

Gazabu, Bali LGA, Taraba State

This voice, haunting and resigned, rises from a Jibawa victim of River Blindness Disease. His home is Gazabu, one of the most intensely endemic areas for the disease in the world. The singer's people live in sparse settlements over the fertile lands. They have been scattered by fear of a malady with unknown cause.

Here, the Gazabu River flows swiftly over rocky boulders. Its waters promise a bountiful harvest for the farmers who venture near its banks. Its rapids also provide a comfortable breeding ground for black flies. In such a fertile land, Gazabu's people are not desperately poor. And yet, their blank stares bear witness to a history of personal misery and resignation. They have come to accept incessant scratching, nodules, roughened skins, white patches on their shins, and their blindness as a way of life. They live with the enemy, but do not know what it is.

Natirde, Ganye LGA, Adamawa State

They are called "floating ghosts", the unseeing people of Natirde. This tiny community on the banks of the Mayo Kam has 7 huts and a population of 34. Ghosts. All others who were born here have fled. Natirde has nothing. Nothing here can be described as a modern comfort. It does not have schools. It does not have markets. It does not have salt. Wretched and miserable, its people barely scrape out a living wholly deprived of flavour or spice.

Conversation might offer some diversion. Yet, as Natirde's men and women talk, they scratch. The sound of cracked nails on roughened skin is a bold counterpoint to their few words. It is a useless motion.

Their frantic efforts to soothe their itching will not cure the affliction that torments them.

They are the ones left behind. All the others have fled.

Nyibango, Gashaka LGA, Taraba State

Of Nyibango's 200 souls, 120 are blind. Spared are 80 women and children. Yet without treatment, these lucky ones are destined to join the fate of others.

The disease has stolen away its victims' sight. It has also snatched their culture and market. Nyibango has no surplus products. It has no clinic. It has no school. Its greetings have thinned to whispers mouthed through faces masked in blank stares.

What future can be expected for Nyibango? In the privacy of their houses the men and women look beyond you and into the world ahead as if in search of an answer to their predicament. An answer will come, though not for those who are already blind. For those who can still see into the future clearly, there is an answer ... there is hope.

INFORMATION PACKET: Page 6

Beyond River Blindness:
The Socio-economics of Disease Control

Description

This page will focus on the socio-economic benefits of controlling River Blindness Disease. Its arguments are designed to appeal to local decision makers who set policy or those who allocate government resources for health programs.

Suggested Text for Page 6: Beyond River Blindness: The Socio-economics of Disease Control

All of us have seen the tragic consequences of River Blindness. The sightless victims of this disease shuffle through our villages and towns. Often they are led by a youth who has sacrificed his future to lend his eyes to a sightless elder.

The burden of this tragedy is not borne by River Blindness victims alone. Its consequences spread throughout whole village areas, and up through Districts, LGAs, States, and indeed to the entire Federation. How can this be?

Consider the following costs charged against the prosperity of your LGA because of River Blindness Disease:

- fertile river valleys abandoned by communities seeking healthier homes;
- 22 productive years lost for each blind adult;
- lost hours of work owing to visual loss and illness;
- wasted resources expended on useless cures;
- reduced production of food and other goods;
- fewer children in schools;
- degradation of cultural life, family unity, and self-esteem;
- lower government revenues.

Now, consider the gains to your LGA that come with controlling River Blindness Disease:

- Increased agricultural production through cultivation of fertile river valleys.
- 22 productive years gained for every case of blindness prevented.
- Reversal of all negative trends listed above.

Finally, consider the additional cost to your LGA government for treating all endemic communities with a free drug once a year:

- under ₦ 5 per person treated — treating every eligible person in your LGA cost may less than buying a single tractor!

Benefits will far outweigh the costs.

For more information about how you can personally assist this program, please refer to page 10 in this packet.

INFORMATION PACKET: Page 7

Ivermectin: A New and Safe Drug for Treating River Blindness Disease

Description

This page briefly describes the history of ivermectin for the treatment of River Blindness Disease, the rationale of the Mectizan Donation Program, and the implementation of the programme in northeastern Nigeria.

The page opens with a praise song composed by health educators in the ATOP area in honor of ivermectin.

Suggested Text for Page 7: Ivermectin: A New and Safe Drug for Treating River Blindness Disease

Song of Ivermectin

*Ivermectin, ivermectin
New medicine, new medicine!
Take it! Take it!
It prevents blindness from River Blindness Disease*

*Do you scratch, do you scratch?
Over your whole body, all over your body?
Take ivermectin!
It prevents body itching.*

*All of you, all of you!
Listen well, listen well!
Heed my words, heed my words!
Take ivermectin once a year
Every year.*

*Avamatin, Avamatin
Sabon magani! Sabon magaini!
Sai ka sha! Sai ka sha!
Yana hana makantar Dundumi*

*Kana susa, kana susa?
Jiki kullun, jiki kullun?
Sai ka sha Avamatin,
Yana hana kaikain jiki.*

*Duk jama 'a, Duk jama 'a!
Kasa kune, Kasa kune!
Ji dakyan, Ji dakyan!
Sha Avamatin sau daya
A shekara kowace shekara*

What is ivermectin?

Ivermectin is a new and safe drug discovered by Merck & Co, a pharmaceutical company that provides the drug free of charge to countries where River Blindness Disease threatens the health and productivity of local populations. Since 1987 ivermectin has been used for treatment of River Blindness Disease. The drug is distributed only by approved organizations and is not sold in the commercial market.

What are the benefits of the new drug?

Ivermectin has many advantages over previous treatments for River Blindness Disease. It requires only one dose of ½ to 2 tablets, according to a patient's body weight. It need be taken only once a year, every year. At each treatment it clears the body of microfilarial worms. In addition, ivermectin may limit the production of further offspring by adult worms. While treatment cannot remove white spots caused by depigmentation or improve damaged vision, it can prevent further deterioration of the skin and sight. In addition, the drug puts an end to intense, persistent itching and restores smoothness to skin roughened by the disease.

Side benefits of ivermectin include its deworming properties. Like any drug, ivermectin may also produce some mild side reactions in a small percentage of people who use it. Some patients experience increased itching, head or body aches, swollen limbs, mild dizziness, and fever. These conditions rarely last more than two or three days and are usually less apparent after the next treatment.

How does ivermectin reach people who need it?

In northeastern Nigeria the manufacturer has approved distribution of ivermectin through Africare, a non-governmental organization with offices in Yola, Lagos, and Washington, D.C. Africare works closely with state and local governments, who provide personnel, transportation, and financial support. Communities in endemic areas are visited and treated at least once a year by onchocerciasis control teams.

INFORMATION PACKET: Page 8

A Partnership for Delivering Ivermectin in Northeastern Nigeria

Description

This page will introduce the reader to the partnership that has been created in northeastern Nigeria in order to support delivery of ivermectin. The members of the partnership will be presented, namely, Merck & Co.; Africare; Donors; National, State and — especially — LGA governments in Nigeria; local NGOs; and advocates.

The discussion will briefly summarize the history of the ivermectin delivery in northeastern Nigeria, with an emphasis on the Adamawa and Taraba Onchocerciasis Program (ATOP) and its expansion into the Borno Onchocerciasis Program (BOP).

Relevant goals, activities, and key accomplishments will be mentioned.

Finally, the current and expected contributions of local governments to the SUPPLY component will be stressed.

Suggested Text, p. 8: A Partnership for Ivermectin Delivery in North-eastern Nigeria

Since August 1991 a partnership has been working hard in northeastern Nigeria to deliver ivermectin — a new drug to control River Blindness Disease — to eligible communities. Populations of affected villages are treated every year to protect them from blindness and other symptoms of the disease. This partnership, named the Adamawa and Taraba Onchocerciasis Programme, or "ATOP", set a goal of treating 25,000 new patients annually for three years. Yet in its first year, ATOP exceeded that goal by 85%. So far, its record of achievement continues unabated.

Partners in this effort include the following:

- Local Governments, which provide health personnel, transport, fuel, financing, and other important contributions to ivermectin delivery;
- State Governments, which offer managerial and technical expertise and occasional logistical support;
- Africare, a nongovernmental organization dedicated to building local capacity to improve human welfare and development in Africa;
- Nigerian NGOs and mission groups;
- National Onchocerciasis Programme of Nigeria;
- Members of State and Local Onchocerciasis Control Teams;
- Merck & Co., which supplies ivermectin to Nigeria free of charge;
- United States Agency for International Development;
- River Blindness Foundation, a non-profit institution; and others.

All of these partners are important. None is more important, however, than your Local and State Governments. Why? First, because the role of democratically elected governments is to protect the lives, rights, and welfare of their constituents. Second, because only such governments are able to provide the kind of ongoing support, year after year, that will end the scourge of River Blindness Disease.

Such support may take many forms. Already, many Local and State Governments have joined the partnership by providing the following:

- **Transport and fuel.** River Blindness Disease typically finds its victims in remote river valleys. Members of the state and local onchocerciasis control teams may use lorries, motorbikes, or boats to traverse roads and streams in order to deliver treatment.
- **Personnel.** Treating communities with ivermectin requires trained and dedicated health personnel. State and local onchocerciasis control teams must be able to conduct surveys to determine which communities to treat, to manage drug distribution and treatment, and to deliver health education messages.
- **Funds.** Travel, transport, and training require financial support. Local government contributions have so far cost under ₦5 per treatment.

Page 9: How You Can Control River Blindness in Your LGA

Description

This page provides an opportunity to focus on each LGA in greater detail. Its purpose will be to lay out a detailed argument for the specific contributions to the program which are requested from the LGA government.

(A variant of this page could focus on each state and the role of the state government to the program; alternatively, an NGO or an individual philanthropist or donor might be targeted.)

A suggested outline of contents may include, but need not be limited to, the following: (1) program plans in the area, past, present, and future; (2) resource requirements to meet expected targets; (3) a timetable for allocation of needed resources; (4) a reminder of benefits gained from the allocation, supported with examples of gains already realized.

Specific, targeted information is more effective with decision makers than is generalized commentary. Moreover, this page is the best opportunity offered in the Information Packet to make a personalized and direct appeal to a recipient.

Suggested points to include in text for page 9: How You can Control River Blindness in Your LGA

FUNDING

- (1) Describe the accomplishments of your delivery programme in the decision maker's locality during the last reporting period. Present the relative contributions made by programme partners, with specific attention to the LGA and State Governments. If appropriate, compare these contributions to those made by other LGAs or States.
- (2) List in detail the government contributions needed for the current programme year in relation to transport, manpower, and financing. Try insofar as possible to quantify your requests exactly.
- (3) Present an annual schedule of activities planned for the decision maker's locality in the next programme year and offer a timetable of WHEN you estimate specific LGA contributions will be required and for how long.
- (4) Offer an estimated budget of funds required for ivermectin delivery in the coming year. Suggest that allocation of these funds be included in the budget for the coming fiscal year. Also, propose a schedule of disbursement for these funds.

PROMOTION

- (1) Suggest that the decision maker assist the programme by visiting intervention communities.
- (2) Encourage him or her to speak on broadcast media in support of the delivery programme.

Annex D-6

**Traditional Arts as Communication Tools
for Community-Level Education
and the A-TOP Festival of the Arts:**

Description, Proposed Budget and Draft Scripts

PROJECT COMPONENT:
TRADITIONAL ARTS AS COMMUNICATIONS TOOLS
FOR COMMUNITY-LEVEL EDUCATION
AND THE
A-TOP FESTIVAL OF THE ARTS

Background

The ATOP IEC activity has developed a Communications Plan (LaPin and Douglass) which proposes initial development of several communications tools. A mixed-media strategy is envisaged, which employs multiple channels targeting three audiences: (1) decision makers, (2) health promoters, and (3) community members. Among the channels intended for the community is the traditional arts, specifically in the form of community-based drama, dance, and musical performances. These media will be developed following oral literary conventions to convey ATOP health education messages. Central messages include the following:

- (1) Take ivermectin once a year every year
- (2) Ivermectin prevents blindness due to River Blindness disease and controls other signs of the disease such as intensive and prolonged itching, nodules, skin depigmentation, and itchy and watery eyes.

A recent health education trial undertaken in rural communities of Borno State has been documented by Akogun (1992). The trial compares the efficacy of traditional arts as educational tools with a second approach using printed images and games. Study results show a significant difference in effect, namely that the traditional arts are more effective -- especially among women -- than the comparison tools; moreover, the traditional arts alone are only slightly less effective than both sets of tools combined. The author has pointed out in personal communication that strong similarities exist in the economy and general culture of Borno State and the Adamawa and Taraba States area which comprises the ATOP target population. These similarities, together with the keen interest displayed by ATOP personnel and beneficiaries in traditional

arts, has led the State Onchocerciasis Control Teams to urge that these educational tools be developed to promote community-level demand for ivermectin and compliance with its treatment regimen.

The Traditional Arts Component: A Description

The purpose of the traditional arts component of the ATOP IEC strategy is to create a sustained demand for ivermectin by educating the community to its benefits through traditional narrative, verse, and dance forms. Performances will be created by communities themselves, in their own languages, and will draw upon genres, personae, and motifs handed down by existing cultural traditions. This process will yield new performances using time-honored ingredients to create new narrative dramas, dances, or verse. Such neo-traditional creations will communicate new messages about ivermectin to audiences through artistic media which are wholly familiar, entertaining, and culturally relevant.

At the outset, dance/dramas, narratives, and ivermectin songs will be developed by communities under the supervision of health workers. Finished products will be selected by the health workers for competition in an A-TOP FESTIVAL OF THE ARTS, which will be organized to coincide with the launching of the ATOP IEC materials.

Two government health education specialists, one each from Adamawa and Taraba States, will oversee the development of the project. They will be assisted in the last stage by a private media house based in Yola, Adamawa State.

Five stages will mark the activities of the traditional arts component. They are (1) training of trainers; (2) development of performances at community level; (3) A-TOP Festival of the ARTS featuring 3 categories of performance: dance/drama, ivermectin song, and storytelling; (4) video and sound recording of individual entries into the Festival event; and (5) dissemination of video and tape cassettes of high-quality performances. Ideally, the Festival will take place in Yola no later than the end of April (before the start of the rainy season) at a time to coincide with the launching of ATOP IEC materials. The Festival will provide the

main entertainment for the launching. While the ATOP area boasts a wide range of professional level performers in all the arts, the hallmark of the Festival is that it will feature traditional, community-level performers and performances. Professionals who are willing to work with communities are welcome to participate, but the competition, overall, should take place between amateurs and not professionals.

The first stage will be a 2-day training of trainers workshop to be held in Jalingo, Taraba State, for 9 local government health workers from ATOP intervention LGAs (Bali-3; Gashaka-3; Ganye-2; Gombi-1). Training will include basic health education for IDP, development of role plays, and instruction in development of dance/dramas, storytelling performances, and songs using IDP messages.

In the second stage of the activity each of the trained health workers will visit at least 3 intervention communities in his or her LGA, convey basic IDP health education, and explain the upcoming A-TOP Festival of the Arts. Over a period of approximately 6 weeks the trained health workers will make at least two additional visits to each community which has agreed to participate in the program. S/he will monitor the progress of the performances and propose corrections of messages where needed. The health worker will not be responsible for artistic content but should ensure that onchocerciasis-related themes are given adequate prominence.

The A-TOP FESTIVAL OF THE ARTS will comprise the third stage of the activity. Here, performances developed at community level and which have passed a local screening by health workers will enter one of the three categories for competition: (1) dance/dramas, (2) musical performances, and (3) storytelling. It should be noted that, traditionally, each one of these generic categories features mixed media. For example, dramas are based on stories and often contain dances, songs and even orchestras; musical performances may tell a story and include poetry and dance; storytelling may weave songs and dance through the narrative performance. Therefore, the contestants themselves will name the category to which their performance belongs. In general, it can be expected that a drama or dance/drama will have a cast of characters, whereas a narrative performance will have a lone actor. In musical performances, song and accompaniment will predominate.

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Prizes will be offered for 1st, 2nd, and 3rd place winners in each category. All prizes will be cash gifts contributed to the local development committee of each community. Songs and stories will receive, in descending order, amounts of ₦500, ₦300, and ₦200; dance/drama amounts of ₦800, ₦600, and ₦400. Judges will be selected by a Festival or IEC committee and should include persons competent in health, social affairs, and the traditional arts. As many as 30 performances will be possible, depending on complexity and length. A pre-selection may be made at a competition at LGA level. It is expected that the local government will assist the contestants with transportation to Yola. ATOP IEC funds will cover accommodation and food in Yola.

The fourth stage of the traditional arts activity will be timed to coincide with the third. It entails the video and sound recording of the festival entries with a view to reproduction and dissemination. A media house will be contracted to undertake this activity.

The fifth and final stage will be the dissemination of video and sound cassettes. Dissemination will be accomplished in two ways: (1) by sending copies to government officials, local health workers, and same-language communities (in the case of sound cassettes) and (in the case of video cassettes) government officials and viewing centers; (2) by offering free copies of the cassettes to local video and cassette duplication houses for eventual copying and sale through the private market.

Proposed Drama Skits for ATOP IDP

Situation 1

A health worker in a village informs the inhabitants about River Blindness Disease (RBD) and its key signs. He explains the benefits of a new drug called ivermectin, which combats this disease. Then he distributes it to everyone. Everyone, including the chief's wife and children and the wakili, agrees to take the drug. However, the chief himself refuses to take ivermectin because he believes that his rank will spare him from the scourge of RBD.

During that year, the chief begins to suffer from itching so severe that he can no longer keep audience in public. The wakili reminds him that the health worker told the village that severe itching was one sign of the disease. The next time the drug is brought round, the chief requests treatment. The itching is relieved, and he feels happy to appear in public. In addition, he encourages others to follow his example.

Characters: health worker, chief, the chief's wife and children, the wakili.

Message: River Blindness disease has no respect for anybody, whatever his position or rank. To avoid blindness due to RBD and other signs of the disease, take ivermectin once a year every year.

Situation 2

Makafi ("Blind") village is very poor. Many adult men and some women can be seen going round the dusty, empty streets with sticks. Most are in various stages of visual impairment. Those who are totally blind sit motionless in doorways or under trees. Some blind people are being led about by small children.

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Musa, a boy of about 15, is guiding his blind uncle Mustapha. The uncle laments day and night about his condition. "God has done this to me," he says. "Why have I deserved such a bad fate? Now all I have is emptiness and darkness."

Musa and others in the village have heard about the disease of hazy vision (dundumi, River Blindness). They know it makes older people go blind.

One day a health worker comes to the village and talks to the people about RBD. He says that a new drug has been given to them called ivermectin, that it will help control the disease. Musa refuses to take the tablets. He says that RB is a disease of the elderly, and that someone his age is not affected. Musa does not like Western medicine, and he has little experience with it because his family is poor.

After a day or two, Wahabi, a friend who took the drug, shows Musa a handbill distributed by the health worker. He tells Musa that itching is also a sign of the disease. Musa realizes that he has been suffering from intensive itching that keeps him awake at night. This is the first time he learned that the cause of itching may also be the cause of blindness.

The next time the health worker comes to deliver ivermectin Musa is the first one in the queue.

Characters: Musa, Uncle Mustapha, Health worker, Wahabi

Message: Intensive and prolonged itching is one early sign of River Blindness Disease and can affect both young and old. People who suffer from this sign should take ivermectin once a year every year to prevent blindness later on.

Situation 3

A feud develops between two large families, and they threaten each other with curses from their patron spirits. The feud goes on for many years, and after some time, Gardama ("Quarrel"), a member of one family, notices that the skin on his legs is changing. He is developing white spots. He concludes that the change is a result of a curse from the enemy family. In order to counter the curse he consults many different traditional healers, one after the other. He tries a multitude of remedies; he drinks potions; he visits mallams; he prays over the Koran; he applies any number of herbal salves and ointments ... all to no avail.

One day, a health worker comes to the village and explains about a new drug. The drug is a medicine to combat River Blindness disease. This disease is common in this area. It is caused by tiny worms living under the skin. It is not caused by spirits or witchcraft. Among the signs of this affliction are itching, white spots on the skin, lumps on the body, and hazy vision.

Gardama listens to the health worker and realizes that -- in addition to his spotted skin -- he also suffers from severe itching and also has a lump on his body. Perhaps his problems are in fact caused by these tiny worms! He goes to the health worker and asks if his problems can be treated with the new drug. The health worker says that they can. The drug cannot remove the white spots that are already there, but the drug can stop others from developing. It can also stop his intensive itching and make the lumps on his body grow smaller. He should take ivermectin once a year every year to prevent further deterioration of his skin, itching, and formation of lumps.

Gardama follows the health worker's advice, and swallows the ivermectin tablets happily. As he does so, he notices members of his enemy family taking the drug as well. As the signs of RB begin to improve, the two families recognize their mistake in blaming each other for their affliction. From then on, the feuding stopped.

Characters: Health worker, Gardama, 4 different traditional healers, quarrelling members of the feuding families.

Message: Spotted skin, intensive itching, and swellings (nodules) may be caused by River Blindness Disease. This disease can be controlled with the drug ivermectin. If you live in an area affected by RBD, take Ivermectin once a year every year.

Situation 4

A couple lives happily in Purum ("Trouble") Village. As the years pass the husband starts itching all over his body, and eventually his skin becomes rough and spotted. He also begins to develop lumps. Each time he starts to scratch in the night, he disturbs his wife's sleep. The wife wakes up, complains, and sings a song (habanci) "Scratch, scratch, scratch, My husband is waking me every night. First he has scratching, then his skin goes rough and ugly, then he gets white spots on his legs. How can I do my work tomorrow without my sound sleep tonight? How will I fetch the water, sweep the house, grind the corn, look after my children, and cook the food?" [She sings the song each time they sleep together, adding at each reprise a new detail about the signs of the disease.] One night the wife ends the song by saying that she decides to run away.

The next day a health worker comes to the village, gives health education about RBD, and treats the village with ivermectin. The husband takes the drug, but the wife refuses, claiming she has no problems and so no cause to take ivermectin. In a few months the husband's itching stops, and the wife forgets all about the disturbances in the night. Meanwhile, the husband continues to take ivermectin once a year every year. But the wife stays on the farm each time the health worker comes to deliver the medicine in the village.

Some years pass and the wife starts itching all over her body, and eventually her skin becomes rough and spotted. She also begins to develop lumps. Each time she starts to scratch in the night, she disturbs her husband's sleep. Every time her husband wakes up he sings a song (habanci) "Scratch, scratch, scratch, My wife is waking me every night. First she has scratching, then her skin goes rough and ugly, then she gets white spots on her legs. How can I do my work tomorrow without a

sound sleep? How will I cultivate my land? How will I feed the sheep and goats? How will I inspect my traps in the bush? And how will I attend the hunter's meeting if I have no sleep?" [He sings the song each time they sleep together, adding at each reprise a new detail about the signs of the disease.] One night the husband ends his song by saying that he resolves to divorce his wife and refuses to sleep with her any more.

The next day the town crier announces that the health worker is coming back to the village in two days' time to deliver ivermectin. Suddenly the husband remembers that his wife's problem is just like his own before he started his treatment. So he says, "Wife, you need to take ivermectin like I am doing to stop you itching. Be sure you remain in the village tomorrow." The wife follows her husband's advice and take the drug. In a few months her skin grows smoother and more lustrous, and her itching ceases. A happy scene is enacted in which her husband touches her arm and is seduced by its softness. He goes to the wife's room to spend the night with her and sings a song praising the wife, the health worker, and ivermectin.

Characters: husband, wife, health worker

Message: Ivermectin can relieve signs of RB such as intense itching, rough and spotted skin, and nodules. Take Ivermectin once a year every year.

Situation 5

Kyakyawa ("Beauty") and Ladabi ("Respect") live in Makafi ("Blind") Village. Kyauta ("Gift") and Ladabi have been discussing marriage. Their parents are consulted and have consented. As time goes by Kyauta begins to notice a flaw in his fiancée: her skin is rough and thick to the touch. He also sees that every time they meet and talk Ladabi hardly hears what he says because she is scratching all over her body.

One day Kyauta visits Ladabi in her house and meets her friend Kyakyawa. As Kyauta talks, Kyakyawa is very attentive to her friend's handsome fiancé. Ladabi as usual is very distracted by the irritating

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itching. Soon, Kyauta begins to visit Kyakyawa at her house and forgets all about the scratching Ladabi. In time, his parents are advised to visit her family and the brideprice is paid. They marry soon after.

Meanwhile, Nasamu ("I've Got It"), Kyauta's friend, was not happy to see Ladabi deserted by Kyauta, as he had always admired her fine character, her gentle manners, and her beautiful smile.

One day a health worker comes to the village to give health education about RB disease and to distribute Ivermectin. Ladabi is treated. and soon her itching disappears and her skin regains its normal smoothness and lustre. Shortly after Nasamu meets her in the market and marvels over the change in her body. His parents pay the brideprice and the two couples live happily after that.

Characters: Ladabi, Kyauta, Kyakyawa, Nasamu, health worker

Message: Ivermectin relieves signs of river blindness such as intensive itching and roughened, leathery. Take ivermectin once a year every year.

IVERMECTIN SONGS

"Song of Ivermectin"

I

Ivermectin, Ivermectin
 New Medicine, New Medicine!
 Take it! Take it!
 It prevents blindness from River Blind-
 ness

II

Do you scratch, do you scratch?
 All over your body, all over your
 body?
 Take Ivermectin!
 It prevents body itching.

III

All of you, All of you!
 Listen well, listen well!
 Heed my words, Heed my words!
 Take ivermectin once a year
 Every year.

"Take Ivermectin!"

Take! Take ivermectin!
 It will prevent blindness due to River
 Blindness;
 It will also relieve itching;
 It will make you healthier
 Take! Take ivermectin!
 It will protect all of you!

"Wakar Avamatin"

I

Avamatin, Avamatin
 Sabon magani! Sabon magaini!
 Sai ka sha! Sai ka sha!
 Yana hana niakantar
 Dundumi

II

Kana susa, kana susa?
 Jiki kullum, jiki kullum?

 Sai ka sha Avamatin,
 Yana hana kaikain jiki.

III

Duk jama'a, Duk jama'a!
 Kasa kune, Kasa kune!
 Ji dakyan, Ji dakyan!
 Sha Avamatin sau daya
 A shekara kowace shekara

"Kusha Avamatin"

Ku sha! Ku sha Avamatin!
 Zai hana makanta Dundumi

 Zai hana duk da kaikai
 Zai baku karfin jiki
 Ku sha! Ku sha Avamatin!
 Zai kareku dukanku!

Annex D-7

**ATOP Training Manual:
IEC Section Scope of Work**

SCOPE OF WORK
ATOP CBD Training Manual: IEC Section

Background and Rationale

The Adamawa and Taraba Onchocerciasis Control Project (ATOP) has developed a Training Manual for Community Based Distributors (CBDs). The manual is intended for use as a tool by Health Workers/Trainers for teaching CBDs in education and delivery of the drug ivermectin.

In its present draft, dated November 1992, the Manual comprises three sections, entitled (Section 1) The Disease, (Section 2) The Drug, and (Section 3) Your Responsibilities.

Delivery of health education messages is included among the objectives of Section 3, together with filling out the Household Ivermectin Treatment Record and Role Play. Appended to this section are three oncho mobilization songs in Chamba, Hausa, and Fulfulde.

The ATOP program seeks to expand the "Your Responsibilities" section, which at present comprises a total of 1 1/2 pages devoted to a basic drug delivery message. The main ideas in the message are: the drug is free; it should be taken only once a year; some people are excluded (listed); weighing is necessary to determine dosage; side-reactions (listed) should be reported and assistance will be provided. Role plays of this message are to figure as part of the training; guidelines for role play are not yet included.

Because the CBD and his trainer are the frontline health workers in the ATOP IDP, they are ideally placed to reinforce a sustained annual demand for ivermectin through appropriate health education messages. Such messages target the opinions, attitudes, understanding, and felt health needs of beneficiaries and in this way offer a *rationale* for the practical and operational information contained in messages on ivermectin delivery.

A recent qualitative research exercise in intervention and non-intervention ATOP villages showed no significant difference between the two groups in knowledge about onchocerciasis, its clinical signs, and prevention of these effects through treatment with ivermectin.

In order to encourage and reinforce delivery of health education messages at community level, a set of IEC materials is currently being developed. These materials include flyer/posters, stickers, T-shirts (chiefly for health promoters), drama, songs, storytelling, and health education talks.

The ATOP Training Manual for CBDs should include a module for 1-day training of CBDs in IEC concepts and strategies. In particular, it will teach the meaning and use of the newly developed health education materials for rural communities and households. It is desirable that the module follow the principles of adult learning (learning by doing) and that its language be clear, precise, and easily amenable to oral translation into local languages. While the target audience of the training module outlined in the manual is the CBD, it will be used as a guide by the health workers/trainers of those CBDs. Therefore, the text should be conceived as a teaching tool for the trainer, not as a textbood for the CBD him/herself. The writer may also propose the content of visual illustrations to be included at appropriate points in the text.

It is emphasized that this Scope of Work relates solely to the IEC module and does not require revisions of other sections; suggestions for alteration of these sections are, however, welcome, especially when their content bears directly on the potential success or relevance of the health education module. An outline of topics to be included in the IEC module is proposed below.

Proposed Outline: IEC Section, ATOP CBD Training Manual

1. Purpose of the IEC module and training objectives

- 1.1 Why IEC is important to the IDP: sustaining demand and supply
- 1.2 Outcomes: skilled interpersonal communication and proper use of IEC materials

2. A brief introduction to IEC and to social marketing
 - 2.1 IEC defined
 - 2.2 Social Marketing: where the consumer (beneficiary) counts first
3. Interpersonal communication: importance and techniques
 - 3.1 Verbal and non-verbal communication
 - 3.2 Importance of two-way communication
 - 3.3 Participatory approaches to health education
 - 3.3.1 "Teach-back" techniques
 - 3.3.2 Songs
 - 3.3.3 Storytelling
 - 3.3.4 Drama
4. Meaning and intended use of ATOP IEC materials
 - 4.1 flyer/posters and health education talks
 - 4.2 stickers and recall dates
 - 4.3 song and mobilization
 - 4.4 story and education
 - 4.5 drama and community instruction through entertainment
5. Sample scripts
 - 5.1 health education talks
 - 5.2 song lyrics and cassette tapes
 - 5.3 story scripts and cassette tapes
 - 5.4 drama scripts, photos, and/or tapes

Annex E-1

Materials Production

Sample Calls for Bids

The bids were submitted to the following suppliers:

Nyapuru Printing and Packaging Company, Ltd.
29, Galadima Aminu Way (near Lamido Cinema)
P.O. Box 394, Yola
Jimeta, Yola
Tel: 075-25519/25496

Team Charade Communications
Sabru House
30, Mubi Road, PMB 2140
Yola
Tel: 075-24767

Bobby Printing Press
(A division of J.A. Orokola & Co., Ltd.)
49 Mubi Road
P.O. Box 747 Jimeta, Yola
Tel: 075-24388

Jagilba Survivals Arts Production Centre
Block 16, Bekaji Estate Circle
Yola
Tel: 24124

Jerry Publicity and Printing, Nig.
87 Mubi Road,
P.O. Box 475
Jimeta/Yola
Tel. 075-24087

SPECIFICATIONS FOR ESTIMATE

Job: Stickers: "Take Ivermectin Once a Year Every Year"

Quantity: 5,000 - 8,000 - 10,000 (quote for each)

Size: 10 cm. X 15 cm.

Stock: Self-adhesive, glossy "leather"

Colors: full color. 1 side

Illustrations: 1 minimum size. Full color

Bleeds: 4 sides

Art: Prepared by Printer

Printing: Silk Screen

Packaging: in 100s

Delivery: local

SPECIFICATIONS FOR ESTIMATE

Job: T-Shirts

Quantity: 1,000 - 1,500 - 2,000 (quote for each)

Size: 36 (large)

Colors: full color

Art: Prepared by Printer

Printing: Silk Screen; 1 front, 1 back, 1 sleeves

Packaging: in 100s

Delivery: local

SPECIFICATIONS FOR ESTIMATE

Job: Handbills: "General Message"
Quantity: 50,000 - 100,000 - 150,000 (quote for each)
Size: A-4 (21 X 29.5)
Final Size: Folded, 3 panels, 21 X 10
Stock: Glossy, art paper, 80 grammes
Colors: 4/4
Illustrations: 5 minimum size. Full color
Bleeds: No
Margin
Traps: Quote separate
Reverses: Quote separate
Art: Camera-ready material
Prep: Color Separations for illustrations
Packaging: wrap in 100s
Delivery: local

SPECIFICATIONS FOR ESTIMATE

Job: Press Kit

Part 1: Folder

Quantity: 500 - 1000 - 1500 (quote for each)

Size: open: 31.5 X 45.5 cm. folded: 31.5 X 22.75 cm.

Pockets: 2 pockets approx. 10 cm. deep

Stock: Glossy, gliss card 125 grammes

Colors: black plus 2 colors (quote separate alternative: full color wrap-around photo)

Bleeds: 4 sides. Covers 1 and 4

Printing: cover and 4 and pockets

Art: Camera-ready material

Packaging: wrap in 100s

Delivery: local

SPECIFICATIONS FOR ESTIMATE

Job: Handbills: "Prevention of Blindness"
Quantity: 50,000 - 100,000 - 150,000 (quote for each)
Size: A-4 (21 X 29.5)
Final Size: Folded, 3 panels, 21 X 10
Stock: Glossy, art paper, 80 grammes
Colors: 4/4
Illustrations: 5 minimum size. Full color
Bleeds: No
Margin
Traps: Quote separate
Reverses: Quote separate
Art: Camera-ready material
Prep: Color Separations for illustrations
Packaging: wrap in 100s
Delivery: local

SPECIFICATIONS FOR ESTIMATE

Job: Press Kit

Part 2: Inside text

No. pages: 10 loose

Quantity: 500 - 1000 - 1500 each page (quote each quantity separately)

Size: A-4

Stock: Bond 80-90 grammes different colors (please list colors and stationery types available; ledger preferred)

Colors: black

Bleeds: No

Art: Camera-ready material

Packaging: wrap each page in 100s

Delivery: local