

PATHS

Nigeria Partnership for Transforming Health Systems

Technical Brief



Better Health Begins with You and Me: Changing Behaviours and Social Norms

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All photos in this Technical Brief by Peter Roberts.



Better Health rally in a village in Jigawa

Better Health Begins with You and Me: Changing Behaviours and Social Norms

Summary

From the outset, the slogan driving the PATHS supported state communication campaigns was *'Better health begins with you and me'*. That slogan touched on a constant and necessary theme for health sector reform: that every Nigerian has a role to play in improving his or her health and that of their family and community. The focus of this Technical Brief is on the Behaviour Change Communication (BCC) interventions carried out in Benue, Ekiti, Enugu, Jigawa, Kano and Kaduna, and at Federal level through the FMOH: how they were developed, implemented, monitored, evaluated, and re-designed.

Ideas and concepts

- People's health does not improve simply because health services improve. Nor does it improve just because knowledge about health improves. Some of the most difficult barriers to improved health are cultural, social, and religious norms that both limit access to services and use of appropriate health knowledge, particularly for women.
- It is the job of communication and social development teams to understand all the underlying constraints to improved health, and then to design and implement effective interventions that will reduce those barriers.
- There is a critical balance between supply and demand side issues; services should not be promoted in advance of their ability to respond to that increased demand.
- Simultaneously, people need to understand their rights and responsibilities around better health. They should be actively involved in identifying and shaping their health priorities and in holding government accountable for those services.

The Process

- Creating improved health for Nigerians was a partnership of communities, civil society organisations, government and the private sector.
- Coordination and planning was critical for local impact. Each state established a state communication steering committee made up of stakeholders from all levels: socio-political level (government, media, and traditional leaders); health systems level (service providers); and community level (CBOs, NGOs, and community groups).
- Communication interventions do cost money, but if well designed, are also very cost-effective. Governments need to invest in more appropriate planning and budgeting around health promotion.

- Health Promotion units within SMOH should ideally be coordinating all health communication efforts.
- However, health is not singly the concern of the Ministry of Health. Many other ministries and parastatals have responsibility for the well-being of their communities: Agriculture, Women's Affairs and Social Welfare, Community Development, Education, Information and Communication, National Orientation Agency. Partnerships involving all those ministries, as well as civil society, can help broaden reach and impact while simultaneously spreading cost.

Strategies

- Effective behaviour change required a coordinated strategy using multiple channels and approaches, appropriate to each local situation. These might include mass media, community mobilisation, higher level advocacy, and capacity and skills building at all those levels.
- A *minimum communication package* for each state involved a systematic process including: comprehensive formative research on health priorities; design of a communication strategy using that information, and using as many appropriate channels as possible; message and materials design, pre-testing, revision and production; implementation of campaigns and ongoing BCC interventions; monitoring, mentoring and supervision during implementation; and impact evaluation and re-planning for the next phase.

Materials and messages

- Materials developed need to be in local languages, and, where literacy is low, emphasis should be on spoken, not written, media: e.g. radio and face-to-face communication versus print materials.
- Messages around specific health issues—e.g. TB—need to be simple and consistent, and have a clear *call to action*, i.e. a specific easily *doable* action for each issue, for example: *If you have*

been coughing for three or more weeks, go for a TB test.

Capacity Building

- Delivering the *minimum communication package* required ongoing capacity building at every level: of leaders and government health promotion staff to understand the necessity and benefits of health promotion; of media for more responsive, engaging programming; of community-based groups, NGOs, and Community Health Volunteers (CHVs) in effective community mobilisation techniques; and of health providers to understand the importance and value of client-friendly attitudes.

Introduction

Good health begins at home. But until the caregiver, the family and the community understand what is going on, what needs to be done, and how to take needed action, they will continue to suffer preventable and curable illnesses unnecessarily. It is the mission of behaviour change communication to help Nigerians understand how to tackle illness, to take preventive action, to help them understand their right to better health, to be able to demand those services, and to help them achieve, in partnership with government, healthy communities. In pursuit of these outcomes, the communication teams worked to:

1. Increase consumer knowledge and understanding of how to address key health conditions such as child illness, safe motherhood, malaria, TB/DOTS, while also increasing consumer demand for appropriate services that can adequately address their needs;
2. Improve the interpersonal and counseling skills of providers to help them interact with clients with appropriate information and greater empathy, understanding, and support.
3. Increase consumers' understanding of their right to health as well as their responsibilities to contribute to their own health and that of their families. This includes involvement in defining what quality in health services means for them, and what measures should be taken to achieve that level of quality.

An Ekiti midwife, her lucky client and Better Health posters



Definitions: Health Promotion and Behaviour Change Communication

Health promotion is the process of enabling people to increase control over their health and its determinants, and thereby improve their health. It is a core function of public health and contributes to the work of tackling communicable and non-communicable diseases and other threats to health.

-Sixth Global Conference on Health Promotion, Bangkok, Thailand, August 2005

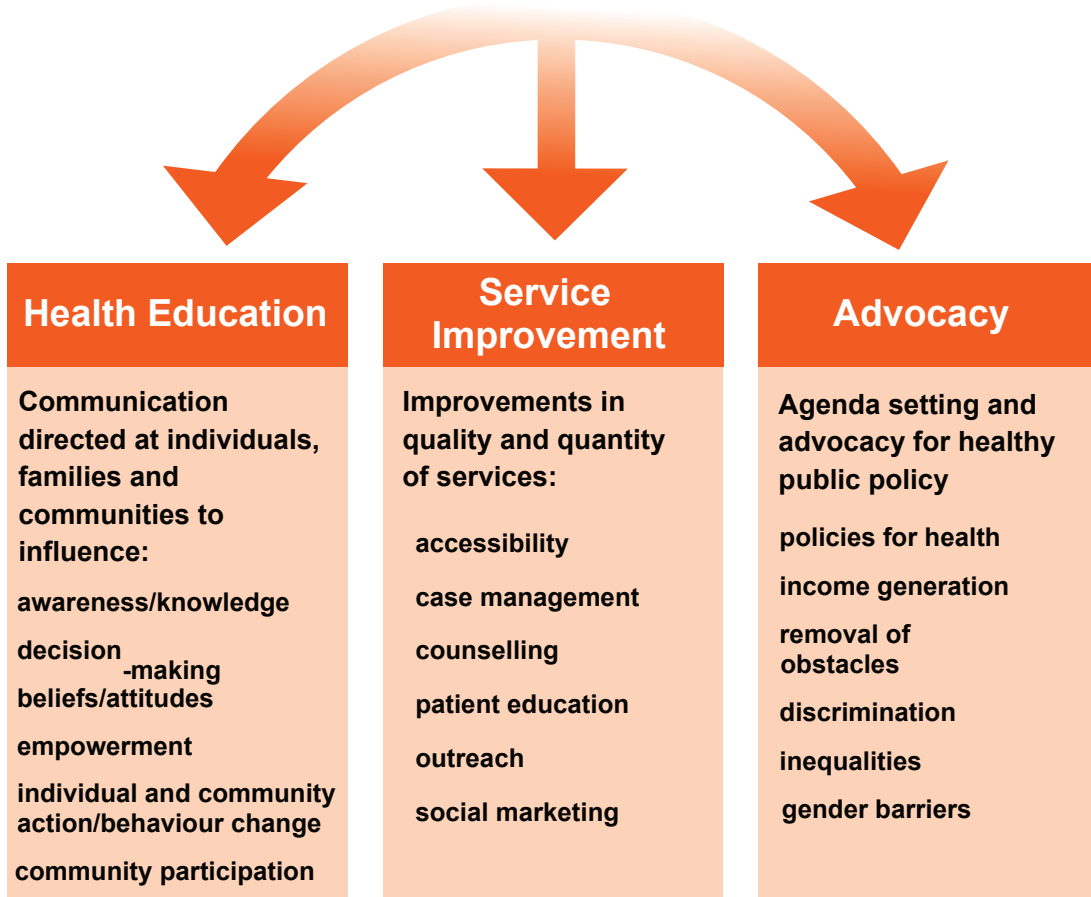
Behaviour Change Communication (BCC) is one component of health promotion, focussing specifically on helping to positively influence individual and community behaviour around health-seeking behaviours. In this report we will use the term BCC, and focus on communication campaigns that addressed priority health issues in each of the states.

An improvement in the quality of health services does not, by itself, improve the health of the community. Many factors influence what people do when confronted by illness, or what preventive measures they take to remain healthy. One of those factors is the quality of the local health services. But there are many other personal, economic, physical, and social barriers that prevent someone from seeking those services or engaging in a healthy lifestyle. So it becomes as important to address and reduce these other barriers as it is to actually improve the facilities (equipment, drug supply, drug price and quality, and competence and friendliness of staff).

Some barriers—like distance from a service or the cost of transport to services—requires additional government resources or other structural change to resolve. But personal, social, and cultural barriers—e.g. lack of knowledge about symptoms of illness or preventive measures, or cultural or religious norms in which women cannot give birth outside the home, or other gender-based restrictions—are in some ways more difficult to change than trying to improve the health system itself. Social and cultural

Three Components of Health Promotion

Health Promotion



norms did not develop overnight, nor will they change overnight, and nor do they change simply because someone has new knowledge. Knowing an action has long-term benefits—e.g. having a child fully immunised—does not mean people will automatically get their children immunised. Many other factors influence that decision. And that is where behaviour change communication plays a critical role.

In 2002 when PATHS started, Nigeria’s national and regional indicators for health were some of the worst in the world¹. Over the lifespan of the PATHS programme, the states have made significant steps towards improving the health of their citizens. On the supply side, states have made many necessary, innovative and systemic improvements². This technical brief looks at the process, the achievements, challenges, lessons learned, and the impact of the BCC state interventions on the health of communities from the demand side.



Young mothers—a key audience for better access to services

1 See the NDHS 2003, considered to have the most accurate national health data over the past 20 years.
2 all documented in other Technical Briefs in this series

The Response

When health systems are largely dysfunctional or inoperative—as they were, for the most part, at the outset of PATHS—a key question is how communication can best be used to improve health outcomes. There is a conundrum for communication. In the absence of services that consumers can use, it is counter-productive and possibly irresponsible to create demand for those services, because they are incapable of responding even to the very low existing demand let alone a significantly increased demand. However, it is also immoral and irresponsible to avoid giving the populace valuable information about disease prevention and basic care around common illnesses, if they are able, as a result of getting that information, to effectively act on it. This might mean, for example, knowing how to treat dehydration caused by diarrhoea—one of the main killers of children under five.

In this context, the key question for PATHS was how to use the power of communication effectively in the absence of adequate health services and while waiting for service improvements that could be publicly promoted. In response, the PATHS communication team moved forward on a number of fronts simultaneously:

Providing basic information about health conditions which communities could respond to even in the absence of good health services. This meant addressing issues with the greatest impact on child and maternal health: diarrhoea and dehydration, sanitation and good hygiene, the treatment of fever, and certain preventive measures against malaria.

Addressing issues around rights and responsibilities for health for all Nigerians. This can be challenging in the period prior to generalised improvement of services, because it can create an expectation for delivery of services that cannot reasonably be met in the immediate future. It requires a delicate balance between advocacy for people's rights to good health and the practical realities of how long it will take to improve the services. If the gap between the two is too long, it can lead to increased frustration at all levels without evident improvement in the health of people in those communities.

Focusing around improving the capacity of key players in communication interventions—the media, government health education units, community-based groups (NGOs and CSOs), and health providers themselves—in preparation for responding to scaled up demand creation efforts.

Working with coalitions to advocate for greater government involvement in BCC, nationally and at the state level. This involved a complex set of discussions linked closely to the overall health reform process which involves addressing policy, protocols, budgeting and planning, and coordination of supply and demand priorities.

PATHS-supported states addressed all of the above in whole or in part. Given the widespread lack of understanding of signs, symptoms, and preventive and curative measures for almost all common illnesses, stakeholders agreed in all states that providing information was a priority. Simultaneously, they agreed that capacity building in the basic skills needed for creating and managing BCC programmes was critically important for all key stakeholders.



KEY STEPS:
Developing BCC programmes

1. Engage stakeholders
2. Identify BCC team consisting of international/regional consultants mentoring local consultants in each state
3. Follow steps in the P Process

Steps in developing a BCC programme

Engage stakeholders

While this brief focuses on state-based BCC campaigns, the state stakeholder-driven, participatory process was designed to tie in with the Health Sector Reform (HSR) agenda. The state BCC interventions were designed in response to a key recommendation in the national HSR strategy to “Communicate that health sector reform requires

transformation of Nigerian society and demands reforms at the household, community and Government levels. The FMOH should act as catalyst and nurture a shared vision for health that engages all stakeholders, including households and community institutions, the primary producers of health. Health Sector Reform should ensure that households, communities and Government are working together so that all Nigerians achieve better health". In the PATHS-supported states, a communication process was set up to facilitate ownership, acceptance and participation in the change process among all stakeholders, including the general population, the ultimate beneficiaries of health sector reform.

The first priority was to identify all the key stakeholders around health communication in each state: the SMOH Health Education unit staff, providers, community members and leaders, NGOs, CBOs and civil society representatives, and, of course, the local media. A communication steering committee was established in each state, under the leadership of government, with the responsibility for overseeing all health communication interventions in the state.

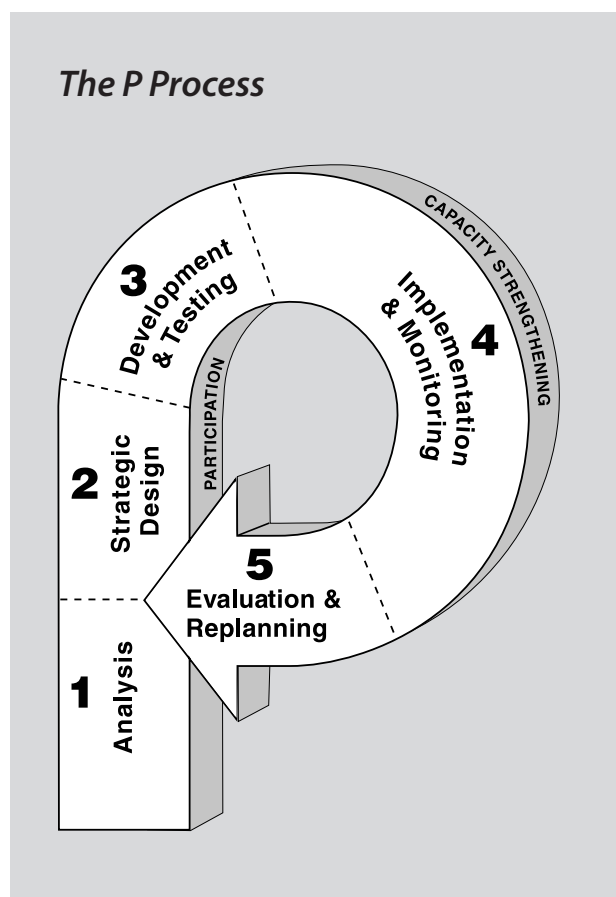
Identifying BCC teams for each state

PATHS and its partners decided early on to take a mentoring approach in the development of communication interventions. Consequently, PATHS identified a small team of international and regional consultants to work with local consultants and state steering committees in the development and implementation of all the campaigns. This allowed on-the-job training to take place while simultaneously developing functioning BCC interventions.

Following steps in the P Process

Once the engagement stage was complete, PATHS introduced the P Process for designing and implementing all BCC interventions. Similar to other design processes for large scale interventions, the P process articulates key steps that move from concept to completion: These include: Analysis, Strategic Design, Development and Testing, Implementation and Monitoring, and Evaluation and Re-planning. Overlaying these five steps are the embedded concepts of participation

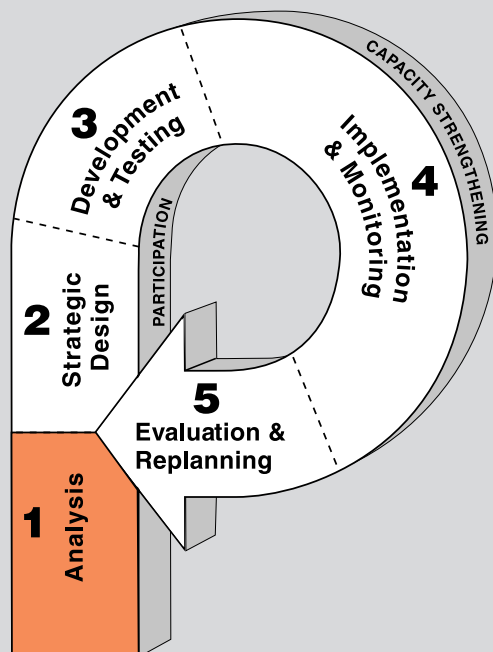
and capacity strengthening. Participation of stakeholders and beneficiaries from the outset is critical to the intervention's short- and long-term success; capacity strengthening of key stakeholders and institutionalisation of that work provide the foundation from which to improve quality over time. While all five steps are important, the first two are critical to ensuring communication interventions are both responsive and relevant to their particular audiences.



Analysis and formative research

Successful behaviour change communication requires a thorough understanding of underlying social and health conditions in relevant communities. The state teams went through a comprehensive analysis of three key areas: a) the overall health situation in each state, b) audience and communication analysis for each priority issue identified, and c) a comprehensive assessment of the capacity strengthening needs for the key stakeholders. A further assessment of the services themselves was completed by other members of the PATHS team, but also fed into the communication strategy.

Key Points for Step 1: Analysis



- Health situation analysis
- Audience and communication analysis
- Assess capacity strengthening needs

The health situation analysis involved a number of key steps:

Determining the severity and causes of health problems in each state

- For this, teams reviewed existing health and demographic data, survey results, study findings,

and any other information available on the problem. Most of this data was sketchy and of poor quality, but similar priority conditions emerged in all states.

Carrying out formative research to identify factors inhibiting or facilitating desired changes

- Consultants conducted desk reviews of existing studies and carried out new formative research in the states to identify the basic social, cultural, and economic challenges facing the people for each priority issue, using both quantitative and qualitative methods.

Developing a problem statement

- Once all that information was gathered, the team of stakeholders developed a clear statement that summed up the problems and challenges to be addressed.

The audience and communication analysis

involved finding out how people thought and acted around the issues identified in the health situation analysis. This involved carrying out a **social and behavioural analysis** which helped the team to assess knowledge, attitudes, skills, and behaviours of beneficiaries at the individual level, using data from the formative situation analysis. It also helped to identify social networks, socio-cultural norms, collective efficacy, and community dynamics (including leadership patterns) at the community level.

Key factors in audience analysis:

What is the key problem?

What are the key factors causing the problem?

What is the desired response?

What are the information gaps?

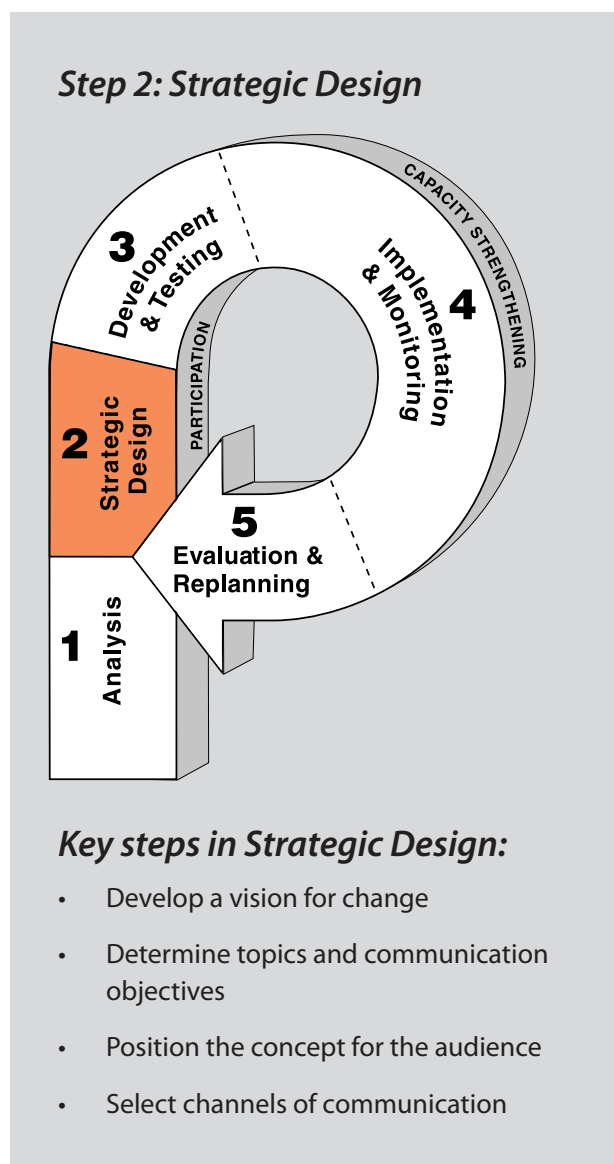
What research is still needed?

What enabling or inhibiting factors (environmental, social, political and economic) affect the problem and how?

For each health priority there tend to be groups who are at greater and lesser risk from that particular issue. For example, emergencies in pregnancy obviously have the most drastic effect on the pregnant woman herself. However, the family (including the baby), and the husband are also affected, through the potential loss of their mother/wife. This process of identifying the different key audiences is called **audience segmentation**. In the example above, pregnant women might be considered primary audiences, and their husbands and family, secondary audiences. For each audience there will be a slightly different set of messages and issues that need to be addressed.

For any particular issue there are also critical audiences at different levels of society. There are those who by seniority and role in society can affect the enabling environment; there are those at the health systems and services level who can influence the quality of health services provided; and then there are the beneficiaries, their families and communities—those most directly affected by the issue. These three levels of audience—at the socio-political (macro) level; health systems and services level; and community/individual/family level—all need to be considered, along with the specific issues and interventions relevant to each. At the socio-political level, the issues are typically around governance, policy making and budgeting and planning; at health systems level, about provision of client-friendly quality services, and a minimum service package; and at community level, about being able to understand and act on health information. In developing their state BCC interventions, the teams identified the key gatekeepers and stakeholders at each of these levels, along with appropriate messages, materials and most appropriate channels of communication.

Finally, the team hired consultants to **assess the communication capacity training needs** of those groups that would be engaging communities in health communication. This included local media, traditional media groups (e.g. folk media, local performers), NGOs and CBOs, communication and advertising agencies; as well as an assessment of the organisational capacity of partners and allies. Research also helped to identify existing access to communication materials in communities, and the level of interpersonal communication and counseling skills among providers.



Developing a vision

In designing state specific strategies, the teams first developed a vision for their state as the driver for change. During the first strategic communication workshops, the teams worked in pairs: Ekiti and Enugu in one team, and Benue and Jigawa in another. Each grouping was asked to develop a vision that described what they would see by the end of 2009 (the original PATHS end date). These visions differed slightly.

Ekiti-Enugu State Team Vision

An effective health care system that meets the health needs of the empowered populace through the integration of relevant services by all stakeholders and sustained partnership with all sectors of the society.

Positioning statement: 'Better health begins with... you and me'.



The Enugu team works on their vision for Better Health

Jigawa-Benue State Team Vision

By March 2007, Nigeria has a responsive, qualitative and sustainable health care system with enthusiastic participation of all stakeholders.

Positioning statement: 'In health we all have a stake.'

These visions were used to guide the development of the communication strategies. The wording of each vision carefully reflected the priorities identified by stakeholders—e.g. *empowered* and *responsive* indicate that the services needed to accommodate clients' needs, not visa versa; *sustained partnership* implied long-term collaboration and equality among partners, rather than short-term "partnerships" of convenience.



The Jigawa team works on the Better Health vision at the BCC workshop 2004

Determine topics and communication objectives

From the data collected, the communication teams developed basic criteria to prioritise the key issues facing the major target audiences:

- Magnitude and severity of the issue in that state
- Type and size of population affected
- Available data which supported those priorities
- Potential quick wins for those priorities considering:
 - Reasonableness of cost
 - Impact on quality of services
 - Potential impact on MDGs
 - Realistic ability to carry out intervention in the shorter term

By consensus, the five priority topics identified for the first phase (2004) were:

- Safe Motherhood (EOC)
- Drug Revolving Fund/Deferral and Exemption schemes
- TB (DOTS)/HIV/AIDS
- Rights and Responsibilities; and Health Sector Reform
- IMCI (Immunisation)

These priorities echoed PATHS supported work on the supply side in each of the States. Given that service improvement was an ongoing process, the communication strategies had to be carefully crafted to ensure that excessive demand was not created for services not yet fully functional.

Any communication initiative must ensure that the state service delivery component of any priority issue is considered as the fulcrum for any BCC intervention so that the demand does not outrun the ability of the service sector to respond to that demand.

Positioning the concept for the audience

An umbrella theme or positioning statement for this vision was also developed. After brainstorming ideas in each of the workshops, the state teams finally agreed on the slogan: "Better Health Begins with You and me". This theme was very flexible and could involve everyone. The "you" could be a community leader, a caregiver, a provider, a governor, or the minister. The "me" could imply "the state", the "community", or the "family". This idea reflected the HSR theme of needing everyone involved in improving the health of all Nigerians.

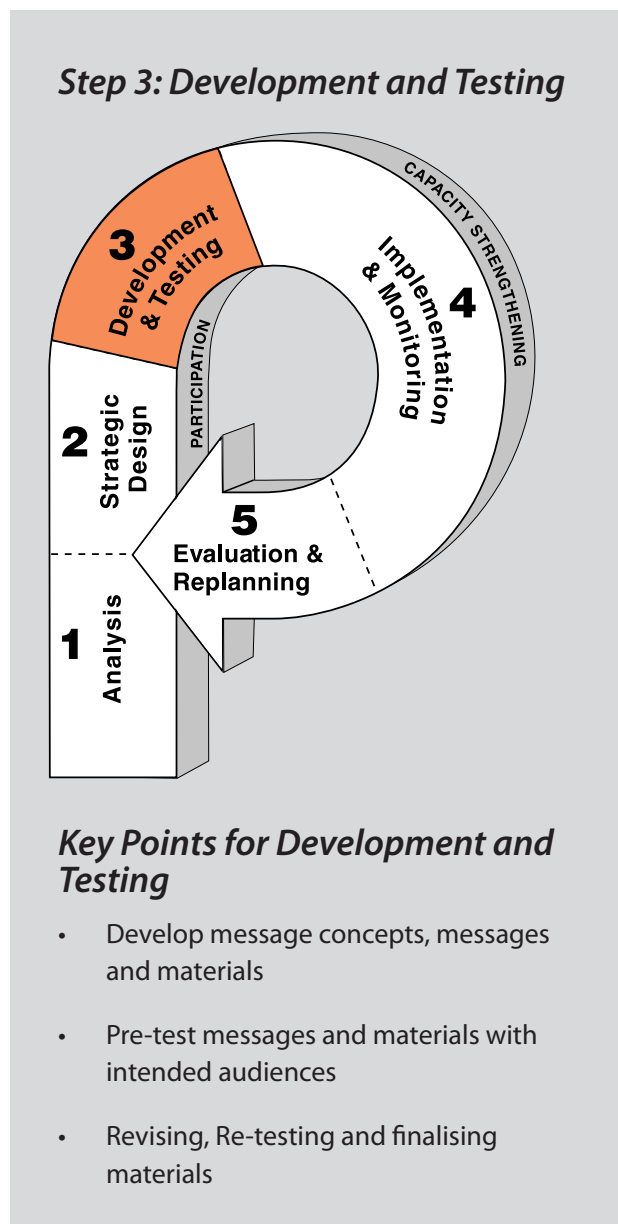
Selecting channels of communication

Extensive research has shown that a behaviour change intervention is most successful if it uses multiple reinforcing channels to reach its intended audiences. Looking at the formative research done by PATHS at the outset, the teams decided on the following complementary approaches:

- **mass media using radio spots and programmes** (produced in partnership with local radio stations) that educate consumers about the priority conditions and promote the services that are being upgraded
- **community mobilisation, demand creation and advocacy efforts** through a) local NGOs and, b) a social marketing agency with capacity to undertake promotional activities at the community level
- **training of clinic-based providers and outreach workers** (nurses and CHEWS) in **interpersonal communication and counselling** skills, and

- **production and dissemination of print materials** through clinic and outreach efforts to support provider and consumer education.

(Details of these approaches follow under stage 4 of the P Process: Implementation and Monitoring)



The third step in the P-Process takes the technical information gathered in steps one and two and adds a creative element as concepts, messages and materials are developed through a participatory process. This creative process is guided by the analysis and strategic design but also aims to evoke a personal and emotional response that would motivate audiences to make positive changes in their behaviour.

Developing message concepts, messages and materials

During this step, the main concepts, messages and materials are developed. It is important to involve key stakeholders such as members of the audience and health workers as well as gatekeepers in the design workshops to ensure the end product meets their needs. It is also critical to assess which approaches and materials will work best for each intended audience.

Once the overarching strategic approach was decided, the groups started to develop specific messages and materials for each of the topics chosen. Designing actual messages for interventions is both an art and a science. The science is driven by the information gleaned from the formative research that has identified how people perceive and behave around particular issues. That data drives the development of the strategy, the channels that will be used to reach people, and identification of the key behaviours necessary for a positive impact. But for any particular topic, there are myriad ways in which one can package it for the audience. This is where the art of effective message design is key. Development of actual messages is usually best done by a small group of creative people, building on the agreed upon information.

In developing messages the 7 Cs of effective communication were taken into consideration.

7 Cs of effective communication

- 1. Command attention.** Attract and hold the audience's attention. Make the message stand out so that it is memorable.
- 2. Cater to the heart and the head.** People are swayed by both facts and emotions. Use both to maximize the persuasiveness of the message.
- 3. Clarify the message.** Ensure the message is clear and easily understood.
- 4. Communicate a benefit.** Stress the advantages of adopting the new behaviour being promoted.
- 5. Create trust.** The credibility of the message is important. Without trust and credibility, the message will go unheeded.
- 6. Call to action.** Include a clear call to action. Tell the audience precisely what they should do.
- 7. Be consistent.** Repeat the same message consistently. This will avoid confusion and enhance the impact of the message through repetition.

Pre-test messages and materials with intended audiences

The prototype print and mass media materials (radio scripts and short spots) were developed in draft form by an advertising agency. They were then reviewed and taken to the field for **pre-testing**. Pre-testing is a critical activity, because it exposes all the developed materials to the identified audiences, to see whether or not the materials make sense; whether the message is easily and clearly understood; and whether the actions that have been suggested in the materials seem reasonable. Materials were pre-tested in each state and changes made to respond to socio-cultural peculiarities identified in each state. For all the materials, the emphasis was on local languages, and English, in order to cover the largest possible audience.

Revising, re-testing and finalising materials

The results from the pre-tests of all materials were collated, analysed and then revised to reflect audience comments and concerns. The materials were then re-tested one last time, to make sure the changes had, in fact, improved the quality and responsiveness of the messages and materials. While this can be a cumbersome process, it was critical to the success of the intervention. Poor quality materials with weak message concepts are a waste of time and financial resources, and can, in fact, be counter-productive. Final materials were then produced and distributed to their relevant states.

The *Better Health* programme had two phases. The first phase ran the five topics - Safe Motherhood (EOC); Drug Revolving Fund/Deferral and Exemption schemes; TB (DOTS)/HIV/AIDS; Rights and Responsibilities and Health Sector Reform; and IMCI (Immunisation). The second phase expanded the programme scope, increased the number of priority areas, and aligned them with MDG goals. For this phase they added *malaria prevention, early antenatal attendance, and community participation in health interventions* to the existing topics.

Each state BCC programme had a complex set of initiatives: a state launch of the programme; mass media support via health-focused radio programmes

and public service announcements; and widespread community mobilisation focused around facilities with improved services. In addition, there were the cross-cutting components of capacity strengthening, and monitoring and mentoring of the implementing groups.

Both phases used all the existing materials, while adding new ones for the new topics. Signage was created for all those clinics that provided either Safe Motherhood (EOC) services or TB/DOTS testing and treatment.

Engaging all stakeholders and partners

Each state created a BCC committee to work closely with the BCC consultant and to provide leadership for local issues. In each state PATHS also hired a local BCC consultant, with responsibility for liaising between the coordinating committees, the local implementing sub-contractors (local NGOs, CBOs and radio stations) and the PATHS BCC team. The dearth of experienced and trained communication consultants in Nigeria, especially those who have worked on large scale campaigns resulted in variations in the quality of monitoring and mentoring across the states.

Materials development: local context is crucial

The following two examples during the material design stage illustrate how pre-testing guided the development of the materials. These examples are from Jigawa.

Yaya kake tsammanin rayuwar lyali ba tare da Uwargida ba?

Bai kamata ya kasance haka ba.



Yi tanadi tare da matarka yadda zata haihu ba matsala

Taimaki matarka taje ta koyo yadda ake shirin tanadin haihuwa a Asibiti da kuma yin aiki dashi


- ▶ Fahimtar Hatsarin da ke samun Mai Juna Biyu
- ▶ Kayi tanadin shirin da zaku yi tare da matarka
- ▶ Kada ayi jinkiri --- a hanzarta zuwa Asibiti lokacin da alamomin gaggawa suka bayyana.

Ingatacciyar lafiya ta fara da kai da kuma Iyalinka.



Yaya kake tsammanin rayuwar lyali ba tare da Uwargida ba?

Bai kamata ya kasance haka ba.




Yi tanadi tare da matarka yadda zata haihu ba matsala

Taimaki matarka taje ta koyo yadda ake shirin tanadin haihuwa a Asibiti da kuma yin aiki dashi

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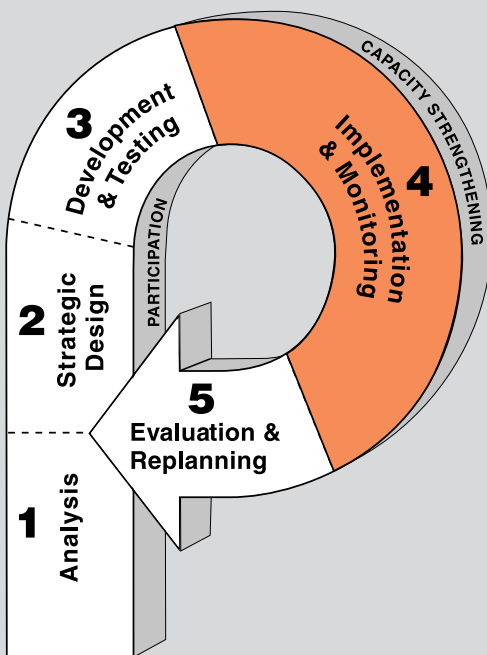


The poster on the left is directed at men. It asks them to imagine what it would be like to lose their wife during childbirth. Pre-testing revealed that most people said the baby was not young enough and the father depicted in the photo was too affluent and well kept. In response the state team took another photo with a much younger child and with a father (poster on the right) more in keeping with the suggestions of the pre-test groups.



Members of a Gwari Ward Facility Health Committee discuss mobilisation efforts

Step 4: Implementation and Monitoring



Key Points for Implementation and Monitoring

- Engaging all stakeholders and partners
- Mass media interventions
- Community mobilisation
- Capacity Strengthening
- Managing and Monitoring activities

Mass Media interventions

Nigerians often identify radio as their *first* source of information on health, ahead of family members, providers, or other sources. They also generally consider radio a *trusted* source, which means that there is a huge responsibility for the information to be clear, accurate, and relevant. All the state programmes used radio as a critical medium for reaching the broadest possible audience in each state.

PATHS facilitated radio design workshops in which representatives from all the stakeholders worked together to determine the content for the ongoing weekly health radio programmes. These covered all the topics, and involved local voices as much as was technically and logistically feasible (e.g. travel costs were limited which restricted producers to no more than one weekly visit to outlying communities to collect local information and interviews).

Those programmes also ran regular public service announcements (PSAs) on all the topics, along with fun contests and awards.

Over time, PATHS consultants helped the producers in all supported states to develop new production and presentation skills, moving steadily towards an emphasis on reflecting local voices and experiences to enhance the sense of local ownership and provide a balance with the more straight forward health information.

CASE STUDY:

RADIO SCRIPT FOR SAFE MOTHERHOOD, FOR HUSBANDS EKITI: Bereaved Father RADIO SPOT 2 minutes

This radio spot was first pre-tested in Jigawa. Everyone really liked it, but a number of mothers told researchers that they needed to give the husband a proper name (he had no name in the pre-test). Their reason: So they can tell their husband: "You should not be like that man Babandi (the name suggested in Jigawa). You should learn from him and save your family". Consequently, in each state, the husband was given a name that typified a man who makes mistakes.

Format:

Fictional testimonial from the father of three children, whose wife died in childbirth. He is an ordinary man, like most of his friends and neighbours. Perhaps he works as a clerk in the government, or as a mechanic. He is economic class C. He is suffering the loss of his wife a year later.

Sound:

(Young children playing in background.)

Baba Ayo:

I am the proud father of two children. But recently my wife died, delivering our last child. We miss her so much, I feel lost without her. And now I realise that it was my fault she died.

You see, when she got pregnant again, I thought it would be simple like before. My wife told me she wanted to prepare a birth plan with providers at the new health centre. But I didn't listen. I said we did not need it.

On her day of delivery, she was at home with her best friend and my mother, as usual. Things started to go wrong but we didn't understand the problems were serious. We stayed at home, hoping it would get better. (SLIGHT PAUSE). It got worse. We realised we needed to go for help, but it was night-time. It took a long time to find transport and it was expensive.

Finally, we got transport. But then we delayed again because we couldn't decide where to go. (PAUSE).

The baby was saved that night (PAUSE). But my wife died. Not because she got sick, but because we did not plan for the birth.

So, my fellow fathers, listen to me: You need to understand the real risks of pregnancy. You need to support your wife in preparing a safe delivery plan. And you cannot delay when problems show. Do this and you will not be like me now.

Narrator:

Fathers, remember it's 1,2,3. One, prepare a safe delivery plan with your wife. Two, know and understand the warning signs in pregnancy. Three, don't delay, act fast in emergencies.

For help in preparing a safe delivery plan, encourage your wife to find out at the nearest Government health centre.

Better health begins with you and your family. This message is from the Ekiti State Ministry of Health

Community mobilisation

From the outset, all the states agreed that community mobilisation around health issues was a priority, and should work in consort with all the other communication and social development interventions. Each state had its own unique history around mobilisation at community level. So it was agreed that while there should be a general overarching approach, it should also fit with the existing process and mechanisms in place in each state.

During the first phase of BCC interventions, the state communication teams identified NGOs with some stated experience in the focal health areas. These groups were chosen based on information they provided about the amount and types of training they had already received for community mobilisation around health. Each NGO was contracted to work in a smaller catchment area typically covering one or more LGA. In their own zones they identified local CBOs whom they then gave basic training in a cascade model. These CBOs were responsible for mobilising people in only a few communities surrounding the chosen improved health facilities.

The CBOs were required to work in collaboration with the CHEW at their chosen health facility, so there was always a connection between the CHEW (facility) and the community. All the mobilisers were given copies of the Better Health kit, which has two distinct sections. One section has basic information about each health topic; the other section has suggestions for how mobilisers can present that information to their community members in interactive, engaging ways. The NGOs were contracted to monitor activities of their CBOs, and to provide reports to the state steering committee.

CASE STUDY:

Community Mobilisation – creating a more harmonised approach in Ekiti

The Ekiti model for community outreach

In Ekiti, a potential duplication of community outreach efforts was identified. UNICEF was planning to identify and train a Community Outreach Person (CORP) for every community, to disseminate information about IMCI. Simultaneously, the Ekiti Steering Committee was planning to develop its own outreach program using community volunteers, trained by state and local NGOs and CSOs, to deliver health information in identified communities. The criteria for the selection of volunteers in both systems were almost identical. The overlap in basic information being provided was also considerable. PATHS facilitated a meeting between all the key stakeholders, principally UNICEF, SMoH, and the steering committee members. It was agreed to do a rapid SWOT assessment of the situation. The result of that assessment was the unanimous agreement that all community outreach efforts around health be undertaken by a single cadre of volunteers trained on a single minimal package of information addressing all the priority health issues, including key child and maternal health issues. PATHS then facilitated the development of a unified curriculum and training regime, and developed a client-friendly Better Health kit that was provided to all volunteers for their use in outreach efforts. The volunteers were given badges of identification, and referral cards which they handed to any person whom they referred to a clinic for further assistance. These cards were then collated at the clinics, and correlated with the reporting forms filled in by the volunteers. Under this unified, harmonized approach there was a considerable increase in clinic usage, not only for IMCI but for all the priority health issues in the community.



An Ekiti CORP mobiliser making her rounds

Capacity strengthening

Capacity strengthening is an integral part of the *P Process* and happens at all five stages, and at every level of stakeholder engagement. It is included under implementation and monitoring for simplicity's sake. The PATHS supported BCC interventions functioned at three levels, each with its own distinct capacity strengthening needs.

Socio-political level

At the socio-political level, the communication teams worked with political, traditional, and community leaders to promote the benefits of, and need for, increased financial and public support for broader demand-side issues. They provided information kits, suggested interventions, and asked for support for ongoing community activities—e.g. in Enugu, the Governor was invited to award the “local hero” prizes for people chosen by their own community members as role models for social change, through the *Change and Smile* TV show in Enugu.

Change and Smile

Change and Smile was the only television show to be used in the PATHS supported states. It was designed, produced, and broadcast in Enugu between 2004 and 2007. Overall, the series produced 52 half-hour weekly programmes, covering a very broad range of topics of local social relevance. These programmes were repeated at least twice on local TV stations. By using television, the state communication team understood that it was reaching a minority in Enugu, but that minority were considered to be gatekeepers and influentials in their own communities. So the purpose of the show was to motivate those more influential viewers to voice their concerns about local issues. The methodology was to demonstrate a new topic of local importance every week through an interesting, participatory and entertaining format. In any particular show there was a short initial trigger drama that set the scene for the real situation (e.g. traditional widowhood rights that threatened the health, well-being and human rights of the widow). There then followed a mini-documentary describing the situation in that particular community. This was then followed

by interviews with government officials, in which the situation was presented to them for comment. At the end of the show there was a regular feature called “Local heroes” in which the presenters asked viewers to recommend someone they know whom they considered a “Local hero” for the work he/she was doing to improve the lives of their community and their neighbours. A “Local hero” award was presented to the winner by the state Governor (or his representative) every 13 episodes (or every three months), in a televised public ceremony. A qualitative evaluation indicated that the show was widely watched and helped community members understand that they themselves could be involved in improving their own communities—a key objective of the Nigerian government’s Health Sector Reform process. The TV show also covered many topics outside health—governance, security, corruption, education, traditional values (e.g. widowhood rights)—and worked in close collaboration with other DfID funded programs in Enugu. The show was also picked up and aired by television stations in other states, and was seen as an innovative model for public programming.

Health workers

Health workers are the face of the health system. As such they carry a heavy responsibility for making their clients feel comfortable and confident about that service. The capacity of health workers was strengthened in numerous ways:

- Interpersonal Communication and Counselling [IPCC] skills of facility and community based health workers were enhanced, to facilitate effective provider-client interactions.
 - At the federal level, IPCC training was given to TB DOTS health providers
 - Relevant modules of the IPCC training were incorporated into the pharmacists in-service training, “Mandatory Continuing Professional Development Program”
 - At the state level, various cadres of health staff including Officers in-Charge, Heads of Departments, Health Assistants and Ancillary staff benefited from the IPCC training
- Radio distance learning, for performance improvement and enhancement of community mobilisation skills, complemented and supported the face-to-face training of providers and Community Health Volunteers.

The IPCC manual that was developed in the PATHS supported states was being considered in early 2008 as the standard curriculum in the basic training for all health providers at federal level.

Mass Media

Radio producers in Nigeria have to cover a huge spectrum of information during a regular week’s programming, and consequently few radio producers and presenters have an in-depth understanding of local health issues. Coupled with the fact that there is virtually no audience research done by local or even federal broadcasters, they also lack in-depth knowledge about the levels of health knowledge among their community members. As journalists, they also tend to provide factual information in a rather rigid, didactic fashion, with little exploration of alternative approaches. This then limits the level of commitment of and interest among listeners, which in turn reduces the potential

impact of the medium. Having identified this issue, the communication team undertook an extensive and broad-based series of trainings for radio producers in the PATHS supported states. The focus was to:

- Improve their understanding of health issues in their communities
- Give them new interview skills, based around having people tell their personal stories related to health issues
- Help them to re-design their programme formats for more dynamic audience engagement
- Improve their station’s technical capacity, through provision of new digital recorders and computer based editing equipment.

To do this, international and national consultants were hired to conduct a broadcast and production capacity assessment of each of the broadcast stations in the PATHS-supported states. A series of three trainings was then conducted over a period of four years, to develop teams of trained producers in each state. The intention was to have those teams of producers, who often come from different stations in each state, meet on a regular basis and learn from and build skills through a peer review process. They could listen to samples of recent programmes; build self-critiquing peer assessment skills; discuss issues that emerge; plan for collective improvement and collaboration over time. In this way, the skills and interest of all the producers was heightened. The trained producers also had the role of mentoring their colleagues at each station, introducing whatever useful techniques they thought appropriate and useful.

Radio was also used as an innovative supplementary training tool for providers and community health volunteers (CHVs). This developed in response to the assessment (see next section) that identified the need to better ongoing support for CHVs. Because the format and content has its own unique attributes, the radio *Distance Learning programme* for the CHVs and Community Health Education Workers (CHEWs) involved two rounds of training for both producers and scriptwriters. The focus of radio *distance learning* was twofold:

1. To provide the listeners (CHVs and CHEWs) with correct information about all the *key health topics* that affected their particular state



Field recording and studio post-production of **Alafia Ekiti**, their weekly Better Health programme



(e.g. safe motherhood, TB/DOTs, diarrhoea and dehydration). This was done through creating a simulated CHV classroom, in which fictional trainee CHVs are being given the exact information that the real CHVs need in the field. This simulated learning allowed for questions to be raised about each issue, to help make sure all the main points were covered, and covered clearly and accurately;

2. To reinforce the *community mobilisation process* by demonstration. This section of the show used an ongoing drama that followed the daily trials and tribulations of a fictional CHV who was trying to get her community more engaged in improving their own health. Through the problems the CHV faced, and the advice she received from an older, more experienced CHEW, the program was able to address real life issues in a realistic and entertaining manner.

Managing and Monitoring activities

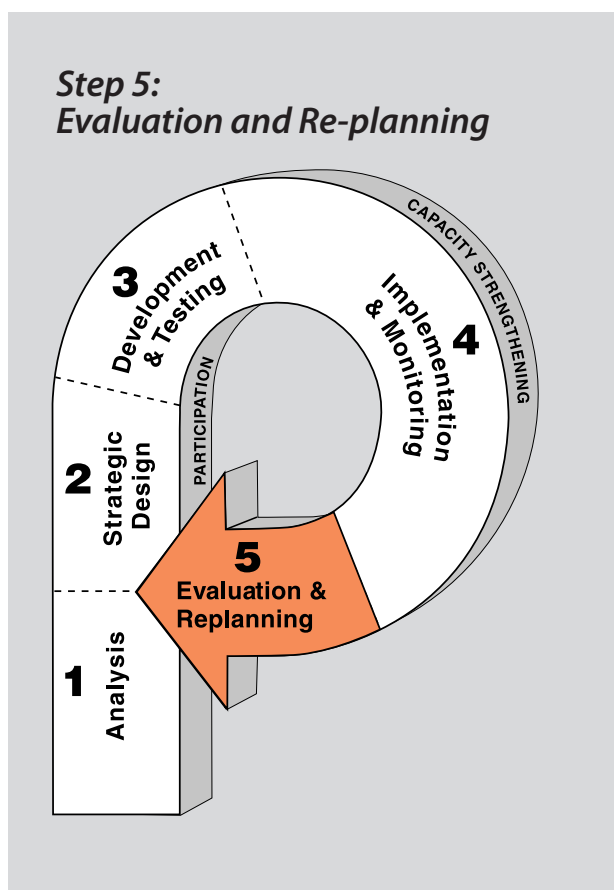
After the first phase of the BCC campaigns, PATHS carried out a qualitative survey to determine how well the community mobilisation activities were going. This mid-term assessment provided a wake-up call for the mobilisation efforts, revealing that the training and methodologies the NGOs had were inadequate. The quality of their methods and the information they provided was poor; their management skills were minimal, and the supervision and monitoring of the NGOs, carried out by the state BCC consultants, was inadequate for reasons mentioned earlier.

As a result, the communication teams re-visited their training, monitoring and supervision routines, revised the training modules, and improved the supervisory process. While they had distributed the Better Health kit to CHVs and CHEWs, they realised it was too complex for all but the CHEWs. Thus a second, lower literacy health information manual was produced called the Community Mobilisers' Manual, which was more appropriate to the low level of education of the CHVs.

The teams also re-visited the way in which community mobilisation efforts were coordinated both within PATHS and across ministries. The key idea was to create a harmonised approach in which all communities benefited from an array of health information, being provided by a single cadre of volunteers, rather than being visited by different volunteers with different sets of information. Each state developed its own steering committee mechanism for this agenda but all had the intent of coordinating a single approach to health promotion at the community level.

Visits to the states by the PATHS BCC consultants determined that while there were issues that needed to be addressed, overall, many aspects of the initial BCC programmes worked well:

- In all states, the launches were well attended. Senior officials in government as well as traditional and religious leaders attended. The launches were reported on television, radio and in the press.
- The IPCC training of providers and CHEWs was completed in all three states.
- Signs for the PATHS supported health centres were erected in all states.
- The community outreach with Experimental Momentum (EM) and the CBOs took place as planned in Ekiti, Jigawa and Benue.
- Radio programmes started slightly behind schedule but were soon on air in three states. By 2008, they were a regular part of each station's weekly broadcast schedule.



Evaluation measures how well a programme achieves its objectives, providing valuable insight into why a program is or is not effective. Evaluation can also provide insight on how to improve or redesign a programme.

Measuring outcomes and assessing impact

PATHS worked with states to conduct numerous formative research efforts to assess knowledge, attitudes and practices around the priority topics—e.g. Safe Motherhood; Tuberculosis; Immunization; and HIV/AIDS and stigma. This research informed the design and implementation of relevant state BCC interventions (see PATHS Toolkit for reports on those issues). Similarly, PATHS coordinated quantitative household surveys in the PATHS states to determine the impact on the BCC interventions (see results below). PATHS also carried out qualitative surveys on some subjects—e.g. on the response of community members to the community outreach interventions. These smaller, more focussed studies were meant to give a snapshot of the responses of small groups of people to the planned intervention. However, because these latter surveys had fewer people interviewed, these studies should not be used for

assessing the wider population response to the issue.

In both cases, the qualitative and quantitative surveys helped the team re-assess and redesign the interventions, with the hope that adjustments would address the shortcomings identified in the research.



KEY STEPS: *Evaluation and Re-Planning*

The process of evaluation and re-planning included a number of key steps:

- Design evaluation plan during the Strategic Design Step
- Include behaviour change indicators
- Use appropriate evaluation methods
- Disseminate evaluation results to all relevant stakeholders and partners
- Plan for continuity

These steps are not described in detail but the methodology and the results of the evaluation of the BCC campaigns are presented.

Results

In early 2007, a quantitative household survey to determine the impact at community level of the PATHS supported communication initiatives was conducted. It was decided that for budgetary reasons it was not possible to cover all PATHS supported states, so the survey took place in only two states, Jigawa and Ekiti, as representative of the two geographic key areas covered by PATHS: the north and the east/central region³.

Issues with evaluating communication interventions

Some researchers have argued that the “golden” standard of programme evaluation is the randomised control trial where subjects are randomly assigned into treatment (exposed) and non-treatment (unexposed) groups. However, for full-coverage mass media communication campaigns it is almost impossible to randomise people into exposed and unexposed categories.

Researchers have therefore tried to identify other methods to mimic a control group comparison without having to limit public access to mass media. One such response is the propensity score matching technique (PSM), an increasingly popular method in programme evaluation (see Rosebaum and Rubin, 1983; Babalola & Vondrasek, 2005; Kincaid & Do, 2006). PSM compares outcomes of programme participants with those of “statistically equivalent” non-participants in an intervention. The respondents are matched on a wide array of socio-demographic characteristics that are susceptible to influence both campaign exposure and targeted outcomes. By controlling for major threats to validity, PSM helps to strengthen claims about causal attribution.

Applying PSM involves a three-stage procedure. First, we predict campaign exposure using relevant socio-demographic and socio-economic variables and obtain a propensity score (the probability of being exposed) for each person in the sample. Second, we match exposed and unexposed individuals on the basis of their propensity score. Third, we compare the outcome (knowledge, attitude or behaviour) of each exposed individual with that of his/her matched unexposed peer, and obtain a difference for each matched pair or group of matched pairs. Programme effect is obtained by averaging the difference in outcome across all matched pairs or groups. We used PSM to assess the effects of PATHS BCC interventions on selected outcomes.

3 See 20/04/COM/31: Impact of a Behaviour Change Communication Program in Nigeria: Evidence from a Household Survey, January 2007, by Stella Babalola, JHU-CCP

Selected Outcomes

Selected knowledge, attitudinal and behavioural outcomes of all respondents, regardless of their exposure to the campaign, are presented in Table 1. In general, the data show that knowledge about relevant health issues was not high while positive attitudes were only moderately common. There were significant differences in the selected indicators

between Jigawa and Ekiti. While the data presented on Table 1 say nothing about the impact of the campaigns, they indicate the level on which future interventions can expect to build.

A key indicator of eventual change in community norms is the extent of interpersonal communication around specific issues. Substantively, the more people engage in open discussion about issues,

Table 1: Selected health indicators

Indicator	Percent	
	Ekiti	Jigawa
Immunization		
Know the correct number of times to take child for routine immunization (five times)	25.6	4.3
Malaria		
Encouraged someone to eliminate mosquito breeding sites during the last 6 months	40.1	60.1
Know at least 2 correct ways of malaria vector control	50.4	46.7
Encouraged someone to take a child with malaria to health center	41.1	66.5
Households with any type of bednet	16.6	24.3
Safe motherhood		
Know at least 2 danger signs during pregnancy	46.3	46.9
Encouraged a pregnant woman to have regular and prompt antenatal care	28.7	57.1
Drug Revolving Fund		
Know what Drug Revolving Fund does	15.9	30.1
Bought DRF drugs during the last six months	6.5	21.4
Diarrhea		
Know correct dosage of Salt-Sugar Solution	39.2	62.4
Know at least 2 danger signs of diarrhea	27.5	46.0
Tuberculosis		
Know that persistent cough for more than 3 months may indicate tuberculosis	44.9	48.0
Know that tuberculosis is curable	61.4	55.3
Know that the services of TB DOTS centers are free	3.3	18.3

Source: PATHS BCC Evaluation Survey, January 2007

Percentage of people that discussed specific campaign materials with other people, by state

Materials	Ekiti	Jigawa
Materials on immunisation	63.0%	84.7%
Materials on antenatal care	58.7	78.4
Materials on diarrhoea	61.0	77.7
Materials on insecticide-treated nets (ITN)	33.4	70.4
Materials on DRF	62.7	85.3
Materials on tuberculosis	43.5	72.0

the more conducive the social environment is for change. The survey results show that the campaigns generated a lot of conversation in the communities about health priorities.

We know from studies, for example, that people who hear information from their trusted friends or family are as likely to take the prescribed action (e.g. go for ANC visit) as are those originally exposed to the communication intervention firsthand - through radio, posters, community mobilisation, etc. So

community dialogue about public health issues is a good and necessary starting point for change. As the table indicates, the state BCC programmes seemed to have generated significant public discussion and debate about health priorities. It remains for future programmes to build on that strong beginning.



A small girl at a BCC community event in Kano holding a spoon given to mothers to mix up homemade SSS (Salt Sugar Solution) to prevent dehydration

Table 2. Percent demonstrating selected indicators (exposed, matched unexposed) and PSM-adjusted effects of the campaign on selected indicators, by state and by gender

Indicator	Percent					
	Ekiti			Jigawa		
	Exposed	Matched Unexposed	Effects	Exposed	Matched Unexposed	Effects
Knowledge about tuberculosis	81.5	29.7	51.8***	77.7	34.4	43.3***
Knowledge about DRF	88.0	8.4	79.6***	85.9	14.7	71.2***
Encouraged someone to engage in malaria	56.0	39.1	16.9***	76.5	55.6	20.9***
Perceived that malaria is a serious malaria	55.8	41.7	14.1***	63.5	61.5	2.0
Personally involvement in malaria control	29.6	18.3	11.3***	38.7	15.1	23.6***
Visited health centre to purchase drugs	50.8	14.3	36.5***	67.9	45.6	22.1***

Source: PATHS BCC Evaluation Survey, January 2007 Significance of effects: *** p<0.001; ** p<0.01; #p<0.1

The number of asterisks identifies the level of significance of the data; so *** represents a significant degree of changes, while no asterisks indicates an insignificant change.



New mothers are chosen from the crowd to participate in song on dehydration, and to be given SSS spoons

Campaign Exposure

The data indicate a relatively high level of campaign reach. Well over three quarters (81.4%) of the respondents from Jigawa and almost three quarters (73.1%) of their peers from Ekiti were reportedly exposed to the campaign and could recall at least one campaign message. In both states women are equally as likely as men to have been exposed to the campaign.

Social Interactions

A key indicator of eventual change in community norms is the extent of interpersonal communication around specific issues. Substantively, the more people engage in open discussion about issues, the more conducive the social environment is for change. The survey results show that the campaigns generated a lot of conversation in the communities about health priorities. For example, about a third of the exposed respondents in Ekiti and more than 80% of their peers in Jigawa discussed the materials on immunisation.

Campaign Impact

The data clearly demonstrated that the campaigns had significant effects on relevant indicators as shown on Table 2 which presents the PSM-adjusted effects of the campaigns on selected indicators. The data indicated that, in both study states, the campaigns helped to increase knowledge about tuberculosis and DRF. Moreover, the data suggest that the campaigns have helped to increase personal advocacy in favour of malaria control and improved audience understanding about the severity of malaria. Personal involvement in malaria control also appears to have become more widespread as a result of the campaigns. Similarly, the campaigns resulted in significant increase in patronage of health centre for purchase of drugs during the last year.

In sum, the effects of the campaign on health-related indicators have been considerable. Translated into actual numbers of people, the results indicated that the BCC campaigns reached millions of people, helping to increase their health-related knowledge and influencing them to adopt health-protective attitudes and behaviours.

Sustainability

Multi-sectoral response at community/state level

Health promotion is typically left to those working in the formal health sector. But good health is not generated by the Ministry of Health. It is generated by everyone in the community—by households, by mothers, by fathers and others.. Likewise, if these states are to sustain an improvement in their citizens' health, promotion of good health should be the responsibility of all the stakeholders across various line ministries and sectors. However, this approach goes against the kind of vertical planning and implementation that exists in most ministries in most countries. But the state BCC communication and demand side teams have begun a process of bringing together relevant ministries at state and local government levels, like the Departments of Social Welfare, Community Development, Agriculture, Information and Communication, Education, and others who have a responsibility for community interests. NGOs and CBOs who operate outside government, have also played a critical role. If the committees can build on that collaborative spirit, multi-sectoral engagement could facilitate scale up by a) broadening the reach and b) providing a consistent, standardised set of messages and approaches across sectors.

Public sector capacity and interest in HP is weak

International meta-analysis of the most cost-effective health interventions in development settings shows that the two most important interventions are community outreach and provision of health information—both happening outside the formal health system. And yet, health promotion remains a very low priority in most health ministries.

Historically, Health Education units in government typically were a service group for all the other departments, and as such were often called on to respond to ad hoc and urgent requests for materials, posters, "health day" events, etc. Health promotion is a much more sophisticated and complex process, and requires significant training, and expertise.

PATHS worked closely with state and federal governments to a) create the enabling environment for greater health promotion by providing development assistance for the Health Promotion Policy; and b) institutionalize training of HP/Health Education unit staff at both federal and state level.

Multi-channeled advocacy needed for increased federal and state funding for HP

Research shows that BCC is most effective when it uses multiple simultaneous channels of communication (e.g. radio, community mobilisation, high level advocacy). The process to achieve all that is expensive: radio and/or TV production and airtime; design, printing and distribution of materials; TOT and step-down training; and regular monitoring and supervision, and, critically, impact evaluation of those interventions, all have significant costs. However, the results, because they are reaching wide audiences can be very cost-effective. Typically those costs have been borne by donors and their implementing partners, but for sustainability, those costs need to be integrated into government budget and planning cycles.

Lessons Learned

There are many lessons learned from the last six years of BCC work through PATHS.

General

These are some findings that have had a significant effect (positively or negatively on the BCC efforts):

- It is important to ensure some level of consistency in the team of consultants who provide technical support as this helps to deepen local knowledge and skills, and provides a more dynamic and active exchange of understanding across the entire process.
- In the development of materials, poor translation can significantly undermine the whole process and derail a communication campaign. Translators need to be able to use the vernacular rather than more formal versions of the local languages, whether for radio or print materials, so that ordinary people will understand and feel more comfortable with the information.
- A regular forum where the state and federal stakeholders can share experiences and ideas for better results can help open dialogue, improve cost-efficiency, and reduce duplication and inconsistencies in messaging around issues (e.g the Round Table forum for Safe Motherhood).
- Pre-testing is essential before final production and distribution of campaign materials so as to establish suitability or otherwise of the materials.
- When doing local workshops for almost any issue, experienced and committed facilitators make a big difference in the quality and retention of the skills building.
- *If you didn't measure it, it didn't happen.* Formative research needs to be done at the beginning of the process to ensure relevance, and high quality impact evaluation needs to be done at the completion of any phase, to know what was achieved.

Monitoring, mentoring and supervision is critical

The BCC Assessment and subsequent qualitative visits have demonstrated clearly that good, rigorous, regular, but supportive monitoring is critical to sustaining quality in all community mobilisation efforts. Without regular visits, there tends to be a fairly rapid reduction in the quality of discussion and engagement by the mobilizers. PATHS learned this lesson after the mid-term review, and as a result worked with the state communication groups to develop better coordinated efforts to monitor activities, by putting in place committees at state, and local government levels. Community groups then reported up to these committees so the flow of information from the top and bottom was improved, and potential problems identified earlier. In this way good monitoring can in itself be a motivating factor for improved performance, rather than a feared burden.

Engagement of health providers

As the saying goes, *you only have one chance to make a first impression*. Health providers are the face of public health, and the first impression they make is a lasting one. Unfortunately, that impression has, for decades, been a poor one. Providers often are cited as rude, inconsiderate, and dismissive of their clients. This attitude is as strong a barrier to access to services as many of the others - distance, cost, lack of drugs, etc. But it is the easiest barrier to change. The PATHS team placed high importance on IPCC skills from the outset, and IPCC skills have been integrated into all PATHS-supported state training and on-the-job training programmes. As a result clients are much more likely to feel providers are friendly and attentive. On the demand-side, this is the first vital step towards making public services viable again⁴.

The other key communication role for providers lies in their ability and willingness to engage with their communities in supporting outreach efforts and in providing feedback about clients' needs to their OICs. Through this feedback, and through the liaising role of the FHCs, there should be a greatly improved level of open productive dialogue around improving community health, based on local priorities.

⁴ Supply side issues obviously have to be improved simultaneously in order for that impression to last!



Happy and proud father and his healthy young son at a PATHS-supported Gwari ward clinic

Private sector engagement is critical

Private sector providers—non-profits, faith-based providers, patent medicine vendors (PMVs) and pharmacists—deliver the majority of first line services (estimated around 70% on average) in Nigeria. In some sectors (e.g PMVs), quality is very inconsistent and standards vary widely and are rarely regulated. On the demand side, PATHS had limited success working with the private sector on the higher regulatory level, where political and institutional vested interests made collaboration difficult. However, if gains are to be sustained, the private sector need to be part of the efforts to improve quality services.

Useful data flow up and down

Information is knowledge and knowledge is power. In most states, the flow of useful information is poor and irregular. If the whole process of mobilisation and engagement of communities is to have sustained impact, an open and regular flow of information is critical. Communities need to know the results of the work that is being done: how many people are using services; what results have there been around key health issues: e.g. cases of malaria; safe deliveries; immunisation rates. At community level, PATHS supported states made real progress in opening up communication between the

community and its facilities, through groups like the Health Management Committees. However PATHS had mixed success in trying to open those avenues for communication within and across government ministries. For example, passage of the Health Bill might have happened more quickly had all the stakeholders, both within the FMOH and among key stakeholders, been more engaged from the outset.

Identifying appropriate skilled partners

The PATHS experience has shown that a full inventory of local community-focused organisations, based on clear, concise and comprehensive indicators, is a necessary precursor to implementation of any broad-based community or BCC programmes. Without it, community mobilisation efforts can be compromised by groups or institutions unable to deliver on their mandates. In addition to the asset inventory, there should be an opportunity to test capacity in actual field work. Prior to the first phase of BCC campaigns, PATHS teams carried out the asset inventories but, once in the field, discovered that many local NGOs and CBOs had only rudimentary skills in facilitation and participatory engagement of community members. Rigorous monitoring and mentoring of groups, in addition to the initial training, will help to remedy that situation.

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CD Resources

There is a CD Toolkit of key resource materials developed under PATHS for Communication issues.

The resources form part of the complete PATHS package of information.



Partnership for Transforming Health Systems (PATHS)



PATHS is a programme of collaboration with Nigerian partners to develop partnerships for transforming health systems in Nigeria. It is funded by the UK Department for International Development (DFID).

The PATHS Programme is managed by an international consortium on behalf of DFID. Members of the consortium are:

