



**Nigeria HIV/AIDS Orality Project
"Show Love and Care"
Final Project Report**

Submitted to

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and
Johns Hopkins University
CCP/Health Communication Partnership**

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Executive Summary

“Perhaps the most remarkable thing about the VFH project was the feeling of empowerment it generated among participants. Because of the small group delivery approach that encouraged individual participation, villagers were able to freely express their fears and concern about HIV/AIDS to each other, and openly talked about high risk sexual behavior, things that were before now taboos to discuss with others. The subject of HIV/AIDS was de-stigmatized, and many felt challenged and motivated to take personal responsibility to combat the spread of this epidemic in their community”. (January 2005) – **Dr. Igbo Ofotokun, Department of Infectious Diseases Emory University School of Medicine**

In partnership with Johns Hopkins University Bloomberg School of Public Health, Voice for Humanity (VFH) completed a pilot project designed to test a new approach to training illiterate and low-literate Africans about HIV/AIDS using dramas, stories, music and testimonies captured in a low-cost digital audio player and introduced into small listening/discussion groups where peer education can occur. This approach relies heavily on indigenous involvement and ownership of the content and distribution effort.

Working through three indigenous Nigerian partners, VFH distributed 650 portable digital audio players, called *Murya* by Nigerians, in three villages in the Nassarawa State starting December 1, 2004. During the two months after distribution, approximately 40,000 people listened to and discussed the HIV/AIDS content—an average of nearly 60 Nigerians per *Murya*.

Post listening surveys, focus group interviews and an external evaluation all indicate that the approach was effective and accepted by Nigerians. Over 90% thought the *Murya* was easy to use and preferred learning about HIV/AIDS through the *Murya* to either a radio campaign or a printed pamphlet. They appreciated the fact that they could listen to the program as many times as they wanted. The project provided a platform for open discussion about HIV/AIDS in ways that had not previously been available. While most Nigerians in the three villages had previously received HIV/AIDS information, they did not openly discuss it. The small listening/discussion group methodology led to many first time conversations about HIV/AIDS.

After listening to *Murya*, there was a significant shift in attitudes towards HIV/AIDS, indicating stigma reduction. There was nearly a 30% increase in willingness to visit and help a family of a person with HIV, as well as a 20% increase in willingness to take an HIV prevalence test. Both information sharing and information seeking behaviors – hallmark signs of successful behavioral change communication – were observed during the course of this project. The fact that 650 players reached 40,000 Nigerians in two months demonstrates the confidence, trust and value placed in the content by participants who shared the *Muryas*. Discussions about the content extended beyond the listening groups as over 90% of the participants reported discussing the content with others who had not had a chance to hear the programs.

While these findings are based on limited evaluation instruments (a more comprehensive evaluation was dropped due to inadequate funding), they do indicate that the VFH approach to education and training among non-literates can deepen and accelerate HIV/AIDS awareness, prevention and care communication efforts, particularly in rural areas.

I. Project Background

The Health Communications Partnership (HCP) at Johns Hopkins University Bloomberg School of Public Health and Voice for Humanity (VFH) partnered to implement a USAID-funded pilot project testing an innovative way to communicate HIV/AIDS related education and training to oral communicators (low literate and illiterate populations) in Nigeria. Access to accurate and reliable HIV/AIDS awareness, prevention and care information has been a problem in those regions of the world where illiteracy and poverty are high. The problem has not been a lack of accurate and informative content, but one of access and delivery that results in positive behavioral change.

This new approach to training oral communicators uses dramas, stories, music and testimonies captured on a low-cost digital audio player and introduced into small listening/discussion groups where peer education can occur. This approach is based on VFH's three-pronged strategy: (1) culturally sensitive and engaging "oral" content that is more suitable for illiterate and semi-literate populations (oral communicators); (2) consistent information through a technology platform of low-cost, digital audio devices that are durable, rugged, solar powered and designed specifically to convey information to indigenous cultural groups of varying literacy and education levels; and (3) small listening/discussion groups established through known and trusted indigenous networks.

USAID provided \$300,000 in funds to Johns Hopkins University to conduct this pilot project with Voice for Humanity. The HCP-VFH contract start date was July 5, 2004. The project concluded February 28, 2005.

The primary implementing partners with Voice for Humanity in Nigeria were ECWA (Evangelical Church of West Africa), FOMWAN (Federation of Muslim Women Association of Nigeria) and CHAN (Christian Health Association of Nigeria). An important aspect of the project was to encourage Christians and Muslims to work together to fight their common enemy of HIV/AIDS. Faith-based groups were sought out for this project because of the need to utilize known and trusted indigenous networks.

II. Project Goals

The following were the goals for the pilot project:

1. Test the feasibility and acceptance of this new approach to HIV/AIDS education and training.
2. Ensure that indigenous partners take the lead in the project.
3. Create information seeking and information sharing behavior, two hallmarks of a successful behavior change information campaign.

III. Timeline and Milestones

Even though HCP and VFH established a July 5, 2004 start date for the pilot project, the project work did not begin in earnest until August. While VFH experienced some delays due to in country strikes and bureaucratic processes in customs, overall the project implementation proceeded rapidly from start to finish. Below is the actual timeline for the project:

<u>Milestone</u>	<u>Date</u>
HCP-VFH contract start date	7/5/04
Content development started	7/15
Discussions to determine village locations for pilot began	7/15

Three villages for project set	8/31
Content recording began	9/10
Content recording and editing completed	10/12
Final content arrived at manufacturing facility	10/20
Training of listening group facilitators	10/24-27
650 Voice players with content shipped from manufacturing facility	11/1
650 Voice players arrived in customs at Abuja	11/2
Listening groups begin with extra Voice players hand carried into Nigeria	12/1
120 Voice players released from customs	12/3
530 Voice players released from customs	12/6
1 st monitoring of listening groups	12/7-8
2 nd monitoring of listening groups	12/17
Collection of post listening group surveys from Agyaragu and Andaha	12/17
3rd monitoring of listening groups	1/15/05
Final collection of post listening group surveys from Kaffin-Shanu	1/15
Final focus group interviews	2/3-2/4
Project activities completed	2/28
External evaluation completed	3/31

IV. Content Development

Principles and processes of content development

The audio program developed was called “Show Love and Care.” The content totaled just over four hours of audio recording, including 127 minutes in Hausa and 119 in English.

The content development process was guided by these principles:

1. *The content should be developed by Nigerians for Nigerians.* VFH did not script the content, but gave guidelines to our Nigerian team who then compiled it on their own. The Health Communication Partnership staff at Johns Hopkins University Bloomberg School of Public Health provided the content framework, and then the Nigerian project partners adjusted it and worked with VFH to produce a culturally relevant program. The drama was written by Thom Ofem, HCP Nigerian staff, and edited by the implementing partners – FOMWAN and ECWA.

2. *The content should be orality based – targeted for oral learners.* The content had to be in a format that non-literate people could understand and digest. Because the target audience was lower-literate Nigerians, we relied on dramas, music, interactive discussions, testimonies and live interviews for our content. We coached our speakers to imagine they were having a conversation with a Nigerian from a rural area.

3. *The content should reinforce the basic facts of HIV/AIDS and promote care.* We were told that many people even in rural areas knew about HIV/AIDS, but even some of our implementing partners were uncertain as to what HIV/AIDS meant. Therefore, the content centered on the basic facts of HIV and AIDS, how it is transmitted, prevented, and treated. It also included messages about testing and positive living with HIV. Another goal was to encourage communities of faith to embrace and care for the infected while supporting those directly affected. Both Muslim and Christian leaders gave collaborating testimony that not only reinforced the teaching about HIV/AIDS, but also brought a sense of community solidarity in fighting the real enemy in HIV/AIDS and not each other.

4. The content should be validated by community leaders. We found that by having community leaders openly support the Show Love and Care project, listeners were more enthusiastic about the message and took it seriously. In addition to political and tribal leaders, we sought the endorsement of both Muslim and Christian religious leaders. Our implementing partners decided to include messages from clerics in order to reinforce the significance of the program for Muslim and Christian audiences. Their round table discussion emphasized the importance of each person living consistently as a religious person according to their deepest convictions.

Content outcome

The content was recorded in English to give a sense of its universal application. More importantly it was recorded in Hausa to take the content to the core of the local culture and promote its local relevance. In each focus group interview at least one person stated that the Hausa made the teaching “real and believable.” When one person verbalized this, all others in the group nodded in approval.

A purpose of the project content was to train listeners about HIV/AIDS – how it is spread, how to keep from getting it, how to treat it, and what to do for those who test positive. The intent was to communicate the basic facts of HIV/AIDS and to encourage the communities of faith to act with compassion toward those people infected or affected with HIV/AIDS. The main chapters of the content were the following:

1. Love Is Being Informed
2. Love Your Neighbor as Yourself
3. We Are All People Living with HIV/AIDS
4. Love Means Talking as a Family

The content included dramas, music, a testimony from an HIV+ woman, round table discussions, a narrated discussion about core teaching points with discussion questions, and interviews with various community leaders. A complete program list is attached as Appendix 1.

While the program itself presented nothing new in the basic facts about HIV/AIDS, it was put together in a way that made those messages more effective. It was produced in the local language (Hausa); it incorporated oral modes of communication; it was distributed through local respected networks; and people could listen to it repeatedly. (See Project Goals Achieved below for more discussion).

V. Technology

The supplied device kit included a digital audio player, a solar power charger, two sets of rechargeable batteries, and a memory chip containing approximately four hours of content. (See pictures below). The Voice player was given the Hausa name *Murya* which means “Voice.”

The digital audio players exceeded expectations in functionality, ease of use and acceptability. Survey results indicate over 90% found the players easy to use (see Projected Goals Achieved below). There were only a few scattered reports of malfunctions with the players. Initially, 20 units (3%) were set aside in pre-distribution tests for various reasons and were replaced by the manufacturer. Three percent is a very low rate for prototype technology devices. Of the players deployed in the field, only five units failed to work properly, which means that over 99% of the players functioned, an extremely high success rate.

There were mixed reports about the battery life and the solar chargers. Some indicated long battery life of 20+ hours after 4-5 hours of charging, while others complained of batteries lasting less than one hour. In one community there was confusion over how to properly recharge the batteries. The solar charger is designed to work in direct sunlight and will fully charge a set of batteries in 3-5 hours. Some apparently held the charger up to a light bulb at night, hoping to recharge the batteries that way. While any ambient light activates the charging process, the length of battery play time depends on a complete charge. Those that tried to charge by light bulb instead of direct sun did not fully charge the batteries and experienced much shorter play times of 45 minutes to one hour. (See more discussion in Lessons Learned below).

VI. Distribution

After extensive consultation among VFH, USAID, HCP and the local implementing partners (ECWA, FOMWAN, and CHAN), Nassarawa State was selected as the location for this project. VFH, its cooperating partners, and the State Health Commissioner, selected three Local Government Areas (LGAs) and individual villages in Nassarawa State to receive Voice players: (1) Kaffin-Shanu is a village of about 5,000 residents and is predominantly Muslim; (2) Andaha is a village of about 8,000 residents and is predominantly Christian; and (3) one of the LGAs in Agyaragu, an area with about 50,000 residents and equally inhabited by Muslims and Christians.

The villages range progressively in economic resources, education level, and access to communication and transportation infrastructure. Kaffin-Shanu is the poorest and least educated village with limited communications technology. For example, no one in the entire village, including the chief, has a cell phone. Agyaragu is the most advanced of the three villages, but is still very rural with limited access to education, transportation and communication resources. All of the villages have a primary school, but there are no high schools or other institutions of higher learning in the towns. The average level of formal education of participants was low: 1.6 years in Kaffin-Shanu, 4.4 years in Agyaragu, and 5.0 in Andaha. All three villages have electricity and road access.

A key part of VFH's distribution strategy was to involve local leaders in the village in the project, starting with the village chiefs. We had the local chiefs appoint the Trainers of Trainers (TOTs) to oversee the distribution and listening/discussion groups. As a result, all of the TOTs were known and respected leaders in the village communities who were able to validate the *Murya* and its content simply by participating in the project.

VFH staff and local partners provided a three-day orientation (October 24-27) on HIV/AIDS, counseling, and small group communication for the TOTs. Each of the 22 TOTs then found an additional six people to form listening groups and to discuss the content. When the Voice players arrived, the TOTs disseminated the messages in their villages and encouraged discussions about Showing Love and Care.

In Agyaragu, the TOTs focused more on small group dynamics and a methodology of forming small groups for the *Murya* distribution. Because the educational base was more advanced in Agyaragu than in the other villages, the TOTs there implemented a more controlled and methodological dissemination. Each trainer invited a limited number of participants to listen and discuss the content. The groups met one or two times (up to four times), and then planned the next generation of listening groups. Leaders were chosen, players assigned, and new groups formed.

By contrast, the other two villages were given more freedom to pursue their own distribution strategies—in less of a Western methodology and more of a Nigerian cultural methodology. As a result, they not only conducted small listening/discussion groups, but also played the *Muryas* at the local farmer’s market and traveled to surrounding villages and hamlets, spreading the content beyond the borders of their villages.

Distribution

Distribution began in early December and the *Murya* players were delivered according to the following distribution table:

<u>Village</u>	<u># of Muryas</u>
Agyaragu	210
Andaha	190
Keffin-Shanu	160
ECWA church (FCT)	20
FOMWAN	10
CHAN	10
ECWA	10
Give aways	20
VFH/HCP offices	<u>20</u>
Total	650

VII. Project Goals Achieved

Goal #1: Feasibility and acceptance of new approach

The first goal of the pilot project was to test the feasibility and acceptance of this new approach to HIV/AIDS education and training. The following findings indicate that the approach was effective and accepted by Nigerians.

1. The content was well received. Listeners reported that they really liked the content, it was easy to understand and it promoted discussion in their communities. All agreed that the oral format was the best way to deliver the content. Many commented that hearing the messages in vernacular Hausa made listening more appealing and believable. Focus group participants appreciated that they recognized the voices of local respected people on the programs. One participant explained it this way:

“I had heard some of this information before, but this time I believed it. It was in my own language, I recognized some of the people on the program, and I was able to discuss it with my family and friends.”

When asked what was their favorite part of the program, participants responded:

“All of it!”

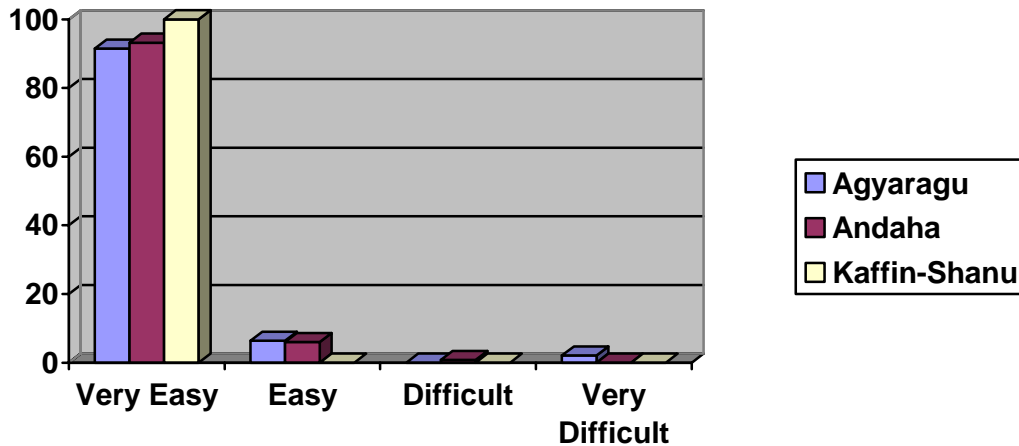
“The drama with Tanko. Please do more dramas.”

“The music. It would be good if you put more music in it. The youth sit and listen to the music again and again.”

Respondents in each village asked for content as soon as possible. They suggested the use of more music, stories, folk tales and Nigerian proverbs.

2. The digital audio players (Murya) were easy to use. Based on data gathered from post surveys in the three villages, over 90% of the users said that *Murya* was “very easy” to use (See Figure 1). Focus group interviews supported the survey data.

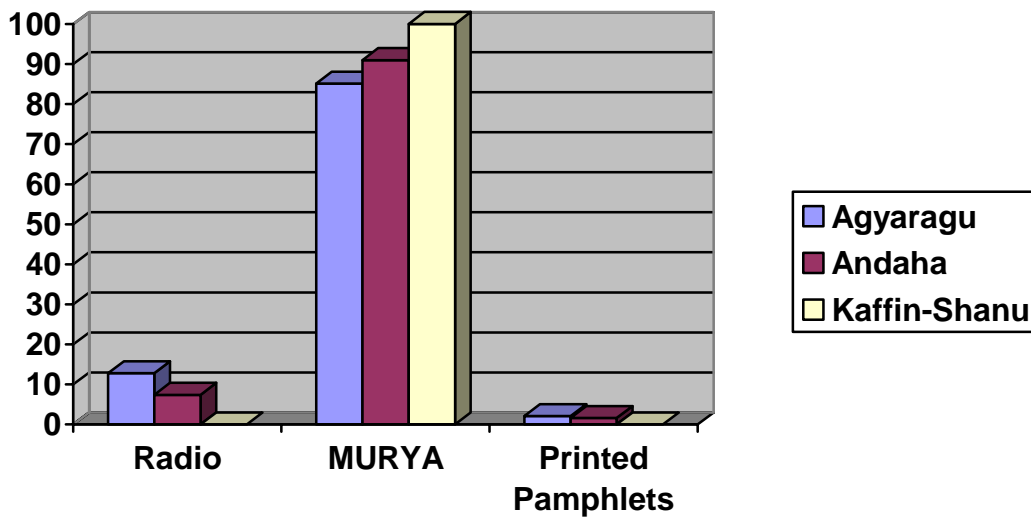
Figure 1: Technology ease of use
Q: How easy was Murya to learn and use?



3. Project participants preferred the Muryas over radio and print information programs. Nigerians from all three villages said they really liked the technology because they could listen to the messages repeatedly and at all times of the day. They also commented that they liked the ability to stop the program in order to discuss it, and then to be able to scroll back and listen to the content again. As a result, a strong majority said that they prefer learning about HIV/AIDS through *Murya* than through radio or printed materials (see Figure 2 below). In focus group interviews, users commented that they trusted *Murya* because they recognized some of the voices on the content and it was given to them from leaders in their communities. They also said that they tend to forget what they hear on the radio and that they cannot listen to the program over and over again to really learn from it. Some people in the focus group discussions recited long portions of the content by memory because they had listened to the program so many times.

Project evaluator, Dr. Igho Ofotokun of Emory University School of Medicine, noted that an additional advantage of the small media device format was that it allowed the village chiefs “to listen for the first time to an in depth discussion of HIV/AIDS in the comfort and secrecy of their own homes.” Because it is culturally inappropriate for these community leaders to attend the mass rallies more typically held for HIV education, these men had not received any substantive training about the disease until now.

Figure 2: Murya compared to other information formats
Q: Which do you think is the best way to learn about HIV/AIDS?



4. The content and digital audio players facilitated discussion and peer education. In all three villages, many participants commented that they talked about HIV/AIDS and the issues surrounding it for the first time in a group setting. While most had heard some of the concepts before, they had kept their thoughts to themselves. Most of the topics were “taboo” from discussion. This approach—using orality based content with small audio players introduced into known and trusted small group settings—created an environment open to raising questions that had before gone unasked.

After he conducted several focus group interviews, Dr. Ofotokun made this observation:

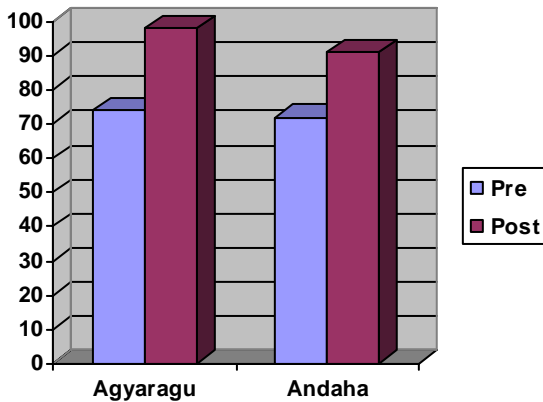
“Perhaps the most remarkable thing about the VFH project was the feeling of empowerment it generated among participants. Because of the small group delivery approach that encouraged individual participation, villagers were able to freely express their fears and concern about HIV/AIDS to each other, and openly talked about high risk sexual behavior, things that were before now taboos to discuss with others. The subject of HIV/AIDS was de-stigmatized, and many felt challenged and motivated to take personal responsibility to combat the spread of this epidemic in their community.”

5. There was a significant shift in attitudes towards HIV/AIDS.

While the scale and scope of the pilot project did not allow for measuring any long-term impact on behavior change, some short-term changes in attitudes were observed based on survey work conducted by VFH’s implementing partners. Pre and post surveys were conducted in two of the three communities. The differences in answers to two questions indicated that some stigma reduction occurred:

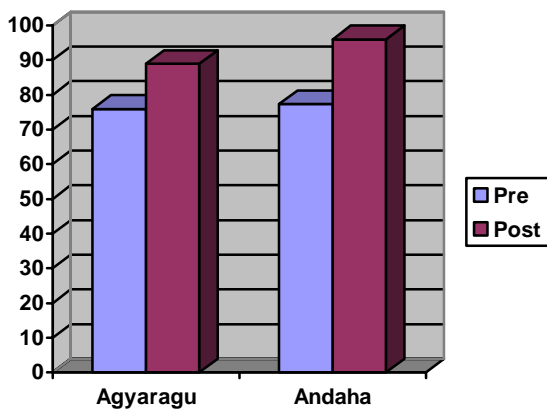
1. *Would you be willing to visit and help a family of a person living with HIV?* In both Agyaragu and Andaha, there was nearly a 30% increase in number of people who would be willing to visit and help someone with HIV and their family (see Figure 3).

Figure 3: Willingness to visit a family of a person with HIV/AIDS



2. *If you have NOT taken an HIV prevalence test, will you?* While this question only asked a person's willingness to take an HIV prevalence test, the results indicate a 20% improvement in attitude towards taking the test (see Figure 4). With a larger funded project and more time, it would have been good to measure exactly how many participants actually took the test.

Figure 4: Willingness to take an HIV prevalence test



Goal #2: Indigenous partners take the lead

The second goal of the pilot project was to ensure that indigenous partners not only take the lead in the project, but that the project in reality would be Nigerians helping Nigerians. This goal was achieved: indigenous project partners took a strong role in the implementation of the project, and evaluation results suggest that Nigerians were empowered and began to take ownership of the HIV/AIDS problem themselves because of their participation in Show Love and Care.

1. The content was "indigenized" and expanded by partners.

Lisa Folda of HCP contributed the content core which the national implementing partners then revised and edited to insure cultural relevance. Each partner provided technical advice and personnel for the script and its recording. The diarist, Rakia Friday, connected the message with a real life testimony of contracting HIV/AIDS and yet living

positively. The high profile Muslim and Christian voices added value to the additional local contextualization of the message.

2. Oversight and project management implemented by Nigerians.

Dr. Dimis Mailafia, Economics Department Chairman at University of Jos and the Nigerian Project Coordinator of Show Love and Care, brought the implementing partners together as regularly as possible with the constraints of budget. He also communicated on-going project needs with all parties concerned. With the difficulties of receiving tariff exemption on electronic equipment the partners also were able to navigate the requirements of the Ministry of Finance. In the end, the project still paid a reduced tariff in order to get the players to the field with minimal delay, but finally received a signed letter of exemption after the delivery of the devices to the villages.

3. National partners trained local leaders.

The trainer of trainers event was organized and executed by the three partners. CHAN and FOMWAN provided some of the HIV/AIDS technical training, and ECWA led the sessions enabling the trainers to equip group facilitators with basis understanding of the pandemic and limited counseling skills.

4. Village Implementation was completely localized.

The participants attending the three day training event at the Enduhu Conference Center and Resort came as appointees from the village chiefs, and were not necessarily recommended by CHAN, FOMWAN or ECWA even though each organization was well known to all the attendees. The trainers subsequently returned to their villages to implement the project at the grassroots level by training village facilitators, administering surveys and reporting results to the Project Coordinator.

Voice for Humanity staff maintained a light presence on the ground during the project, allowing indigenous project partners to take the lead in developing culturally appropriate audio content, choosing actual locations for distribution, carrying out the distribution through existing networks, and conducting the assessment surveys. During focus group interviews, listeners reported that because local people were in charge of the distribution and no outsiders were present during the small group listening sessions, the program seemed indigenous and the content more acceptable.

As Dr. Ofotokun reported in his evaluation, "There was a sense of ownership and empowerment and for the first time they felt their communities were actively mobilized in a project to combat a killer disease they had felt powerless against for a long time."

Goal #3: create information seeking and sharing behavior

The third goal of the pilot project was to create information seeking and information sharing behavior to maximize project impact. The results indicate strong success in this area as well.

In our original scope of work, we planned for 54 different listening groups, spread proportionally among the three villages. Each listening group would have 10 participants for a total listening population of 540. This estimate seemed reasonable based on typical Western (and literate) thinking. In probably the strongest indication of information sharing behavior, over 40,000 Nigerians ended up listening to the program over a two month period of time, dwarfing our original estimates.

Estimated Listening/Discussion Audience from 12/1/04 – 1/31/05
(based on the average number of unique listeners reported by group leaders)

Agyaragu	14,700
Andaha*	16,300
Keffin-Shanu*	<u>9,600</u>
Total	40,600

* Includes surrounding hamlets

What happened is simple: VFH tapped into natural grass roots social communication networks whereby the program spread rapidly.

While the pre-arranged listening groups did occur, most listening happened spontaneously, with people listening to the program and discussing its content in homes, market places, churches, mosques, schools, and “under a tree.” For example, on market day in Andaha, facilitators walked around the market with the *Murya* hanging around their necks so they could play it for people in the streets.

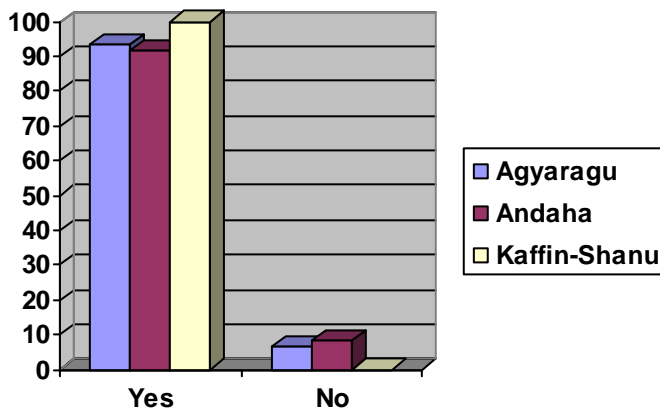
Within four days of having the *Muryas* in Kaffin-Shanu, leaders reported that they were sharing the programs and discussing them with as many as 30 people each day. Of the five facilitators interviewed in a follow-up focus group two weeks into the project roll out, one reported that on that very morning 100 people had been at his house listening. Just two days after the listening groups started, leaders from three surrounding villages approached the chief, asking him to send the trainers to their areas with the messages that can keep them from AIDS.

In all three villages, VFH heard reports of the *Muryas* being shared in nearby villages and hamlets. The leaders in Andaha actually developed a strategy to share the *Muryas* with as many of the 100 hamlets surrounding their villages as possible. At the end of two months, they had reached at least 35 of those hamlets.

In post-listening surveys collected from all three villages, over 90% of participants reported sharing the Show Love and Care program with others. (See Figure 5).

Figure 5: Self-reported information sharing behavior

Q: Have you talked about the Show Love and Care programs with people who have not been able to listen to Murya?



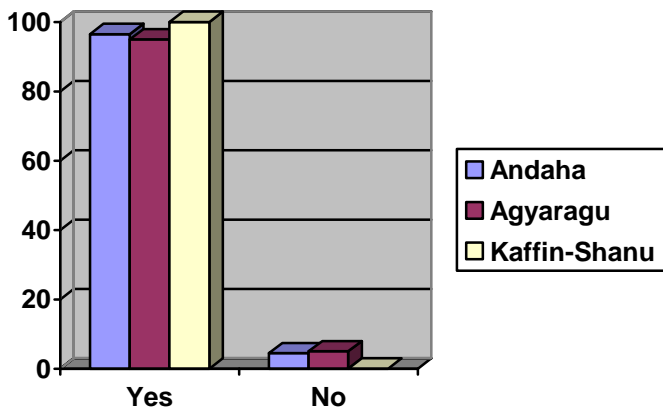
The same can be said about other Nigerians seeking to listen to the content. Within days of the start of the listening groups, delegations from surrounding villages and

hamlets traveled to each of the three villages, asking to hear the messages about HIV/AIDS.

Over 90% of the Nigerians who filled out the post surveys reported that people had approached them asking to listen to the Voice player (see Figure 6).

Figure 6: Information seeking behavior

Q: Has anyone asked to listen to the Show Love and Care programs on Murya?



VIII. External Evaluation

Dr. Igho Ofotokun, Assistant Professor of Medicine, Division of Infectious Diseases, at Emory University School of Medicine and a Nigerian who specializes in HIV/AIDS, submitted an evaluation of the Show Love and Care project on March 31, 2005 (a copy of his evaluation is available upon request). He based his evaluation on field site visits to all three communities, focus group interviews, review and analysis of VFH generated survey material, review of project protocol, and listening to all the recorded material. In each village at least four trainers or facilitators and 6-50 listening participants gathered for debriefing. Dr. Ofotokun asked questions about the use of the player, information seeking and sharing behavior, and general content retention. Based on both qualitative and quantitative data, Dr. Ofotokun found that:

- Community leaders and surveyed small group participants expressed a high level of appreciation for the cultural sensitivity of the project.
- The use of local facilitators and the absence of outsiders during implementation enabled local communities to gain a sense of ownership and empowerment.
- There was an immediate post-intervention shift in HIV perception, likely stimulated by the VFH program alleviating fears and stigma of HIV infection.
- Previously taboo subjects were discussed for the first time in small group settings.
- There was uniform desire and willingness to share information from the audio players with others.
- There is a functioning relationship between VFH and multiple faith based partners in Nigeria with networks that can be mobilized for HIV awareness campaigns in rural communities with poor access to HIV information.
- There is value to the VFH digital audio technology for delivering culturally adapted HIV information in small listening discussion group settings established through known and trusted indigenous networks.

The only significant criticism Dr. Ofotokun reported was about the quality of the survey data collected by local facilitators. While he appreciated the use of local staff for assessment implementation because it “may have enhanced local participation and community mobilization” for the project, he wrote that the western style survey technique was “too foreign and too sophisticated” for the low level of formal education of participants. Dr. Ofotokun recommended that future evaluations use a survey instrument adapted for non-literate oral communicators.

VFH acknowledges the disconnect between the uneducated project participants and Western assessment methods. Ironically, although the project content was geared for oral communicators, the evaluation as it was implemented was not. In the original proposed project budget, funding was included for teams of paid survey workers to complete the task orally following a comprehensive training on survey techniques. With budget cuts, we were not able to provide complete training nor allow for enough time to conduct all the surveys orally.

Our modified plan was for each village group facilitator to administer a short pre-listening survey prior to listening to the *Murya*. A few days after listening to the *Murya*, the post-listening surveys were then to be collected. The two surveys were designed differently and were to be printed in two different colors to keep them separate. Instead, the printer delivered them both on white paper and, in a few instances, facilitators got the two surveys confused. Furthermore, in Keffin-Shanu, the surveys were filled out in the same sitting after listening to the *Murya*.

As a result, VFH discarded most of the pre-listening surveys from Keffin-Shanu, as well as the surveys that had gotten mixed up (that is why the number of post-surveys in Agyaragu is only 47). Where the surveys were administered properly, VFH kept that data and presented it in this report. Similarly, Dr. Ofotokun isolated the survey data that he found maintained enough empirical integrity to analyze and presented his analysis in his report.

IX. Conclusions

Project results show that the Voice players are indeed an effective tool for addressing critical issues and stimulating discussion and action at the grass roots village level among semi-literate and non-literate people. We have concluded the following:

1. Nigerians who participated in the project felt empowered to talk about HIV/AIDS and take action. Prior to listening to the Voice players, most Nigerians in the villages said that they did not talk about HIV/AIDS much because of fear and because they thought that since there was nothing they could do about it, there was no reason to talk about it. The small listening/discussion groups got many of them talking about HIV/AIDS for the first time and opened the flood gates to questions and worries that had been pent up. After listening to *Murya*, they realized that they could take some action to fight HIV/AIDS and could reach out in love and care to their family members and neighbors who might be sick. Before *Murya*, they felt helpless; now they feel empowered.

An example of this is what happened when a family in Andaha listened to the messages of Show Love and Care on *Murya*. One man had been reclusive, fearing that he was HIV positive because he thought that he was manifesting the symptoms. After listening to the drama on *Murya* about a young man testing for malaria when he thought that he

had HIV/AIDS, the Andaha listener immediately decided to be tested for HIV. He was diagnosed with tuberculosis, not HIV. Rather than hiding in deadly silence, he sought help that truly saved his life. Now he is taking medication for TB, and health care workers believe that he did not wait past the critical moment and that he is on the road to full recovery.

2. Information spread very fast. This project was marked by rapid information dissemination, as *Muryas* were quickly listened to and passed around within villages and their surrounding areas.

3. The technology makes it easy for people to listen anywhere, anytime, and often. People played the Voice players repeatedly and at all times of day. They memorized sections of content. A common remark heard at focus group interviews was that the people listened to the messages over and over. They did so in homes, schools, churches and mosques, in the markets and under the trees. Because the material was not just heard once at a seminar but listened to repeatedly, oral learners more easily absorbed and remembered the important information.

4. Orality methods worked. VFH staff found that even though the message was not new, it resonated with the audience because it was presented in a way that makes sense to oral learners. Conversational taboos have historically hindered prevention, care and the dispelling of stigma surrounding HIV/AIDS in Nigeria. People want to know about how to prevent and/or treat HIV/AIDS, but the sexual nature of the discussions combined with the fatalistic outlook concerning this deadly disease inhibit or prevent discussion in most contexts. However, when presented orally with the facts and in a trusted setting in which to discuss them, Nigerians talk freely about most aspects of the disease.

5. This strategy transcends age and gender barriers. Both young and old gravitated to the groups, the message, and the technology. Men and women shared equal enthusiasm and participation.

6. This strategy promotes both information seeking and information sharing behavior. People came to hear without an invitation – exhibiting information seeking behavior. Visitors came from neighboring villages to hear the Show Love and Care messages, and asked for our trainers to come visit to teach them how to avoid getting AIDS. Once someone hears the message they want to share it with others – information sharing behavior. Although we asked our trainers to share the Voice players within their villages, the fact that they went beyond this obligation and spread them far and wide shows how valuable they find them. Common questions for VFH are when the next program will be and how their area can receive more *Muryas*.

7. People treated the Voice players as collective – not personal – property. Villagers reminded each other that the Voice player does not belong to the person playing it, but to the entire village. This underscores the value that they found in the players and in the message.

8. Learning stimulates in-depth questions. Some of the questions asked by listeners were those that would normally be expected from a more literate audience. The most frequently asked questions included:

- What help will we get to be tested? We cannot afford the test or travel easily to the central hospital.

- If we are positive, how do we get the drugs we need?
- Technical questions about HIV and AIDS.

9. Community leaders have bought in to the project. Nigerian regional and local leaders embraced the VFH communication strategy immediately. Word spread among other local government areas, and Ministry level officials have approached VFH to seek participation in this and later projects. Decision makers from various levels (from village chiefs to the State Health Commissioner) invited VFH and our partners to bring our innovative projects to their areas for building immediate and long-term education and information dissemination opportunities.

10. Faith-based organizations are effective at engaging at the community level. Support and collaboration of local, regional and national FBO leadership contributed significantly to broad community support of programs in Nigeria. The relations between Christian and Muslim residents proved to be a very positive factor when both pastors and imams contributed to the program. Villagers worked together on a common concern which resulted in a sense of unity. International organizations brought capacity enhancement to local partners. ECWA, FOMWAN and CHAN had all previously developed similar content of the basic facts about HIV/AIDS. The resources provided by HCP and VFH simply enabled FBO leaders to impact people at the grass roots in ways they had not previously attempted.

11. Nigerians want to take the lead in reversing the spread of HIV in West Africa. All the local partners criticized the habitual practices of Westerners who come to tell Nigerians how to think, what to say, what to do and how to do it. Instead, the cooperative approach taken by VFH and HCP to work very closely with Nigerian partners proved that the resources of the West can be filtered through the experience and expertise of local partners to yield maximum results. Even at the grassroots level, villagers understood that those from the outside cannot ever solve the problem of HIV/AIDS. Solutions must come from the people themselves, with assistance from their global family. Both cultures are needed to impact the issues.

12. This strategy is ready for scale up throughout rural Nigeria. Because of the results and impact of this pilot project, Nigerians at the village level as well as at the national level believe it is time to scale up this approach to reach and impact many more Nigerians. When the Honorable Minister of Information and National Orientation Chief Chukwuemeka Chikelu first heard about the VFH project, he did not believe it was true. He contacted Dr. Madinger, our Regional Director, and asked for an immediate audience. After hearing about the project, he made the following statement:

“I could not believe the reports I received concerning your project. Now I see how it works. Would Voice For Humanity be willing now to help us on a variety of issues including the National Census later this year?”

Sam Archibong, Communications Specialist at NACA, has expressed great interest in incorporating VFH technology and strategy into their programs. He has requested a memorandum of understanding with VFH be established with NACA to facilitate collaboration with all of its national partners involved in education and training in rural, less educated settings.

Dr. Ola Soyinka, ICASA Conference Coordinator, has asked VFH to submit several abstracts, as well as make a presentation at the upcoming conference this December.

He is convinced that the VFH strategy is right for Nigeria and wants to give VFH maximum exposure for accelerated implementation.

What these Nigerian leaders see in the VFH strategy is a way to get messages and training distributed at a grass roots level in a form that will really connect with and energize rural Nigerians—whether that is HIV/AIDS related information, general health information, community development education or National Census and democracy training.

X. Lessons Learned

As with any pilot project, VFH learned many lessons throughout the course of the project. The following are lessons learned that can be carried forward into any future project using the VFH strategy:

Content:

- While the orality focus of the content was appreciated and successful, it did not go far enough. In the future even more care should be taken to have substantive content that teaches *through* music, drama, and other orality modalities, instead of content that simply *includes* supportive music and drama.
- Listeners connect with vernacular heart languages. Using vernacular Hausa rather than formal Hausa positively impacted the reception of the messages beyond our expectations. Residents also suggested that in future programs the messages reach even to deeper roots by using more localized regional dialects in addition to Hausa.
- Based on the positive response to the limited local messages on Murya, more local and known voices should be incorporated into the content.

Distribution:

- More time needs to be spent on understanding and using the Voice players. Since the devices were held in customs for so long this was not possible for the pilot project. Group leaders need time to learn to use it comfortably and then be able to teach others.
- In the TOT event, the training should include more emphasis on how to interact with those seeking HIV/AIDS information, as well as practical advice on how to take the *Murya* players to other villages.
- During the training sessions for TOTs, more emphasis should be placed on understanding the content that is on the device so that the trainers can better facilitate a discussion about the content.
- During the training sessions for TOTs, greater emphasis needs to be placed on solar charger and battery management. In addition, we plan to provide a simple pictorial instruction sheet to go along with more detailed audio instructions with each *Murya* kit.
- Nigerians want to take ownership of addressing the HIV/AIDS crisis. More effort should be made to ensure that listeners feel empowered to determine their own *local* solutions to the issues surrounding stigma reduction and the care and treatment of HIV+ family and friends.
- Although faith-based organizations were critical partners in this project (especially in the content phase), more effort needs to be made to incorporate more FBO involvement in the distribution. Show Love and Care attempted to use governmental gatekeepers as the entry to the villages. Unfortunately, a pastor/imam orientation was also planned but had to be cancelled due to the customs delayed arrival of the players. The TOT was postponed and the subsequent orientation eliminated since some of the Muslim participants were finishing Ramadan at that time.
- We found that some small listening/discussion groups were spending more time listening than discussing. We recommend that in the future listening sessions could be shortened to promote discussion. More frequent, but shorter, sessions could be offered. However, ultimately it is the local implementers who have to make these decisions about how the small media technology can best suit their needs.
- To avoid paying tariffs and having significant time delays in customs, materials for all USAID funded projects should be shipped directly to the USAID Abuja office since USAID has an arrangement with the GON. The steps to getting a tariff exemption for materials being shipped into Nigeria otherwise are the following:
 1. A letter of support from the Minister of Finance.
 2. Additional documentation to accompany the request to the Minister of Finance including the project description, a letter of donation from VFH to our national partner(s), and copies of the partner's national registration.
 3. File a Clear Report of Inspection document with local financial institution.

4. The Minister of Finance needs to officially endorse the procurement; then the documents pass through the hands of the desk officer, three supervisors, the Director of Budget, the Minister of Finance, the President of Nigeria, the Minister of Finance (again), who sends the final letter of approval.

Evaluation:

- Since the target audience for this strategy is oral communicators, the evaluation instruments for measuring impact and results necessarily need to be designed for oral data collection, not written.
- More time should be spent teaching and reviewing the process of monitoring, evaluating and reporting with local indigenous partners.
- A more comprehensive evaluation using more quantitative data is needed to establish empirical evidence of long term impact of the VFH strategy. More attention needs to be given to establishing pre-intervention base line data for comparison with intervention results. While qualitative results from focus group interviews and anecdotal evidence are valuable, robust quantitative data collection is also needed.
- A longer time horizon for data collection and evaluation is needed in order to measure long-term impact of the VFH strategy.

XI. Final Financial Report

See attached spreadsheet.

XII. Project Pictures

See attached file of pictures.