

Annex III

Results of Participant Survey

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BACKGROUND AND METHODS

The First Regional Meeting of the HIV/AIDS BCC Network was held in Kampala from November 3 to November 6, 2003. This meeting, the first of its kind in the region, brought together more than 130 attendees and HIV/AIDS behaviour change communication (BCC) specialists from east, central and southern Africa. It provided participants with an opportunity to learn from each other, to network, and to exchange ideas. It also provided a chance to examine the BCC priorities and needs of the participants, and to determine how these needs can be addressed. The focus of this meeting was behaviour change, with a specific focus on HIV/AIDS. To obtain the views of the participants, a self-administered questionnaire was e-mailed to them before they arrived in Kampala. Almost all of the participants completed the questionnaire, either before they arrived or during the course of the meeting. This annex presents the results of the participant survey.

RESULTS

As shown in Table 1, 96 questionnaires were completed and returned. The respondents were evenly split between men and women, and came from 17 countries (see Table 2 and Figure 1). When asked what was the highest level of education they had achieved, just under half (43%) said they had attended a university (i.e., received a bachelor's degree); 56% said they had received a post-graduate degree (i.e., a master's degree or above). These accomplishments were reflected in the level of experience reported by the respondents: when asked how many years they had been active in BCC, participants reported an average of 10.2 years of experience in general BCC and 7.4 years in BCC specific to HIV/AIDS.

Table 1 also shows the main areas of expertise among the delegates. The majority (53%) considered themselves programme managers or programme implementers. About one-fourth (24%) stated that they were trainers, 15% were research, monitoring and evaluation specialists, and about 11% were media specialists.

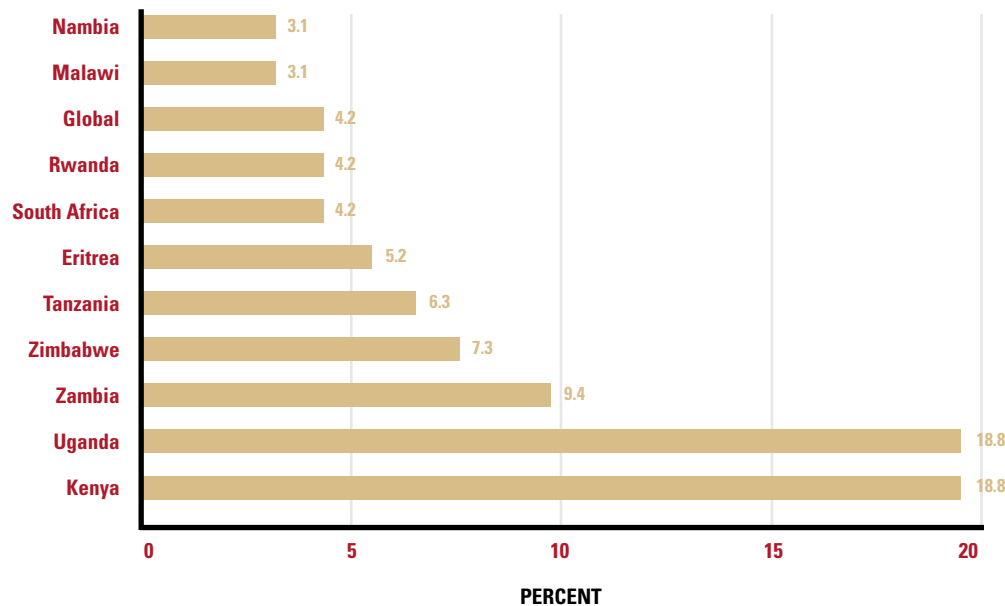
Table 1: Characteristics of Respondents

CHARACTERISTICS	N = 96
% Female	50
Highest level of education (%)	
Completed university (bachelor's degree)	42.7
Completed post-graduate (master's degree or above)	56.3
Mean number of years in BCC (years)	
General BCC	10.2
HIV/AIDS BCC	7.4
Main area of expertise (%)	
Programme manager, coordinator, implementer	52.7
Trainer	23.7
Research, monitoring and evaluation	15.1
Media	10.8
Academician	7.5
Donor/CA	3.2

Table 2: Countries Represented by Respondents

COUNTRY	NUMBER OF RESPONDENTS
1. Angola	1
2. Burundi	2
3. Democratic Republic of Congo	1
4. Eritrea	5
5. Ethiopia	3
6. Kenya	18
7. Madagascar	2
8. Malawi	3
9. Namibia	3
10. Rwanda	4
11. South Africa	4
12. Sudan	2
13. Tanzania	6
14. Uganda	18
15. United States	3
16. Zambia	9
17. Zimbabwe	7
18. Global (persons who work in multiple countries)	4
Total	96

Figure 1: Countries Represented by Respondents in BCC Meeting



BCC EXPERIENCE. One of the main reasons for conducting this survey was to document the level of HIV/AIDS BCC experience among meeting participants; the results are shown in Figures 2, 3, and 4. (Note: The rule of one-third is adopted for the interpretation of these results; that is, topics for which one-third or more of the participants responded that they have only “limited or no experience” are considered to reflect a need for training; topics for which two-thirds or more of the participants expressed “strong experience” are considered as not needing further training immediately.)

As Figure 2 shows, the responses suggest that the participants consider themselves fairly proficient in the following areas: programme management, training, conducting needs assessments, advocacy, pretesting, and BCC strategy development. On the other hand, participants considered themselves as having only “limited or no experience” in the following areas: resource mobilisation (52%), gender-responsive HIV/AIDS programming (44%), finance and budgeting (34%), and research (33%). These are areas where further training may be desirable.

When asked which communication strategies they considered themselves skilled at using, at least two-thirds of the participants reported the following: print materials, interpersonal communication and counselling, peer education, and community mobilisation (see Figure 3). On the other hand, participants considered themselves as having “no experience or limited experience” in the following: local/small scale media (60%), folk media (52%), social marketing (52%), materials for low-literate audiences (45%), and mass media (40%).

Figure 2: Percent of respondents who feel they have “experience or extensive experience” in selected BCC areas

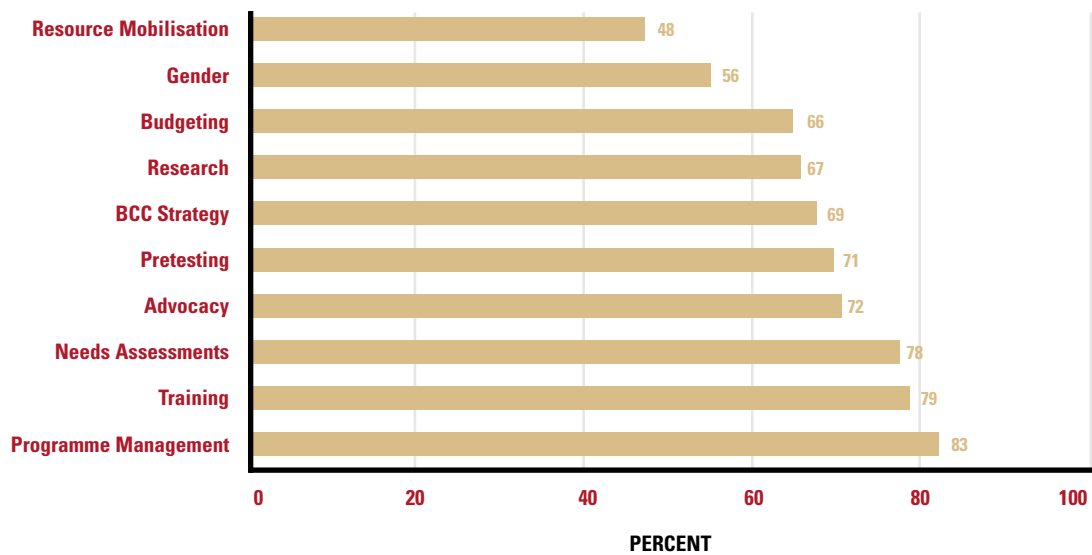
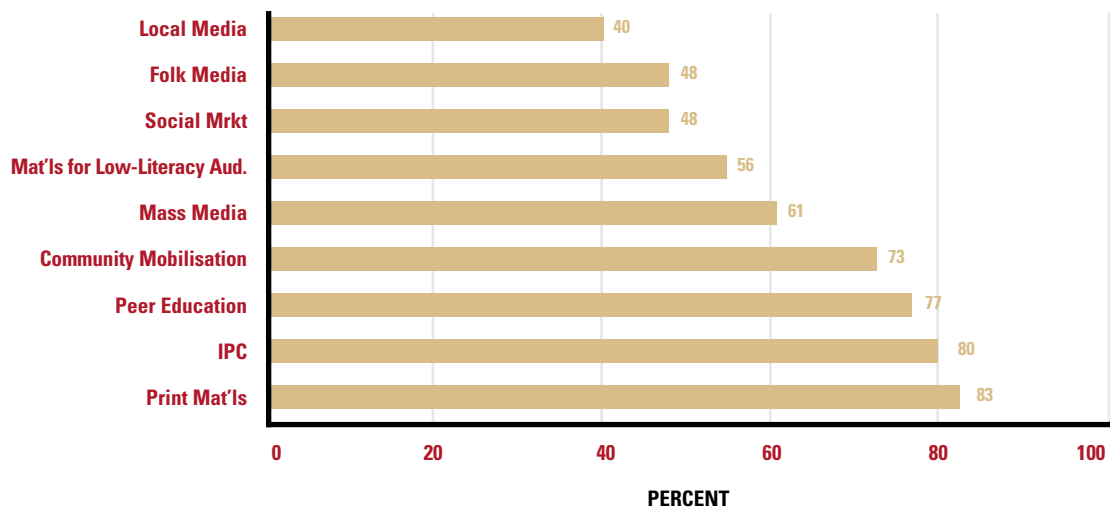
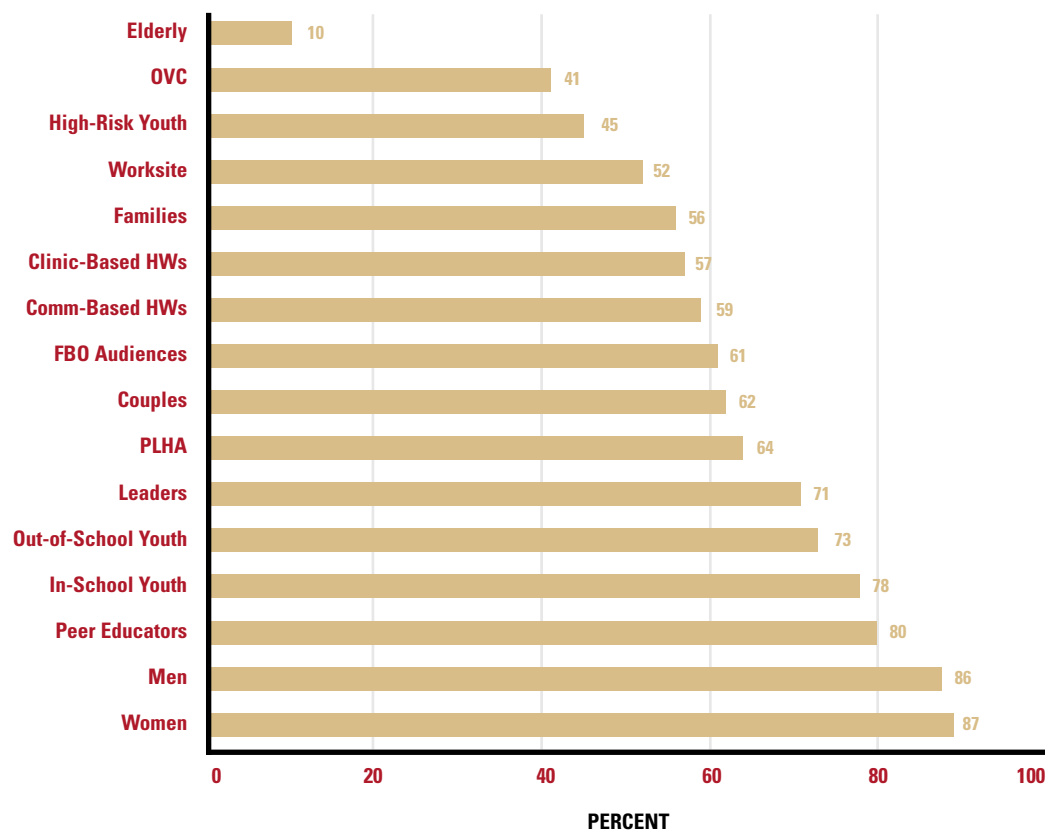


Figure 3: Percent of respondents who feel they have “experience or extensive experience” in selected communication strategies



When asked about their expertise working with specific audiences, at least two-thirds of the participants felt fairly skilled in working with adult women, men, peer educators, in-school youth, out-of-school youth, and leaders (see Figure 4). On the other hand, participants felt inadequate in addressing a large number of key audiences, including the elderly, orphans and vulnerable children, high-risk youth, employees/worksite audiences, families, both clinic-based and non-clinic-based health workers, faith-based audiences, couples, and people living with HIV/AIDS.

Figure 4: Percent of respondents who feel they have “experience or extensive experience” working with selected audiences



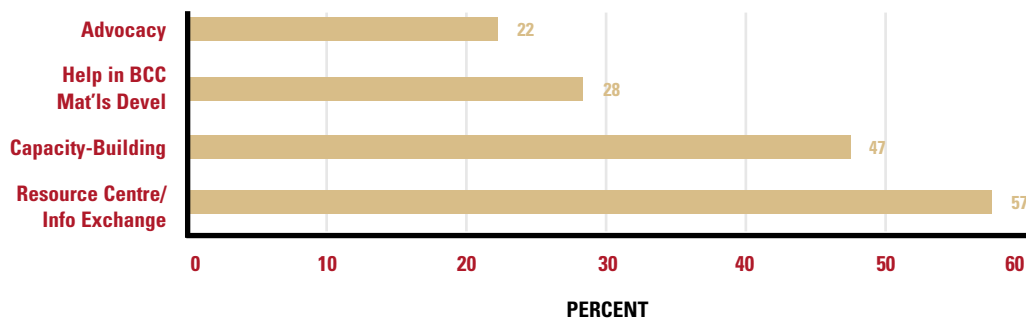
TRAINING NEEDS. To find out the specific areas of BCC in which participants wanted further training, respondents were asked to select from several subjects and to specify how they would like the training to be implemented. The results are presented in Table 3. Of the items presented, most participants reported that they needed training in cost-effectiveness analysis (65%), evaluation (64%), BCC strategy design (62%), strategic planning (62%), and programme monitoring (60%). The participants felt that the training would be best provided through seminar series or through a short-term training course. The subject areas that participants felt were of lower training priority were pretesting, qualitative research methods, and programme budgeting. The implications of these results should be assessed with caution because the results may be more indicative of the resources that are available to the respondents than of a lack of interest in the subject matter. For example, the fact that the majority of participants felt they did not immediately need training in budgeting and research, compared with other areas of BCC, could be due to the possibility that they can outsource these efforts to technical experts, and thus they themselves do not need to be specialists in the subject matter.

Table 3: Training Needs Identified by Respondents

SUBJECT AREA	% Who Want Training	PERCENT WHO PREFER FOLLOWING MODES OF TRAINING					
		Seminar	Distance Education	Short-Term Course	Long-Term Course	Computer Assisted Learning	Practicum/ Internship
Cost-effectiveness analysis	64.6	70.7	2.4	17.1	2.4	7.3	0.0
Evaluation	63.5	53.7	5.6	20.4	3.7	7.4	9.3
BCC strategy design	61.5	40.7	7.4	33.3	9.3	5.6	3.7
Strategic planning	61.5	40.7	7.4	37.0	11.1	3.7	0.0
Project monitoring	60.4	42.3	9.6	26.9	9.6	5.8	5.8
Gender	59.4	50.0	15.4	21.2	3.9	7.7	2.0
Participatory research methods	53.1	46.7	6.7	26.7	8.9	4.4	6.7
Programme management	52.1	31.5	4.2	33.3	18.8	6.3	6.3
Technical issues in HIV/AIDS	52.1	41.3	26.1	13.0	4.4	8.7	6.5
Resource mobilisation	52.1	53.1	2.1	25.5	2.1	10.6	6.4
Internet and information technology	51.4	24.4	11.1	13.3	6.7	40.0	4.4
Peer education techniques	49.0	48.4	11.6	27.9	2.3	4.7	4.7
Materials/message development	45.8	26.2	9.5	38.1	16.7	4.8	4.8
Quantitative research methods	44.8	32.4	13.5	29.7	10.8	5.4	8.1
Needs assessments	44.8	70.7	2.4	17.1	2.4	7.3	0.0
Behaviour change theory	42.7	19.4	25.0	19.4	19.4	16.7	0.0
Programme budgeting/costing	42.2	33.3	7.7	33.3	18.8	6.3	6.3
Qualitative research methods	41.7	33.3	8.3	33.3	19.4	5.7	0.0
Pretesting	29.9	50.0	11.5	30.8	3.9	3.9	0.0

BCC CENTRE OF EXCELLENCE. Participants were asked whether they would support the establishment of an HIV/AIDS BCC Centre of Excellence in the region. Nearly all (95%) agreed that they would support such a centre. When asked what they felt the contribution of the centre should be, the majority (57%) felt it should be a venue for knowledge management, networking, documentation, and idea exchange. Some participants proposed that the centre could start by nurturing the HIV/AIDS BCC Network that is emerging from this meeting. Others suggested that it could act as an HIV/AIDS BCC resource centre or clearinghouse from which practitioners could obtain materials. Participants pointed out that the collection and dissemination of materials should not be done blindly, however; they suggested that the centre could conduct a critical analysis of existing materials (and programmes) and recommend those that are likely to be most successful. In addition, some participants suggested that the centre could translate materials into international languages to facilitate their use in other areas.

Figure 5: Suggested Role of BCC Centre of Excellence



Some participants also suggested that the resource centre could perform its own research—including operations research to test various approaches—on topical HIV/AIDS BCC subjects. Others felt that it could raise funds and finance research activities itself. It was mentioned periodically that the target audience for the resource centre should not be limited to HIV/AIDS BCC practitioners, but that it should also include others such as the media. Participants noted that all of these dissemination roles would necessitate an online or offline publication or web site for the network.

The second most-mentioned role for the Centre of Excellence was capacity-building (47%). This included capacity-building in the development of HIV/AIDS BCC materials, capacity-building in research and evaluation, setting quality standards for HIV/AIDS BCC, and certifying HIV/AIDS BCC practitioners. Some participants suggested periodic training in thematic areas in order to respond to the meeting's needs. Where needed, the centre could also be a source of BCC consultants who could assist programmes.

The third most frequently mentioned role for the centre was provision of support in the development of BCC materials and communication strategies (28%). For example, participants felt that the centre could help network members develop a “minimum package for HIV/AIDS BCC,” help NGOs develop HIV/AIDS BCC materials, help NGOs apply behavioural theory, and help organisations measure the impact of their communication campaigns. Some participants proposed that the centre could coordinate HIV/AIDS BCC messages and targeting in the region. Others felt that it could play an instrumental role in standardising materials, such as training manuals, and others that the centre could be a venue for disseminating BCC cutting-edge results and interventions.

The fourth most frequently mentioned role for the BCC centre was HIV/AIDS advocacy (22%). For example, participants felt that the centre could train policymakers in BCC in an effort to gain their support for other interventions. Others felt that it could be a centre for advocacy (e.g., advocacy for PLHA). Another mentioned role was to provide policy guidelines for BCC in the region, to advocate for BCC, and to advocate for the role of research.

Summary

This report presents the findings of a self-administered questionnaire completed by participants at the First Regional Meeting of the HIV/AIDS BCC Network held in Kampala between November 3 and November 6, 2003. The objective of the survey was to document the level and kind of experience of expertise available from HIV/AIDS BCC specialists in the

region. A total of 96 participants (out of over 100 conference attendees), the majority being programme managers/implementers, completed the questionnaire. The participants came from 17 countries in eastern and southern Africa, and the United States.

The results indicate an educated and experienced group of HIV/AIDS BCC professionals, with an average of 10 years of general BCC experience and over 7 years of HIV/AIDS-specific BCC experience. They reported being fairly confident in several BCC skill areas, but they also identified specific subjects in which they would like further training. They supported the idea of a BCC Centre of Excellence, and made specific recommendations for activities that could be performed initially by the centre.

Participants for the meeting were selected specifically because of their contributions in the area of HIV/AIDS BCC and, therefore, they are a specialised group. While they may not represent the typical HIV/AIDS BCC worker in the region, they do indicate a strong BCC presence that could be harnessed.

The survey attempted to document what areas of training are needed by the participants by (a) examining the areas of expertise available in the group and (b) asking the participants to select what topics they required training in from a pre-structured list. As could be expected, both questions can lead to different answers. However, it is hoped that the survey findings provide some broad parameters around which HIV/AIDS BCC capacity-building could be structured for the region.