FEDERAL REPUBLIC OF NIGERIA

Nigerians Together:

Keeping our Community Strong!

The National HIV/AIDS Behaviour Change Communication Strategy 2009-2014

FINAL DRAFT

Published by the
The National Agency for the Control of AIDS (NACA)
2008

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Foreword

The National Action Committee on Aids was first established in 2000, and was given full Agency status in 2007, when it became the National Agency for the Control of AIDS, reporting directly to the Presidency.

NACA has, since its inception, moved progressively from an emergency position in the early formative years, to the more coordinated, prioritized, strategic, and multi-sectoral response evident today. From 2000, NACA worked with stakeholders to create several important enabling policies, frameworks, and strategies including the National AIDS Policy, the National Strategic Framework, and the National Behavioral Change Communication Strategy. These documents formed the foundation from which guidelines and supporting systems were developed to facilitate their coordination and implementation.

However, to be effective those documents need to be flexible and adaptive. As conditions change, so too should those policies and strategies. Regular review and updating, involving all key stakeholders, is a key factor in ensuring continuing relevance and application as new realities and evidence emerge.

Over the last 18 – 24 months, NACA with the support of its partners has initiated a series of highly participatory reviews and assessments of the national response, including the World Bank supported MAP 1 programme, the midterm review of the National Strategic Framework (2005-2009), a review of the BCC Strategy, an evaluation of the public sector response, and HIV AIDS Fund under MAP1. NACA has also commissioned further studies and assessments such as the socio-economic assessment, a gap analysis of programmes and funding, and a sustainability study to help inform future advocacy, policies, and directions.

During this period, NACA re-invigorated its earlier efforts to develop a national Aids priority plan, in line with the Paris declaration on national system development and ownership, and with the global task team recommendations on donor harmonization and alignment of support to the National responses. In 2007, the midterm review of the NSF became the platform for a state wide situational analysis that in turn informed the development of the national priority planning process which culminated this year with the agreed National Prevention Plan. The new prevention plan highlighted the need to reinforce our efforts on prevention and behavior change communication to address both the general population and most-at-risk members of Nigerian society.

Implicit in the prevention plan was the need to review the BCC Strategy that was earlier drafted in 2004. The review which had already been implemented had clear objectives: to determine the strategy's effectiveness; to make the document more evidence based; to be technically sound but more user-friendly for program managers and those with little or no technical background in such a specialized area; and to prioritize key interventions that would have maximum impact in the application of the updated strategy across a multi-sectoral response.

The BCC Strategy review ran in tandem with the efforts of the technical working group of the expanded Theme Group on prevention to develop the National Prevention Plan. BCC thereby

became an integral part of the overarching National Prevention Plan, with its own set of performance indicators.

The new strategy is testament to the efforts of all our stakeholders and our efforts to deliver a more informed, more user-friendly, and ultimately more effective strategy in our battle to reduce the impact of HIV on all Nigerians. I strongly encourage everyone involved with HIV and AIDS work in Nigeria to use this Strategy as your guide, and anticipate that it will set a new standard for the design, coordination, implementation, and evaluation of future BCC programming across Nigeria.

Professor Babatunde Osotimehin
Director General
National Agency for the Control of AIDS

List of Acronyms and Abbreviations

AFPAC	Armed Forces Project Advisory Committee
AIDS	Acquired Immune Deficiency Syndrome
ARN	Alliance Rights of Nigeria
ARVs	Anti-retroviral Drugs
BC	Behaviour Change
BCC	Behaviour Change Communication
CCP	Johns Hopkins University Bloomberg School of Public Health Center for Communication Programs
CiSHAN	Civil Society for HIV and AIDS in Nigeria
CBOs	Community Based Organisations
DFID	Department for International Development
EU	European Union
FBOs	Faith Based Organisations
FCT	Federal Capital Territory
FHI	Family Health International
FLE	Family life Education
FSW	Female Sex Worker
HCW	Health Care Worker
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
IBBSS	Integrated Bio-Behavioural Surveillance Survey
IDU	Injecting Drug User
IGA	Income Generating Activities
IPCC	Interpersonal Communication and Counselling
LACA	Local Agency for the Control of AIDS
M&E	Monitoring and Evaluation
MARPS	Most At Risk Populations and Settings
MOE	Ministry of Education
MOH	Ministry of Health
MSM	Men who have Sex with Men
MWAYD	Ministry of Women Affairs and Youth Development
NACA	National Action Committee on AIDS
NARHS	National AIDS and Reproductive Health Survey
NASCP	National AIDS and Sexually Transmitted Infections Control Programme
NEPWHAN	Network of People Living with HIV/AIDS in Nigeria
NFACA	National Faith Based Advisory Council
NIBUCCA	Nigeria Business Coalition against AIDS
NGOs	Non Governmental Organisations
NPP	National Prevention Plan
NSF	National Strategic Framework for HIV and AIDS
NURTW	National Union of Road Transport Workers
NYNETA	Nigeria Youth Network on HIV/AIDS on AIDS
OVC	Orphan and Vulnerable Children
OIs	Opportunistic Infections.
PEP	Post Exposure Prophylaxis

PEP Model	Peer Education Plus Model
PLWH	People Living with HIV
PPTCT	Prevention of Parent to Child Transmission
PWD	People with Disabilities
PTA	Parents Teachers Association
SACA	State Agency for Control of AIDS
SBC	Strategic Behavioural Communication
SFH	Society for Family Health
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
TV	Television
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development

Part 1:

Introduction and Background to the National BCC Strategy

Executive Summary

The National Behaviour Change Communication (BCC) Strategy (2009-2014) will enable NACA, SACAs, LACAs, line ministries/departments, public and private sector, civil society and all implementing partners to develop and implement more effective HIV interventions by strengthening the BCC capacity of their program managers. It will also provide a strategic focus to planning BCC for a harmonised and coordinated response at all levels.

This revised document builds on the National Prevention Plan for Nigeria, launched in 2008, which seeks to provide states with a minimum package of prevention activities. It draws on best practices and lessons learned both internationally within prevention and behaviour change, as well as an in-depth situational analysis within Nigeria, including visits to six states, consultative meetings with key stakeholders, and participatory development of the revised document and methodology.

Approach

The Strategy provides program planners with a user friendly, hands on guide to developing behaviour change communication strategies for key priority audiences in Nigeria. The strategy also guides donor partners on areas of support and interventions that require national resources. Because of the tremendous diversity of Nigeria's 36 states, and the federal capital territory, the strategy is designed to be flexible, using illustrative stories of key priority audiences and checklists to guide program planners in developing tailored communication strategies based on state's or LGA's local, cultural, and other contextual diversities.

Organisation of the National BCC Strategy

To build and strengthen the BCC capacity of program managers, the strategy provides Program Planners a five step process for planning their interventions at national, state and local levels.

Step 1: Know your epidemic. This section describes where we are now, nationally and within states, and identifies the main drivers that fuel the epidemic and will need to be addressed through BCC interventions.

Step 2: Know what works in BCC. This section describes what works in BCC and priorities to strengthen BCC efforts in Nigeria.

Step 3: Develop your BCC strategy and key strategic interventions. This section states the objectives of what needs to be achieved through the proposed interventions, and outlines the conceptual framework and priority audience strategies based on research evidence.

Step 4: Operationalize the strategy. This section outlines the key steps programme planners need to consider at national, state, and local level to take the strategy forward as well as identifies the roles and responsibilities at different levels.

Step 5: Measure what you have achieved. This section outlines the key M&E framework and indicators for the strategy components.

Nigeria's epidemic

Nigeria's national prevalence rate of 4.4% in 2005, masks great diversity in the epidemic at state level. The epidemic can be generalized in higher prevalence states and concentrated in other states, affecting different populations in both urban and rural settings. Most at risk populations are also changing to include the needs of new priority audience such as MSM and IDUs.

This demonstrates the need for the response to be state driven because of the variation within and among states. While the main drivers of the epidemic have been identified across states to include low risk perception, high risk sexual behaviours, multiple concurrent partners, informal transactional and intergenerational sex, lack of STI services, gender inequalities, stigma and discrimination, and inadequate health care system, state planners will need tailor BCC interventions to their local epidemic and cultural context.

What works in BCC

The Minimum Package of Behaviour Change Communication Interventions recognises that individuals cannot change their behaviour without an enabling or supportive environment. Therefore, in order for behaviour change to occur within individuals, strategic interventions are required at four levels: for the individual, community, health system, and policy maker levels. Reports from the recent XVII International AIDS Conference in Mexico suggested the term *"Combination Prevention"* as the necessary integrated multi-level response, with a movement away from the ABC focus in communication.

The National BCC Strategy

Goals and Objectives

Drawing on the National Prevention Plan, the National BCC Strategy seeks to

"Reduce the rate of spread of HIV infection in Nigeria by 25% by Year 2014".

The key behavioural objectives across priority audiences will be to:

- Delay first sex among young women and men until the age of 18.
- Reduce reported multiple concurrent partners among all groups.
- Increase consistent and correct condom use among all men and women who are sexually active, particularly among paid and casual partners.
- Increase early STI detection, treatment and partner notification.
- Increase uptake of HIV testing.
- Increase uptake and adherence to HIV related services including PPTCT services.
- Reduce reported stigma and discrimination among PLWH.
- Increase number of community support services.

- Increase support and encouragement of community normative changes that support behavior change and behavior maintenance
- Reduce reported high risk cultural practices.
- Improve provider-client interaction within health facilities (by all groups).

For each priority audience strategy, strategic communication objectives have also been identified as a means to measure progress towards achieving behavioural outcome objectives.

Priority Audiences

Based on priorities of the National Prevention Plan, the strategy provides program managers the following ten priority audience strategies, listed in alphabetical order, for local adaptation.

1. Female Sex Workers (FSW)
2. Health Care Workers (HCWs)
3. Injecting Drug Users (IDUs)
4. Men who Have Sex with Men (MSM)
5. Orphans and Vulnerable Children (OVCs)
6. People Living with HIV (PLWH)
7. People with Disabilities (PWDs)
8. Transport Workers and other men who travel
9. Women and Men of Childbearing Age
10. Young People

How to Use the Priority Audience Strategies

Each priority audience BCC strategy begins with an illustrative story, and lays out the five key steps in programme planning using a checklist and examples from the story to identify strategic behaviour change communication interventions for the individual, community, system, and policy maker levels. They are:

Barriers

Across all key audiences the following twelve barriers will need to be addressed at different levels:

1. Low personal risk perception
2. Lack of confidence and culturally appropriate life skills
3. (Knowledge gaps on issues of HIV or SRH)
4. Lack of partner, family and peer support
5. Lack of community dialogue on issues of SRH and HIV
6. high risk sexual behaviors including alcohol and drug abuse with their attendant dis-inhibition tendencies
7. High stigma and stigmatisation related to HIV and SRH.
8. Gender inequalities at all levels of society that need to be addressed within HIV and SRH.
9. Harmful sexual and reproductive health practices in communities that increase

STI/HIV transmission.
10. Low male and community involvement in HIV and /SRH activities
11. Low access to SRH products (condoms and family planning)
12. Poor client and service provider relationship which has led to dissatisfaction in the quality of services and low utilization of services.
13. Lack of supportive policies and laws to strengthen access to services, protect fundamental rights, and foster linkages between sectors.

Strategic Interventions

Program will develop strategic Interventions that focus on:

- *Media communication* on these themes using all channels.
- *Peer/mentoring* with life skills.
- *Community transformation* (communities, workplaces, places where people meet) to support reduction of stigma, address harmful gender and cultural norms, encourage norms that support reduction in risky sexual behaviors and increase community involvement.
- *Increasing access to quality products and services* by strengthening provider – client interaction for education and adherence, positioning key products where clients can reach them easily, and increasing visibility of quality services through branding.
- *Advocacy to address the wider policy environment* that determines access, protects fundamental rights, and promotes linkages between sectors as well as support provisions for capacity development in prevention activities.

All the interventions developed will:

- Be driven by the priority audience affected as planners for strategic interventions.
- Highlight personal positive stories of real people and communities
- Emphasize local solutions based on a problem solving approach
- Focus on doable actions at all four levels for impact.

The Operational Plan

There needs to be a coordinated, harmonized response for prevention efforts at all levels to protect Nigeria's communities. Coordination and support for the implementation of the National BCC Strategy involves many different players at all levels of society. At national level, NACA is responsible for coordinating the response to the HIV epidemic in Nigeria. In its capacity, it acts as liaison between government at national level and between the states, engaging both non for profit and private sectors, coordinating initiatives, steering policy, framing the important issues and assisting organisations to develop capacity. NACA will also serve as the clearing house for HIV related information, materials, and relevant databases. At state level, the SACAs are responsible for coordinating implementation of the state response to the epidemic. Implementation of these strategies, however, rests with the many organisations, both local and international, whose mandate it is to address the HIV & AIDS crisis.

The draft operational plan for the National BCC Strategy provides a road map for NACA to coordinate and provide sustained support at the national level, and to ensure that

programs implemented at all levels are part of a coherent and managed national response. The plan focuses on a number of key areas: media communication, community mobilization, peer/mentoring, advocacy, monitoring and evaluation, and budgeting to ensure that programs implemented at all levels are part of a coherent and managed national response. The state SACAs, in turn, will need to tailor the operational plan to meet the needs of their particular state.

Monitoring and Evaluation

It is critical to understand if and how the strategies identified are having an impact on behavioural objectives set. This strategy builds on NACA's Monitoring and Evaluation Framework and on a number of survey instruments, of which the key ones are the National AIDS and Reproductive Health Survey (NARHS) and the Integrated Bio-Behavioural Surveillance Survey (IBBSS). The NARHS, conducted every two years among male (15-64 years) and female (15-49 years) in all states of Nigeria, explores key knowledge and practices around both HIV and sexual and reproductive health. The latest NARHS 2008 is an important guide to both NACA and to the States in finalising the targets set for the National BCC Strategy and State Strategic Plans.

The IBBSS (2007) provides important baseline information about most at risk populations including FSWs, MSM, IDUs, transport workers, and men and women in the uniformed services. The study took place in five states (Anambra, Cross River, Edo, Kano, and Lagos) and the Federal Capital Territory (FCT) and identified knowledge and beliefs about STI, and HIV, as well as key risk practices among these groups.

There are many other opportunities to refine our understanding of cultural beliefs and practices by sharing existing research of implementing partners, including NGOs, research institutions , universities, and private marketing companies. Specific impact evaluations should also be carried on all of the larger individual interventions to identify best practices for scaling up within and across states.

Introduction

Nigeria's communities are at risk. The country's population of more than 140 million people, representing extraordinary ethnic and cultural diversity, faces an HIV epidemic that could easily spin out of control. Although the national HIV prevalence rate was cited at 4.4% in NARHS 2005, this translated into more than 2.9 million people living with the virus and in need of services, and support, the third highest burden for HIV in the world. The picture at state level varies dramatically. Some states are facing epidemics of as much as 13%, others less than 2%. Even within states, populations most affected also vary considerably. Some states have more of an urban epidemic, others a rural epidemic, and still others seem to have pockets of high prevalence found among high risk groups that could easily explode into the general population through bridge populations.

What is clear is that there needs to be a coordinated, harmonized response for prevention efforts at all levels to protect Nigeria's communities. There is much that can be done. The fact that 95% of Nigerians remain HIV free is a tremendous opportunity for the country. The newly launched National Prevention Plan also strategically places prevention efforts, and within that, behavior change communications as a priority area for all partners. and has done much work to build national consensus on the way forward.

The National Behavior Change Communication Strategy is imbedded within the National Prevention Plan (2007-2009), and builds on the strategic focus of the national prevention plan that emphasizes a 'minimum package service interventions and integration of prevention services into clinical care settings with media interventions as reinforcing. key areas identified to reduce risks of sexual transmission of HIV through, appropriate behavior changes and increase uptake of quality comprehensive prevention services including access to male and female condoms, STI management, HIV counseling and testing, prevention of parent to child transmission of HIV, reduction of biomedical transmission, encouraging male circumcision and ART.

The Strategy seeks to reduce the impact of HIV on Nigerian communities by providing the NACA, SACAs, LACAs, line ministries, civil society, private sector and all implementing partners with a user-friendly, hands-on guide to developing behavior change communication strategies for key priority audiences in Nigeria. The strategy is also intended to guide donors on areas of support and interventions that require national resources.

It draws on best practices and lessons learned both internationally within prevention and behavior change, as well as an in-depth situational analysis within Nigeria, including visits to six sample states, consultative meetings with all key BCC stakeholders, and participatory development of the revised document and methodology.

Because of the tremendous diversity of Nigeria's 36 states, and the federal capital territory, the national strategy is designed to be flexible, using illustrative stories of key priority audiences and checklists to guide programme planners in developing tailored communication strategies based on state's local epidemics and cultural diversity.

Behavior change communications recognizes that beyond the individual's desire, confidence and skills to change, individual behavior is influenced by many different factors and seeks to address these factors at family, community, health system, workplaces, and within the policy environment as well. This requires do-able actions and strategic interventions at all levels in order for any individual to make changes in their daily lives. It also requires linkages and partnerships beyond health to other key sectors working in gender, livelihoods, agriculture, private sector, faith, and the media among many others. We all have a role to play to prevent further spread of HIV within our communities, and to provide a supportive environment for those living with the virus to access treatment, care and support and contribute to a strong Nigeria.

Every Nigerian, be s/he a programme planner, community or faith leader, media planner, man, woman, young person or child, should take personal responsibility and act to ensure that everything we do, as Nigerians, makes a difference in terms of HIV prevention. In our different roles, we can fight stigma and discrimination, help to transform cultural and gender norms that underscore risk behavior for both men and women, and put our children at risk. We can strengthen links between sectors to ensure that all Nigerians in need have access to related health care products where and when they most need them, quality health services and community support, access to economic opportunities and legal protection. Our aim is to keep Nigeria's communities healthy and strong, to ensure a future for all Nigerians by providing an enabling environment for everyone to take care of his/her health.

Who should use this document?

This document can be used at national level by NACA, all SACAs, civil society, private sector and other coordinating bodies to strategically plan and provide oversight to state implementation.

This document is a guide that can be used by states to develop state specific strategic plans based on the local realities of the epidemic and relevant behavioral information.

Program planners can also use this document to define program specific strategies based on specific areas of focus, primary audiences and communities that they work with. Donor communities can also use this document to guide their award and implementation of supported/funded HIV prevention programs relating to BCC.

How is the document organised?

Because of the tremendous diversity of Nigeria's 36 states, and the federal capital territory, the national strategy is designed to be flexible, using illustrative stories of key priority audiences and checklists to guide programme planners in developing tailored communication strategies based on state's local epidemics and cultural diversity.

The strategy is organised into five key sections as steps programme planners need to take in planning their BCC interventions at national, state and local levels.

Step 1: Know your epidemic. This section describes where we are now, nationally and within states, and identifies the main drivers that fuel the epidemic and will need to be addressed through BCC interventions.

Step 2: Know what works in BCC. This section describes what works in BCC and priorities to strengthen BCC efforts in Nigeria.

Step 3: Develop your BCC strategy and key strategic interventions. This section states the objectives of what needs to be achieved through the proposed interventions, and outlines the conceptual framework and priority audience strategies based on research evidence.

Step 4: Operationalize the strategy. This section outlines the key steps programme planners need to consider at national, state, and local level to take the strategy forward.

Step 5: Measure what you have achieved. This section outlines the key M&E framework and indicators for the strategy components.

Priority audience strategies are organized in alphabetical order, into individual chapters.

What are our guiding principles?

The following ten principles guide the National BCC Strategy's development and implementation and underscore the approach needed for behavior change communications to be strategic and effective.

1. *Recognize the many accomplishments in prevention, care and treatment and promising interventions.*

A number of evidence-based interventions currently underway have shown promise. Examples of successful models will be shared for replication and for scaling-up in states where they are already being implemented.

2. *Complement prevention, care and treatment efforts*

Prevention and treatment are mutually reinforcing strategies to address HIV and AIDS. This strategy will ensure that advantage is taken of the enormous gains made in treatment, will reinforce prevention in the care setting, and will expand prevention with PLWH.

3. *Recognize diversity within state epidemics, geographical, cultural differences and designs strategies that are tailored to their needs*

Ongoing interventions differ in their scope and intensity. There are also differences across states in local vulnerabilities and individual behaviors driving the HIV epidemic. The strategy needs to be adapted and modified by the states and at local government

Guiding Principles

1. Recognise accomplishments made and promising interventions.
2. Complement prevention, care and treatment efforts.
3. Recognise diversity within state epidemics, geographical, cultural differences and designs strategies that are tailored to their needs.
4. Do what is easiest first.
5. Develop interventions at all four levels for an enabling environment to behaviour change.
6. Prioritise those actions that will make the most difference.
7. Focus on harm reduction and small doable actions.
8. Draw on ordinary people's voices and stories.
9. Build partnerships, collaborations across sectors, between states, and at local levels.
10. Achieve gender equity.

levels, tailoring interventions to each state's particular situation.

4. Do what is easiest first

A key starting point is to scale up existing activities that have been demonstrated to work. This approach might mean replicating successful interventions in new locations, or conducting these interventions at a broader scale in the same location. In addition, interventions that do not require further policy discussions could proceed without waiting for the strategy to be formally approved.

5. Develop interventions at all four levels for an enabling environment to behavior change.

To date, prevention interventions have placed emphasis on individual behavior change, with very mixed results. But HIV and AIDS exist within a complex social structure. Social and communal norms are as influential in their effects on the epidemic as are individual behaviors. Increasingly, evidence points to the need for a broader more multi-sectoral and community focused response and a stronger focus on stigma and reduction of harmful cultural and gender norms at community, system and policy levels.

6. Prioritize actions that can make the most difference

Human and financial resource constraints require programs to make difficult choices. Because not all good ideas can be carried out, priority should be given to those with the greatest impact on HIV prevention. These activities should be selected for their potential in achieving one or more program objectives.

7. Focus on harm reduction and small doable actions

Harm reduction works on the idea that people cannot always do the "perfect" or preferred behavior—e.g. reduce partners immediately. But there should still be some smaller, more do-able action people can take to reduce their risk (reduce the potential harm to themselves and others), e.g. finding one person that you trust to disclose your HIV status, rather than disclose your status to your partner, or community.

8. Draw on the voices of ordinary people

People need to feel they are part of the solution, not simply recipients of information. By focusing on providing channels (e.g. radio or town hall meetings) for people to speak their minds, the debate will better reflect real local issues and challenges. This will help lead to better local, home-grown solutions. The use of real personal stories as role models of do-able actions also reinforces the fact that real people can make a difference to their own and other's lives.

9. Work through collaboration and partnerships across sectors, between states, and at local levels.

A key principle is to implement this strategy within the frame work of the existing National Strategic Framework (NSF) and National Prevention Plan (NPP). Effective collaboration will be needed among all partners to harness the potential of the diverse resources that each stakeholder can contribute.

10. Achieve gender equity in access to prevention services

Recognizing that a disproportionate burden of the epidemic is borne by young women, all efforts will be made to create an enabling environment in which women are

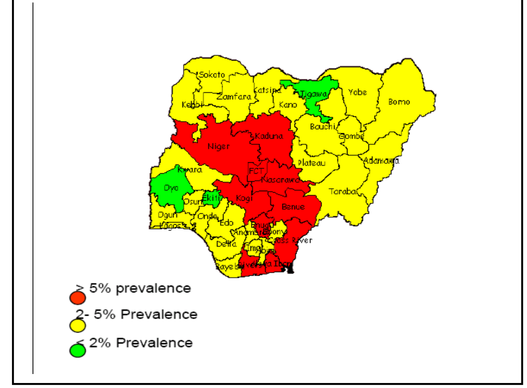
empowered to access services that will reduce their vulnerability. Men as partners will be a key strategy to facilitate male support for women in making appropriate choices. Gender-based violence, which is closely linked to HIV transmission, will be addressed in collaboration with the national organizations charged with the primary responsibility in this area.

Step 1 Know your epidemic

As programme planners, we need to know the epidemic we are dealing with. This section describes Nigeria's epidemic at national and state level, the main drivers of the epidemic, our current opportunities, gaps, and priorities to address.

Where are we now?

Nigeria is the largest country in sub-Saharan Africa and the tenth most populous in the world. Nigeria's community reflects extraordinary diversity and richness with more than 400 ethnic groups in existence and six major languages spoken. This vast country is predominately a rural one with more than 2/3rd of its 134 million people living in villages in 2005. Nigeria's people are also young, with half the population under the age of 15 years of age.



Nationally, the sero prevalence rates of 4.4% in 2005 translated to over 2.9 million people living with the virus (NARHS 2005). This placed Nigeria as having the third greatest burden of people infected with HIV in the world. Over the last two decades, the HIV epidemic in Nigeria has gone from affecting only a few populations with higher-risk behaviors within a 'concentrated' epidemic in a few states, to a 'generalized' epidemic in many states.

The picture at state level varies dramatically. In some states, the prevalence rate was higher than 10%, in others 2%. High prevalence states traverse the country affecting the states of Benue, Kogi, Nasarawa, and Niger. However, it is important to reiterate that no state is unaffected, and *the NARHS (2008) to be released later this year may show a very different picture regarding changes in the epidemic by state, population and areas of concentration.*

State prevalence figures can also mask great differences within the states, regarding who is most affected by the virus. Some states, like Benue, FCT and Niger, face more of an urban epidemic, other state epidemics found in Akwa Ibom, Kaduna and Abia hit more of their rural populations, and other states like Taraba, Cross River, and Nasarawa had epidemics more evenly distributed between both their urban and rural communities. Low literacy and poverty are likely to be contributing factors to the epidemic's spread within states and certainly affect access to information and services.

Like many other countries in Africa, HIV is most prevalent among the most productive members of society (age 25-29), with young women, in particular, affected. The epidemic also had a disproportionate impact on women and girls in their reproductive years, with 4.9% of pregnant women age 25-29 infected followed by women age 20-24

with 4.7%. More alarming, 3.6% of women age 15-19 were infected as well suggesting early sexual debut.

High and early fertility among young women across Nigeria's vast and diverse nation, suggests that many more children will also be infected as a result due to parent to child transmission. Already, more than 1.2 million children were reported to be infected in 2005. It was estimated that 75,780 new infections would occur among children less than 15 in 2006, with the number of child-headed households increasing due to the death of their parents. This indicates a greater need to link HIV within reproductive health services to reach both women and men within the general population with more responsive family planning, HIV testing and comprehensive PPTCT services. It also suggests the need to strengthen holistic interventions to protect vulnerable young populations with increased education and social support services.

The IBBSS (2007) showed a different picture of Nigeria's epidemic with certain *most at risk populations* more adversely affected by HIV than others. FSWs, MSM, IDUs carried the greatest burden of HIV with prevalence rates significantly higher than those reported in the general population. On the other hand, armed forces, and transport workers, showed prevalence rates lower than the national average in some cases, suggesting success in reaching out to these populations through previous prevention efforts. With high prevalence rates of more than 30% for FSW across all states surveyed and 13.5 % among MSM, the risk of transmission through bridge populations into the general population could easily explode into an exponential growth of the epidemic across all states.

Because of the tremendous diversity within Nigeria's population, it is clear that as planners, we need to look carefully at data within our states in making strategic plans as well as recognize the diverse needs for planning our response. In such a dynamic environment, it is also important to consider the drivers of Nigeria's epidemic to ensure that programme planners stay in tune with future changes in the epidemic's growth.

What are the drivers of Nigeria's epidemic?

Behind the numbers, we need to look at why HIV prevalence affects certain states and populations more than others. The main drivers fuelling Nigeria's epidemic include low risk perception, multiple concurrent sexual partners, informal transactional and intergenerational sex, lack of STI services, gender inequalities, stigma and discrimination, and inadequate health services.

Drivers of Nigeria's Epidemic:

1. Low risk perception
2. Multiple concurrent partners
3. Informal transactional & intergenerational sex
4. Lack of STI services
5. Gender inequalities
6. Stigma & discrimination
7. Inadequate health services.

1. Low risk perception

The NARHS 2005 showed that 67% of Nigerians felt no risk for HIV and only 29% perceived themselves to be at low risk for HIV. Even the IBBSS 2007 showed that MARPs did not perceive themselves as being personally at risk for HIV, despite high HIV prevalence rates among FSWs, MSM and IDUs. Low risk perception for HIV among Nigerians means that they are unlikely to take calls for action to prevent HIV seriously, regardless of high knowledge about the virus.

2. *Multiple concurrent partners among men and women.*

One of the most crucial drivers of the epidemic in Nigeria is multiple concurrent sexual partners. Across all male and female Nigerians, including most at risk populations, multiple concurrent partners were reportedly high despite low risk perception. In the NARHS 2005, 28% of unmarried men and 26% of married men reported having more than one sexual partner in the past 12 months.

Among most at risk populations, the IBBSS (2007) also reported a high number of multiple concurrent partners among FSWs, transport workers, uniformed personnel, and groups like MSM and IDUs. While transactional sex is one factor contributing to high risk sexual behaviour, in which MSM and female IDUs report low condom use, most of the sexual encounters occurring between casual partners, boyfriends and girlfriends condom use is relatively low across all groups, including among FSWs, MSM, and IDUs.

Underlying multiple concurrent partnerships are cultural norms that encourage polygamous relationships, particularly among men. Common practices of having "inside and outside wives" and societal norms that assume "all men are polygamous, encourage men to have multiple partner to demonstrate their masculinity. Even among formal polygamous relationships, where there is presumed greater protection, men and women were reportedly not always staying within the relationship (Kemp 2002). Women within polygamous relationship in rural areas were more likely to have extra-marital affairs than among monogamously married women as a means to economic security.

This suggests that without partner reduction and increase condom use, HIV will continue to spread rapidly from bridge populations to the general population.

3. *Informal transactional and intergenerational sex*:

There is a great deal of evidence that many women, particularly young women, are exchanging sex for gifts, favours, and money outside of a brothel setting. Women who engage in informal transactional relationships are less likely to use condoms than women in formal commercial sex encounters.

Many of these women are young, and are involved in relationships with men who are at least five years older than themselves. This age difference increases their risk for HIV dramatically, as well as reduces their power to negotiate safe sex. Cultural norms that deprive women of economic security and encourage early and forced marriages of young women contribute to transactional and intergenerational sex and increased risk for HIV.

4. *Lack of established STI services, particularly for MARPs.*

Despite high reporting of unusual genital discharge and ulcers among female sex workers, transport workers and uniformed personnel, most do not access STI services, and are unlikely to notify their partners of their need to be treated. Untreated STIs increase the risk of HIV transmission, and are more difficult to detect in women versus men.

5. Gender inequalities that influence risk behaviour and limit access to key HIV and SRH services.

Underlying risk behaviours among men and women are fundamental gender inequalities that put women, in particular, at risk for HIV. While cultural norms vary from state to state, gender based violence, sexual abuse, and in some places, restrictions on women's mobility, access to education and economic opportunities are commonly reported and increase women's risk for HIV by limiting their ability to control their own sexuality, and affecting their access to key information, services and financial independence.

Cultural norms that relegate women to a subordinate role within marriage make it difficult for women to negotiate their right to safe sex, refusal of sex, or use of family planning methods to prevent unwanted children. This is compounded by a significant age difference between husband and wife, particularly in polygamous relationships, which further makes it difficult for young women to access power in the relationship. Other harmful cultural practices including wife inheritance, traditional wife sharing, early and forced marriages, female circumcision and sexual cleansing not only increase women's risk for infection but also further undermine women's rights to autonomy and self determination.

6. Stigma and discrimination

Stigma related to HIV keeps many people from responding to prevention, care and treatment interventions for HIV. It prevents Nigerians from accessing HIV testing for fear of positive results, disclosing their HIV status to their partners, and uptake of prevention of parent to child transmission services, including safe feeding of newborn children. The NARHS 2005 reported widespread stigma against PLWH by all segments of the population including health care workers.

7. Inadequate health care system

Nigeria's health care system is in a poor state. Much of the country lacks basic health care services, including essential supplies, drugs and equipment. This makes it difficult to introduce HIV related services, particularly prevention of parent to child transmission services, which also relies on a strong maternal and child health service delivery.

Where HIV related testing and treatment are available, the numbers are few, and difficult for most of the population to access. Attitudes of health care workers, particularly towards PLWH, are also highly stigmatizing making it difficult to motivate people to use the limited services available.

Generally, confidence in health care services is low. There are hidden costs in accessing health care. Not only are services and products not free for many Nigerians who cannot afford to pay, but opportunity costs such as travel and time lost in work must be factored in when people access health care. Because of the low quality of public health care available, most Nigerians seek private care, use local pharmacies and traditional healers with a very wide range of knowledge, skills, training and legitimate interest in public health.

What are our opportunities within Nigeria's community?

The fact that 95% of Nigerians still remain HIV free is a tremendous opportunity for prevention efforts in our communities. Not only is our combined strength and commitment key to fighting the spread of the epidemic, most of us can do a great deal to prevent ourselves from becoming infected, and from spreading it to others. It is already evident that Nigerian communities, at all levels, have made important strides to address the epidemic.

Key Players and Policies:

Spearheading the national response is the NACA, SACAs at the state level, and LACAs at local level. The National Strategic Framework (2005-1009) was developed to guide states with a comprehensive plan that includes treatment and states have developed State Strategic Plans drawing on this document.

Building on the NSF, is the National Prevention Plan. This document identifies key prevention priorities for states to further strengthen their future strategic plans with a minimum package of prevention activities for greater impact on the epidemic at state level. The development of this national document involved many stakeholders in its development, and lays out the areas in which the National BCC Strategy can be operationalised as well as further develop strategic areas of focus.

There are also many policies in place to draw on Including the National Policy on HIV and AIDS, the National Workplace Policy, the Health Promotion Policy, and policies for reproductive health, gender, young people, OVCs, and health care access and safety that are being domesticated by specific states. Currently, the bill on stigma and discrimination against PLWHA is awaiting signage through the National Assembly.

While the three tier system of government poses challenges to coordinate a national response for HIV, NACA is seen by the states and implementing partners as playing a key role in leadership and capacity building the states. While capacity to spearhead coordination at state and local level, varies, some states are well organised and have made impressive gains which could support other states in building capacity for coordination and leadership.

The Civil Society Constituencies, which are organized according to the key national constituencies around HIV, are are also a great opportunity for mobilisation and coordination of key areas of the National BCC Strategy. These include the Civil Society for HIV and AIDS in Nigeria (CiSHAN), which is the network for all the civil society groups and constituencies working within the national response. The main constituencies are Network of People Living with HIV/AIDS in Nigeria (NEPWHAN), Nigeria Youth Network on HIV/AIDS (NYNETHA), National Faith Based Advisory Council on AIDS (NFACA), Nigeria Business Coalition against AIDS

Enabling Policy Environment

- National Policy on HIV and AIDS (2003)
- National Workplace Policy on HIV and AIDS (2005)
- National Reproductive Health Policy
- National Youth Policy
- National \health Promotion Policy
- Free ARV Treatment Policy (2006)
- National Gender Policy
- National OVC Policy
- National Blood Transfusion Policy (2006)
- National Policy on Injection Safety and Health care Waste Management (2007)
- Bill on stigma and discrimination against PLWH submitted to the National Assembly

(NIBUCCA) and National Women Coalition on AIDS (NAWOCA), whilst the catalytic constituencies are the Nigerian HIV/AIDS Research Network (NARN) and the Media, Arts and Entertainment. The other constituency serves the interest of the vulnerable populations and it is known as the Dicersity Network, which includes the Alliance Rights Nigeria working with MSM and Nigeria Network of sex worker projects which focus focus on delivering services to sex workers.

These Networks are reffered to as Constituency Coordinating Entities and they are all coordinated by CiSHAN in the National Response. They are viable platforms for mobilizing and engaging the different constituencies. Already, there have been some key efforts made by the NFACA, to develop state based Islamic policies to engage faith leaders on key HIV issues.

For the private sector, the Nigerian Business Coalition Against HIV/AIDS (NIBUCCA) mobilizes the business for profit sector to develop and implement workplace policies and also mobilizes resources from the private sector for HIV/AIDS interventions.

There are also local institutions within the HIV sector with communications expertise that can scale up evidence based interventions, many examples of promising interventions and prevention opportunities identified from the states, and regional/international interventions that could be adapted to meet state needs.

Finally, Nigeria's culturally and ethnically diverse communities are themselves a tremendous opportunity to play a critical role in preventing HIV transmission. There is a strong culture of community groups that could be mobilised for related HIV prevention, care and support efforts in culturally appropriate ways.

Civil Society Constituencies

- Civil Society for HIV and AIDS in Nigeria (CiSHAN)
- Network of People Living with HIV/AIDS in Nigeria (NEPWHAN)
- Nigeria Youth Network on HIV/AIDS (NYNETHA)
- National Faith Based Advisory Council on AIDS (NFACA)
- Nigeria Business Coalition against AIDS (NIBUCCA)
- National Women Coalition on

What are the gaps in existing prevention efforts?

There is still much we can do to improve our efforts in behaviour change based on lessons learned and new priorities to address. Findings from a national situational analysis of the previous BCC Strategy implementation showed some key gaps in implementation of the previous national strategy and identified some new priorities that will need to be addressed in light of the National Prevention Plan. The following summary reflects some of the most important areas to strengthen in the National BCC Strategy.

Strengthen strategic communication:

- Capacity for developing strategic communication interventions remains weak
- There needs to focus greater attention on reaching rural audiences. Rural audiences were not being reached in current communication efforts. IEC materials were often developed in English and require high literacy to understand.
- Demand creation for HIV related services was not always directly linked to where services are available.

- There is a need to increase and expand interpersonal communication and community mobilization approaches to all LGAs.
- Because the National BCC Committee was not fully operational, the National Strategy lacked clear and sustained management, monitoring and coordinating support.
- Reinforcement of messages with consideration for dosage and intensity necessary to stimulate behavior change to be emphasized in strategic communications

Ensure adaptability of the national strategy to state needs:

- The size of the country and variation of prevalence rates from state to state, make it critical for organizations to understand the epidemic at the state and LGA level.
- The strategy was very technical and not easy for states to use as a guide.
- Recognition of drivers of the epidemic as they affect specific target populations at state and local government levels

Address new priorities based on the National Prevention Plan:

- Support the scale up of HIV-related services, including Prevention of Parent to Child Transmission services.
- Support an integrated approach between RH and HIV, including a stronger focus on the links between STIs and HIV.
- Address the needs of new high risk audiences such as MSM and IDUs.
- Ensure a stronger focus on gender and cultural norms.
- Strengthen risk perception, role of alcohol, and risks around intergenerational sex.
- Encourage and support multilevel prevention intervention approaches with emphasis on the minimum package intervention of the national prevention plan

Step 2 Know what works in BCC

This section identifies best practices internationally, and components of *the Minimum Package of BCC Interventions.*

What works?

Research indicates that there needs to be a dramatic shift in how prevention efforts, and behaviour change communication interventions in particular, take place in order for there to be an impact on HIV prevalence globally and in Nigeria.

Reduction of Multiple Concurrent Sexual Partners is key for impact on HIV prevalence.

- Within a 3-4 month period
- High viral load at infection
- Sexual network expands rapidly

There is now compelling international evidence that suggest that in countries like Nigeria where male circumcision rates are almost universal, the single most crucial intervention that will have impact on the HIV epidemic is reduction of concurrent multiple partners.

“Multiple concurrent partners” is defined as a person having more than one sexual partner at the same time during a 3-4 month period. This behaviour can dramatically speed up the transmission of HIV through the network of sexual partners. While it is not surprising that the number of sexual partners will in itself, increase the risk for HIV transmission, what is now becoming clearer, is that the viral load immediately after HIV infection, is also significantly higher, greatly increasing the risk of transmission. This means that if one person in the sexual network contracts HIV, everyone else in the network is also at very high risk of infection as well.

Meta-analysis studies showed that prevention programmes which **did not work** were:

- Condom use
- HIV testing
- Treatment of STIs
- Vaccines and microbicides
- Abstinence

In Nigeria, where multiple concurrent partners has been identified as a key driver in the epidemic, a great deal of focus needs to be put on increasing the knowledge of personal risk inherent in concurrent multiple sexual partners, and the benefits of partner reduction, even if it is only reduction of one partner at a time.

There are also compelling arguments for why a shift from individually focused preventive efforts to a more direct engagement of couples and families is key for other preventive interventions to have greater impact. Also the need for BCC intervention packages to be cognizant of prevention with positives approaches as key with specific population targeted intervention for averting new infections.

Globally, meta-analysis studies showed that most prevention programmes, including condom use, HIV testing, treatment of STIs, and abstinence, were not having an impact on behaviour change.

Increasing access and uptake of condoms for short term, casual and paid sexual partnerships is, of course, a very high priority. But, promotion of consistent condom use has been shown to be very challenging for men and women in long term relationships where there is meant to be 'trust'. There needs to be a much greater emphasis on how to make male and female condoms acceptable in the context of relationships of trust as a method of dual protection, particularly in light of the greater risks of HIV to partners within long term relationships

Likewise, management of STIs, while important in its own right, is unlikely to have great impact unless there is greater emphasis on partner notification and treatment as well.

Trends to "normalize" HIV testing through integration of HIV into routine health care services with reproductive health services, within STI clinics, TB, etc, and introducing opt-out vs opt-in approaches where there is a generalized epidemic can greatly reduce the stigma around testing. Nevertheless, for prevention efforts to be more effective, there needs to be a greater focus on testing of couples rather than individuals, and to target programs towards family and community responses as much as towards individuals.

Rethinking ABC messages to culturally appropriate interventions that focus on:

- Participatory dialogue to support community driven responses to community problems
- Emphasis on harm reduction and do-able actions
- Strengthening self efficacy by modelling behaviour through personal stories.

Lastly, there needs to be a rethinking of ABC approaches which tend to over simplify behaviour change into messages for abstinence, being faithful and using condoms, in terms of their impact. The evidence suggests that interventions work best when they facilitate community change through participatory dialogue to support community driven responses to community problems. Rather than messages, there needs to be a focus on identifying small do-able actions for individuals, communities, and at system levels that reduce harm and move towards our broader behaviour change objectives. Finally, strengthening self-efficacy and modeling positive do-able behaviours using real people and community voices resonates with people's experience, strengthens their sense of personal identification, and builds their own ability to see change in their own lives.

What is the *Minimum Prevention Communication Package*?

The *minimum prevention communication package* recognizes that behaviour change occurs when there is an enabling environment to support an individual's ability and willingness to adopt healthier behaviours. This requires interventions at different levels – the individual, community, system, and enabling environment level based on promotion of do-able actions, which will have an impact.

The minimum prevention communication package addresses the sexual and reproductive health behaviours within the community as well as unreliable health seeking behaviours of the different priority audiences identified.

Minimum Prevention Communication Package:

Individual level: campaigns on cross-cutting themes and peer education to build life skills

Community level: community transformation tools to foster problem solving based on real stories

System level: interactive tools to support client-provider interactions, positioning of products and services where people can reach them, branding to increase visibility, and acknowledge excellence.

Policy maker level: advocacy packages based on real stories to develop supportive policies and strengthen links between sectors.

For each audience, do-able actions and strategic interventions have been identified for the individual, community, health system, workplace, and policy maker levels. **The minimum communication package requires that the planner selects at least one priority action and intervention at all four levels in order for impact to be made on that behaviour.**

Interventions will draw on different media channels available, which make the most sense in reaching individuals at that level.

Media communications, and campaigns target cross-cutting issues related to risk perception, stigma, unequal gender norms, male responsibility through reinforcing channels of radio, TV (where appropriate), and low literate friendly print materials drawing on easily understood story based pictures, and minimal language using local words and languages.

Peer mentoring focuses on culturally appropriate life skills development using real stories and positive modelling.

Community mobilization utilizes community transformation tools that draw on real stories and foster community problem solving around cultural norms, values and practices that inadvertently put men and women at risk. Tools also focus on strengthening community responsibility and action for linkages with key sectors like health for referral and quality assurance and development of community based care and support services. Communities include villages, places where people meet, and the workplace.

At health system level, the *utilization of interactive tools,* such as flipchart guides using real stories for routine group counseling, video, and user friendly take home materials to build adherence support quality provider client interactions.

Positioning of RH products and services in places where clients can easily reach them and exploring ways to support access by hard to reach populations like those with disabilities, MSM, and young people by encouraging partnerships with lay members of these communities will support utilization by most-at-need populations.

Branding quality "friendly" sites and health care teams will increase their visibility and build morale of providers who offer services based on standards of excellence.

Advocacy at policy maker level draws on strong advocacy package materials again data driven but drawing on real stories to develop supportive policies, guidelines, and strengthen links between sectors for a coordinated and strategic response.

The media is an important partner to involve in strategic communications development, to ensure that existing opportunities for communication are utilised and to benefit from their expertise as communications professionals.

The private sector is also key to involve in planning strategic communication interventions because of their ability and resources to reach often hard to reach individuals with information, products and services in a flexible and innovative manner.

Civil Society has a critical role to play in shaping the response to accommodate the realities, barriers, priorities, and interests of individuals, families, and communities. All

the evidence points out that for sustained impact, civil society needs to be an integral and equal partner at every level of engagement—from conception to completion of communication strategies,

Finally, the *faith community* leaders, are influential in mobilizing their communities to explore values and norms that may inadvertently place members at risk and to call on strong beliefs around compassion and support to help those most in need.

Step 3 Develop your BCC Strategy and strategic interventions

Drawing on the goal of the National Prevention Plan, this National BCC Strategy seeks to:

"***Reduce the rate of spread of HIV infection in Nigeria by 25% by Year 2014".***

The key behavioural objectives across priority audiences will be to:

- Delay first sex among young women and men until the age of 18.
- Reduce reported multiple concurrent partners among all groups.
- Increase consistent and correct condom use among all men and women who are sexually active, particularly among paid and casual partners.
- Increase risk personalization disposition within high risk groups
- Reduce high risk sexual behaviours
- Increase early STI detection, treatment and partner notification.
- Increase uptake of HIV testing.
- Increase uptake and adherence to HIV related services including PPTCT services.
- Reduce reported stigma and discrimination among PLWH.
- Increase number of community support services.
- Reduce reported high risk cultural practices.
- Improve provider-client interaction within health facilities (by all groups).

For each priority audience strategy, strategic communication objectives have also been identified as a means to measure progress towards achieving behavioural outcome objectives. These are listed under the conceptual framework and under each priority audience strategy.

Priority audiences

The BCC Strategy lays out different priority audiences identified within the National Prevention Plan based on their particular vulnerability or their critical role as influencers and care givers. These include, in alphabetical order:

- Female sex workers
- Health care workers
- Injecting drug users
- Men who have sex with men
- Orphans and vulnerable children
- People with disabilities

Our Priority Audience Strategies:

1. Female sex workers (Grace's story)
2. Health care workers (Irene's story)
3. Injecting drug users (Samson's story)
4. Men who have sex with men (Thomas's story)
5. Orphans and vulnerable children (Rosaline's story)
6. People with disabilities (Joshua's and Lami's story)
7. PLWH (Kabiru's story)
8. Transport workers and men who travel (James's story)
9. Women and men of childbearing age (Binta's Story)
10. Young people (Sara's story)

- People living with HIV
- Transport workers & other men who travel
- Women & men of childbearing age
- Young people

1. Female Sex Workers (FSWs)

Grace's story represents the needs of female sex worker, in a brothel based setting, though many women (like Bessie) live and work outside of a brothel based setting as well. With over 30% of all FSWs infected with HIV, female sex workers have been identified as the sub-population most affected by HIV in Nigeria. FSWs are poor, marginalized and stigmatized. Their risk for HIV is extremely high due to frequent multiple concurrent partners, and high incidence of STIs.

Although condom use in commercial sex is reported to be high, largely due to the success of interventions in brothel based settings, condom use with boyfriends and casual partners is considerably lower, and FSWs have enough of these types of sexual partnerships to identify this as a potentially significant bridge for HIV to move from these networks to the general population. There needs to be emphasis on the use of oil based lubricants instead of water based lubricants among sex workers, to avoid condom breakage which can reduce confidence in condom use by sex workers. Rape, violent sex and even sexual harassment and abuse from the law enforcement agents also undermines their ability to negotiate protected sex all the time. Most FSWs did not perceive themselves as being at risk of HIV and the proportion of FSWs receiving HIV counseling and testing, and education from peer or outreach workers was quite low, particularly among the FSW of Lagos. Nevertheless, because their work is illegal, it is difficult to reach FSWs, particularly outside the brothel setting, and protect their fundamental rights.

2. Health Care Workers (HCWs)

Irene represents the needs of health care workers. Health care workers are a priority audience because of their critical role as entry points to necessary health services, but also in their role as influencers for effective HIV prevention, treatment, care and support. HCWs need to provide friendly, nonjudgmental and confidential services to all members of society regardless of age, occupation, disability, sexual orientation, or HIV status, and yet by their attitudes and actions they often stigmatize HIV and PLHW. Those attitudes, particularly towards PLWH, need to be addressed so that all Nigerians are motivated and supported to benefit from HIV related services available. Finally, HCWs have a critical role to play in strengthening effective, integrated service delivery in both facilities and within communities.

Medical transmission of HIV is also critical to address with this group. HCWs do not always handle blood and blood products safely, re-use injection needles, and lack safe disposal of blood products and needles, placing themselves and others at risk for HIV. They may not see themselves at risk for HIV, from either medical or sexual transmission, or feel they have access to PEP, confidential HIV testing and treatment services.

3. Injecting Drug Users (IDUs)

Samson's story represents the needs of injecting drug users. IDUs had the third highest HIV prevalence after FSWs and MSM in Nigeria. IDUs are considered at higher risk of contracting and spreading HIV primarily through the sharing of needles and syringes, as well as practicing unsafe sex. IDUs, particularly those in Kano, reported highly risky injecting behaviour, and were more likely to share needles/syringes than IDUs in other states. IDUs were reported to be very sexually active with both girlfriends and with FSWs. Many female IDUs sell sex, as well, increasing the risk of HIV spreading into the general population through their clients. Because their behaviour is illegal, it is difficult to reach IDUs with appropriate information, condoms, services, and harm reduction measures including access to safe needles and rehabilitation services. In general, very low proportions of IDU had received HIV counseling and testing or had received HIV interpersonal communication or services in the past 12 months.

4. Men who have Sex with Men (MSM)

Thomas' story represents the needs and issues of men who have sex with other men. After FSWs, MSM recorded the next highest HIV prevalence rates within Nigeria. MSM represent a diverse group of people who may have sex with other men for different reasons – sexual preference, economic benefit, confinement or sexual assault. MSM are generally a young population with 3/4 under 25, are educated, with the majority completing secondary education, and highly mobile. Because of cultural taboos and lack of legal protection, they are also a highly stigmatized population with limited access to relevant information and services appropriate to their needs. Exposure to interventions among MSM was reportedly very low, with only around one quarter receiving safe sex education from peer or outreach workers. Nevertheless, because of stigma, they are likely to be difficult to reach, and often may be married to women, with children, increasing the risk of HIV spreading into the general population.

5. Orphans and Vulnerable Children (OVC)

Rosaline's story represents the needs of orphans and vulnerable children. The number of children affected and infected by HIV is increasing rapidly in Nigeria. OVC are a diverse young population who, in addition to dealing with the stress of losing parents and/or living with HIV, are at great risk of poverty, sexual abuse and dropping out of school. They are a difficult group to reach because they may be marginalized by living on the streets, trafficked or otherwise facing exploitation. Like other children, they often have no voice but are put in the difficult position of having to care for other siblings, often with no means to provide for them. They may have little control over their sexuality, livelihood or have access to education, health, social services, and protection of fundamental rights.

6. People Living with HIV (PLWH)

Kabiru's story represents the situation of PLWH. PLWH are afraid to disclose their status for fear of stigmatisation, discrimination and in the case of women, violence and abandonment. This is critical to address because many couples are discordant. PLWH need to learn about prevention in the context of living positively, to protect themselves from OIs, and protect partners from HIV. PLWH also have wider reproductive health needs that should be addressed. PLWH are a very diverse group representing children, young people, men and women (some pregnant or breastfeeding), and vulnerable individuals who may face additional barriers to accessing related information and services.

7. People with Disabilities (PWD)

Joshua represents the needs of people with physical disabilities. People with disabilities are among the poorest, least educated, and most marginalized populations worldwide. People with disabilities are also a diverse group who may have varying physical impairments that affect their access to needed information and services. They are often stigmatized because of their different abilities, and treated in ways that relegates them to an inferior position within society with little access to education, skills development, job opportunities or recognition of their sexual and reproductive health rights. Women who are disabled are particularly vulnerable to sexual abuse and need to have protection. Lami represents the needs of people with psychiatric disabilities who are institutionalized. This is a difficult group to reach because they have little ability to advocate for their own rights or protect themselves from exploitation and abuse.

8. Truck Drivers and Other Men who Travel

James represents the needs of truck drivers and other men who travel. While army, police and transport workers returned HIV prevalence levels considerably lower than the 2005 general population estimates in the IBBSS (2007), 30-40% of all three groups reported multiple sexual partnerships during the 12 months leading up to the survey. They also reported higher prevalence of STI symptoms including genital ulcers/sores and unusual genital discharge. Like female sex workers, condom use was far less likely to be reported in boyfriend/girlfriend relationships. While the focus is on truck drivers, there are other key groups to consider in this strategy including migrant workers, fishermen, men who work on oil rigs, areas of conflict, etc. This group is also critical to address because they reflect gender and sexual norms that encourage men to have multiple concurrent sexual partners.

9. Women and Men of Childbearing Age.

Binta's story represents the needs of all women and men of childbearing age in the general population, though looks at the particular risks for women. High prevalence of HIV among women is due to a range of factors including biology, gender and socio-cultural norms that relegate women to lower status & decreased decision-making power and encourage men to have polygamous relationships. High birth rates in Nigeria, coupled by prolonged breastfeeding among women, also increase the risk for parent to child transmission of HIV. Women and girls face additional risks of violence for refusing sex, requesting condoms, accessing testing services, and for testing positive and often have little access to education, income generation opportunities, and services. In certain places, they may be subjected to harmful cultural practices including wife inheritance, traditional wife sharing, female genital circumcision, sexual cleansing, and early and forced marriages. Women and girls also bear the greatest burden of care for those living with HIV, and for orphans.

10. Young People

Sara's story represents the needs and issues of young women and men from age 12-19. Both young men and women are vulnerable for HIV due to their age and gender norms which affect boys and girls differently. Young women, in particular, face high HIV prevalence and maternal mortality rates. Early first sex takes place in many different contexts including through peer pressure, early and forced marriages, pressure for

sexual exchange for economic benefits, and sexual assault. Some female youth/children are also vulnerable due to disability, and marginalised status/lack of protection (their needs are addressed under OVCs, and disability). Early and unwanted sex increases young women's risk of HIV due to their biology. Coupled with early pregnancy which has its own risks, young women also increase the risk of parent to child transmission of HIV. Young men often face peer pressure to use drugs and alcohol and demonstrate their sexual experience. All young people lack access to SRH/HIV related information and youth friendly services due to their age and gender.

The conceptual framework

Strategic BCC interventions recognise that individual behaviour is influenced by many factors

The development of strategic behaviour change communications interventions requires analysis of a problem situation at the individual, community, system and policy levels.

The priority audience strategies developed are based around an illustrative story of a person whose behaviour is putting him or her at risk. The stories given and checklists provided are meant to be illustrative of a process that every program planner needs to go through for their states, LGAs, or program areas. There are many stories out there that illustrate different circumstances in which men, women, young people are put at risk, and we welcome any of the document users to come up with other stories that reflect the situation that they face in their areas.

There are five simple steps given which we, as programme planners must go through to develop our strategies. The steps, checklists and examples provided for each step are important regardless of the stories provided.

Step by Step Approach for Each Audience Strategy Using Checklists

Step 1: Identify your problem behaviours.

Step 2: Identify barriers at each level.

Step 3: Identify assets and opportunities at each level.

Step 4: Identify do-able actions at each level.

Step 5: Choose your strategic interventions at each level.

Step 1: Identify the problem behaviours and circumstances in which they take place that affect your priority audience. Problem behaviours may include unsafe sexual behaviours that increase risk of HIV transmission or unreliable health seeking behaviours that affect their access, utilisation of key HIV/RH products and services.

Step 2: Identify which barriers at the individual, community, system, or policy maker levels needs to be addressed for your priority audience. Barriers include low risk perception, lack of confidence and skills at the individual level, peer, partner and family pressure, harmful cultural and gender norms, and stigma at the community level, lack of friendly and accessible health products and services, or supportive workplace policies and programmes at the system level, and lack of supportive policies in place at the policy maker level.

Barriers need to be addressed clearly because the doable actions and strategic interventions are based on the key barriers identified.

Step 3: Identify what are the assets/opportunities available that can be used to address the barriers at the four levels. Assets and opportunities can include widely held cultural values, beliefs and practices in place, community structures, and opinion leaders/gatekeepers to access, existing groups, organisations, and programmes to draw upon, as well as examples of promising interventions, and tools available within Nigeria, the region and internationally that can be used.

Step 4: Identify the doable actions at individual, community, system, media, and policy maker level. The examples provided are based on the main story given as example. Doable actions must be perceived as doable by the person who is supposed to do it. Thus, any small step identified and promoted must be explored with the audience you are trying to reach with your interventions.

Step 5: Identify the strategic interventions at each of the four levels that can be done. The section identifies guiding principles for working with each priority audience given, the key behavioural objectives for that group, and the main interventions, ideas and resources for each level based on the key barriers identified.

Keep in mind, that as programme planners, you might need to focus on interventions at community level, before addressing individual barriers in order for behaviour change to occur.

The priority audience strategies have been organized alphabetically into ten separate chapters in Part 2 of this strategy document. Each chapter begins with a background page which highlights the key issues, problem behaviours, behavioural objectives, and strategic communication objectives and interventions Targeting the different levels indicated in the table below.

Table 3:1

Level of Intervention	**Key BCC Objectives**	**Key Interventions.**
Individual Level	• Increase personal risk perception • Develop culturally appropriate life skills • Reduce myths and misconceptions	• **Media communication** on key themes using all channels • **Peer/mentoring** with life skills
Community Level	• Increase community dialogue • Reduce reported stigma and discrimination • Reduce reported gender inequalities • Modify high risk cultural practices • Strengthen peer and community support groups	**Community transformation** (communities, workplaces, places where people meet) to address stigma, harmful cultural and gender norms, and strengthen community response for referral and service delivery.
System Level	• Strengthen positive provider-client interactions	**Increasing access to quality products and**

	• Increase access to condoms and family planning • Increase number of HIV related service sites • Increase referral to HIV related services including ART.	**services** by strengthening provider –client interactions for education and adherence, positioning key products where clients can reach them easily, and increasing visibility of quality services through branding.
Policy Maker Level	• Increase friendly workplace policies • Increase supportive legislation	**Advocacy to address the wider policy environment** that determines access, protects fundamental rights, and fosters linkages between sectors.

All the interventions developed will:

- Be driven by the priority audience affected as planners for strategic interventions,
- Highlight personal positive stories of real people and communities,
- Emphasise local solutions based on problem solving approach, and
- Focus on doable actions at all four levels for impact.

Step 4 Operationalise the Strategy

The Operational Plan

Introduction

The operational plan will assist NACA management to implement the national BCC Strategy (2009-2014). The activities will include day–to-day management support, advocacy, technical advisory support, research, monitoring and evaluation. The plan recognizes that NACA operates in a three-tier government federal system without jurisdiction over the other two tiers of government, state and Local Government Authorities (LGA). Accordingly, NACA will advocate and encourage SACAs to implement the BCC Strategy (2009-2014) at state level. Overall, the plan will ensure that people responsible for the strategy at all three tiers of government are aware of it, that they have the means to realize the intent of the strategy, and that a monitoring system to know that the strategy is being implemented is put in place.

Goal

The goal of the operational plan is to enable NACA to effectively coordinate the implementation of the National BCC Strategy (2009-2014). Specifically, it will enable NACA to coordinate and provide sustained support at the national level, and ensure that programs implemented at all levels are part of a coherent and managed national response

Objectives

To establish mechanisms for coordination, strategic leadership and capacity building of Behavior Change Communication.

Approach

The operational plan for the National BCC Strategy provides a road map for NACA to coordinate and provide sustained support at the national level, and to ensure that programs implemented at all levels are part of a coherent and managed national response. While program planners of donor-funded projects have their own objectives and deliverables for BCC, these should be compatible with both the timeframe and strategic framework for roll out of the BCC Strategy, as outlined in the Operational Plan.

The Plan Activities

The plan focuses on a number of key areas: quality strategic interventions, harmonization and coordination at national, state and LGA levels, capacity building,

resource mobilization, advocacy, information and research, media and financial management.

National HIV/AIDS BCC Strategy: Draft Operational Plan 2009 – 2014

S/N	Activity	Responsibility	Time Line	Funding
	NACA Management			
Objective: To establish mechanisms for effective coordination and national leadership for implementation of the BCC Strategy._				
1	Strengthen the BCC management function			
2	Produce Approved Strategy in print, CD-Rom and website format			
3	Establish BCC TWG and provide TORS, modes of reporting…etc.			
4	Conduct Board Briefing			
5	Conduct Policy Briefings to all relevant policy makers			
6	National Launch of Strategy			
7	Encourage Sacs to replicate the coordinating structure at state level			
8	Advocate that program planners develop collaboratively with key stakeholders including members of priority audiences communication materials based on ideas around doable actions.			
9	Conduct state monitoring visits			
	Technical Working Group			
Objective: Keep abreast of existing activities and gaps that need to be addressed to develop effective BCC and establish baseline for specific priority areas, and improve the quality of communication strategies and materials developed				
10	Define a minimum package of materials that could support all states as prototypes.			
11	Facilitate the mapping of existing communication print and electronic materials and interventions that can potentially be scaled up and/or adapted.			
12	Review regional/international models of best practices that could be adapted for Nigeria's diverse cultural context.			
13	Identify mechanisms for sharing and scaling up best practices.			
14	Facilitate the piloting and evaluating of promising interventions.			
15	Identify organizations with key areas of expertise and/or representing key stakeholders to take lead in developing packages with priority audiences that can be tested and then shared widely			
16	Link innovative/more developed states that have services and infrastructure to mentor other states that could benefit from piloting and lessons learned.			
17	Identify communication activities that could be subcontracted to agencies that have capacity			

National HIV/AIDS BCC Strategy: Draft Operational Plan 2009 – 2014

S/N	Activity	Responsibility	Time Line	Funding
	and expertise to conduct key formative research and develop model communication materials that can be adapted to state needs.			
	Capacity Building			
Objective: Strengthen BCC capacity at NACA, SACAs and LACAs.				
18	Develop strategy training manual			
19	Conduct National Strategy Training			
20	Conduct Zonal Strategy Training			
21	Develop and coordinate multi level capacity inventory and needs assessment			
22	Work with all partners to develop a coordinated plan for long-term capacity building			
23	Identify national institutions to take on long-term capacity building responsibility			
24	Develop and maintain a national database on consultants			
25	Provide ongoing professional development programs for the consultants on the database			
26	Develop and coordinate agreements between public and private training institutions, donor-funded projects, to encourage secondments to projects for students' practical experience			
	Resource Mobilization			
Objective: Mobilise resources for implementation of minimum package of strategic interventions at all levels. (perhaps the focus for year one would be the main campaign activities including phase 1: stigma, phase 2: cultural norms)				
27	Specify the required resources, where they might be obtained and how they might be secured: GON, MAPII, GF, UN System…			
28	Advocate for specific inputs from both Government and international Partner sources			
29	Develop funding guidelines to assist all funding partners to ensure grants supported activities are evidence based and aligned to the BCC strategy			
	Policy Environment			
Objective: Advocate for key policies based on the strategy at national and state level				
30	Identify key players to be part of advocacy subgroup to identify priorities and detailed plan of action			
	(Develop advocacy packages based on identified priorities to support national campaign: phase 1: launch, phase 2: passing stigma bill Etc…..			
31	Advocate strategy to all relevant policymakers			
32	Identify gaps or areas that need strengthening			
33	Advocate for review and revision of policies			

National HIV/AIDS BCC Strategy: Draft Operational Plan 2009 – 2014

S/N	Activity	Responsibility	Time Line	Funding
	when required			
34	Provide technical assistance and input into the development or sector-level policies			
	Publicity & Media			
Objective: Ensure that media messages are harmonized, consistent and effective at all levels				
36	Establish media platform to take the lead in national campaign planning			
37	Facilitate planning of national intervention (under umbrella campaign brand that identifies phased approach to key sub campaign themes over the next year: phase 1: launch of strategy, phase 2: stigma, phase 3: cultural norms, etc.): through a creative design forum			
38	Partner with Health Promotion division and other public and private sector communication partners (NOA, MOI, etc) to oversee launch of BCC strategy			
39	Develop longer-term partnerships with media and communication partners to coordinate media events and campaigns			
40	Develop and Coordinate regular media briefings on strategy implementation			
	Research, Monitoring and Evaluation			
Establish mechanisms for coordination of research, dissemination and utilization of research results				
41	Identify key partners for a research subgroup.			
42	Collate existing research from all existing sources to support effective planning for implementation,.			
43	Identify research gaps based on strategy needs.			
44	Provide information and analysis to states and ministries to assist them in fine-tuning their responses			
45	Provide access to all interested parties to operational information on best practices and data on supplies and procedures for implementation			
46	Present regular updates on implementation, challenges, constraints and successes			
47	Develop research capacity at the local and implementation level			
48	Put in place a simplified M&E framework			
	Financial Management			
Objective: Facilitate effective implementation of different strategy components through funding				

National HIV/AIDS BCC Strategy: Draft Operational Plan 2009 – 2014

S/N	Activity	Responsibility	Time Line	Funding
BCC activities				
49	Ensure that all BCC allocations reflect BCC strategy priorities			
50	Ensure accountability systems are in place for channeling and tracking funds			

ANNOTATED ANNEX

1. NACA will strengthen the BCC management function and, the BCC will serve as the secretariat for the BCC TWG
2. The BCC TWG will be modeled after the successful M&E BCC TWG; It will consists of key BCC stakeholders, who will.
3. TWG will streamline the development of national media materials that will support the key themes of the strategy.
4. BCC TWG will assign lead agencies to provide leadership and synergy around different audience strategies. Ideally, a lead agency will be an organization that has the resources/capacity to support strategic leadership.
5. The strategy be branded.
6. BCC TWG will report to the Expanded Theme Group on invitation.

Step 5

Measure what we have achieved

Our Monitoring & Evaluation Framework

Monitoring and Evaluation Framework

A major weakness of many HIV and AIDS BCC programmes is the lack of rigorous evaluation. Consequently, within the context of this strategy and national HIV and AIDS response activities in Nigeria, BCC implementers are highly encouraged to consider evaluation as a key programme component. This requires the development of a thorough monitoring and evaluation plan for each BCC initiative. This may include the identification prior to intervention of specific results that a programme hopes to achieve and requires an understanding of measurement and indicators.

There is a simple distinction between monitoring and evaluation. Monitoring is the routine assessment of ongoing activities and progress being made in a programme or project. On the other hand, evaluation is the periodic assessment of overall achievements and the extent to which they can be attributed to specific interventions. In short, monitoring looks at what is being done while evaluation examines the effectiveness of what has been done.

Evaluation draws from data generated by the monitoring system and links this to primary beneficiaries to determine the impact of programmes. Monitoring must be integrated within the programme management structure, whilst evaluation with its comparative characteristics may not need such integral component.

An effective M&E system has a clear logical pathway of results which encompass the major levels that include inputs, outputs, outcomes and impacts. Figure 1 demonstrates these interconnections where:

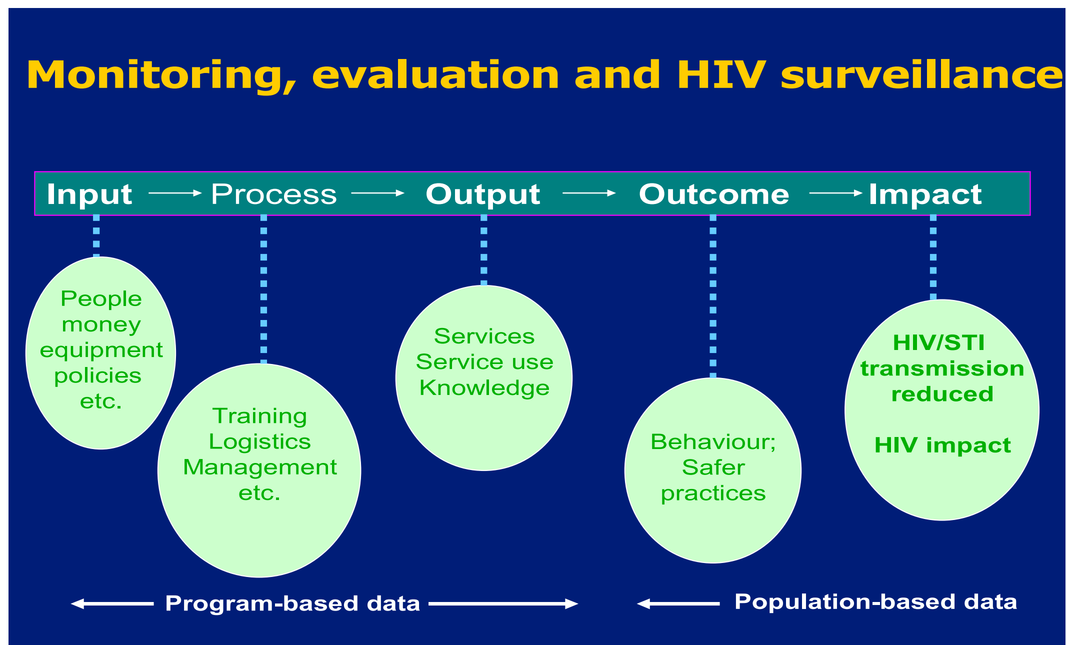
i. **Inputs** are the people, materials and resources that are put into a programme in order to achieve the delivery of services;

ii. **Outputs** are the activities or services delivered, including HIV/AIDS prevention, care and support services, in order to either improve the well being of beneficiaries or change their behaviours;

iii. **Outcomes** are changes in behaviour or skills, especially safer HIV prevention practices and increased ability to cope with AIDS;

iv. **Impact** is, for example, measurable health changes that are associated with outcomes, particularly reduced STI/HIV transmission.

FIG 1: Monitoring & Evaluation Conceptual Framework



Basic guideline for monitoring and evaluation of BCC activities will include:

- What you wish to achieve (objectives)
- How you propose to do it (activities)
- How you will show that the objectives were reached (results and process indicators)
- Means of verification of indicators (data sources)
- How often you will collect data (frequency)
- Who will collect data (person/department/organization responsible).
- How data will be analysed, used and disseminated.

Where possible baseline information should be obtained and used to provide points of comparison against which implementers can measure whether programme objectives have been accomplished. While small scale projects may undertake research to identify pre intervention baseline information, large scale zonal or national programmes may avail themselves of national data available.

Data from the following national surveys and routine system of data collection are already in Nigeria, and are relevant to BCC programmes in terms of provision of baseline information, programme design and implementation, and for evaluation of progress and impact.

A. HIV Sentinel Surveillance

HIV sero-prevalence surveys among pregnant women attending antenatal clinics in Nigeria have been carried out since 1991; from 1999 data have been consistently collected every 2 years. It is designed to generate prevalence estimates that can be extrapolated in the general population. It is coordinated by the FMoH through NASCP and enables the Ministry of Health to monitor trends of HIV prevalence and make general population estimates and projections of the HIV/AIDS epidemic and its impact in the country.

B. National AIDS and Reproductive Health Behavioral Survey (NARHS)

The National HIV/AIDS and Reproductive Health Survey is a nationally representative survey aimed at providing information on key HIV & AIDS and reproductive health knowledge, attitudes and practices. The NARHS is conducted by NASCP and carried out every two years since 2003. From 2007 the NARHS has incorporated biological-markers on syphilis and HIV, and has been called NARHS Plus.

C. Behavioral Surveillance Survey (BSS) and Integrated Biological and Behavioral Surveillance Survey (IBBSS)

The Behavioral Surveillance Surveys (BSS) are designed to systematically monitor trends in HIV risk behaviors over time in key population sub-groups thought to be at higher risk of HIV infection. The BSS is coordinated by NASCP. The first was conducted in 2002 and focused on youths only. The second was conducted in 2005 and focused on several additional population sub-groups including female sex workers, uniformed services personnel, long distance truck and bus drivers and university students.

In 2007, NACA with the support of the US government and technical assistance from various national government departments, NGOs, international and multi-lateral agencies conducted Nigeria's first integrated biological and behavioral surveillance survey (IBBSS) in 6 states (Edo, FCT, Kano, Lagos, Cross River and Anambra). The IBBSS sampled an additional two high risk groups about whom little is known in Nigeria, namely men who have sex with men (MSM) and injecting drug users (IDU).

The relationship between the national HIV M&E Framework and the national BCC strategy M&E Framework

Nigeria has developed an HIV M&E Framework called the Nigeria National Response Information Management System (NNRIMS). An accompanying NNRIMS Operational Plan followed for the period 2007 – 2010. "The main goal of NNRIMS is to provide a simple and robust monitoring and evaluation system that will facilitate the tracking of progress in the implementation of the National HIV/AIDS response

NNRIMS is a multi-level and multi-sectoral M&E system. Also, Nigeria is committed to applying the "three ones" principles (i.e. one AIDS action framework, one national AIDS coordinating authority, and one country-level monitoring and evaluation system). Therefore the M&E activities of the national BCC strategy will be as much as possible integrated into NNRIMS for the collection of routine statistics.

Given that the Operational Plan is implemented at the national, LGA as well as program implementation levels, monitoring activities will also be multi-levelled. Data will be collected at the programme implementation level (health facilities, NGOs and CSOs field offices, communities, households, individuals, etc) and will make its way up the hierarchical ladder, either as paper document or as electronic files. As data flows from the bottom-up, analysis becomes more and more aggregated. At the national level, the

M&E unit at NACA prepares a national report summarizing data collected on the NNRIMS indicators.

A strong link exists between a national HIV/AIDS M&E system - the goal of which is to track the progress made in terms of the national response - and the M&E systems of specific programmatic areas (such as PMTCT, HIV Care and Treatment , PMM system, VCT and OVC etc). A national M&E system provides a national overview to enable decision-making and track progress from a national perspective.

A programmatic-level M&E system should collect data for use by the implementers of the HIV program *and* for feedback to the national M&E system. Thus, a program-level M&E system will collect more data on more indicators than is required by the national M&E system. But, as a minimum requirement it should collect *ALL* of the information that is needed to measure the national indicators.

Thus, a program-level M&E system *should* provide some of the data that it collects to the national level, whilst the additional information that has been collected will be used at program level. This implies the need for the information that is collected at local level to be useful to the sector or partner that collects it – the principle of *"collect it, only if it is useful to use".*

A list of key indicators by program area is given below. Indicator matrix in Appendix.... contains a full list of indicators.

Outcome and Output Level Indicators by Program Area

A. Prevention – Knowledge and Behaviors

Key Outcomes

- Percentage of schools with teachers who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year
- Percentage of young people aged 15-24 who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission
- Percentage of never–married young men and women aged 15-24 who have never had sex.
- Percentage of never married women and men 15-24 who had sex in the last 12 months, of all (never married men and women) respondents.
- Median age at first sex: The age by which one half of young men and women aged 15-24 have had penetrative sex (median age) of all young people surveyed.
- Percentage of young women and men aged 15-49 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months
- Percentage of women and men (disaggregate by young people and adults) reporting the use of condom the last time they had sex with a non-marital, non-cohabiting sexual partner
- Percentage of high-risk groups reporting the use of condom the last time they had sex (with a non-marital, non-cohabiting sexual partner)
- Percent of sex workers who in the past 12 months who used a condom consistently during sexual intercourse with clients

Key Outputs

- Number of people trained to provide HIV/AIDS peer education.
- Number of people in the general population reached with HIV/AIDS prevention programs
- Number of people in high risk groups reached with HIV/AIDS prevention programs.
- Total number of condoms (male) distributed by social marketing outlets in the country.

Counseling and Testing

Key Outcomes

- Percentage of high risk groups who received HIV counseling and testing services and received their test results in the last twelve months.

Orphans and Vulnerable Children

Key Outcomes

- Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child according to national guideline.
- Ratio of current school attendance rate among orphans to that among non-orphans, aged 10-14

Key Outputs

- Number of orphans and vulnerable children whose households received free basic external support in caring for the child

At program level, NGOs and CBOs are encouraged to monitor program activities and collect information relevant to inputs, processes and outputs. Such data should be used for programme improvement and modification.

Examples of indicators for monitoring BCC activities at the program level include:

- Number of persons (disaggregated by target group) trained to provide HIV/AIDS peer education.
- Number of persons (disaggregated by target group) reached with HIV/AIDS prevention programs.
- Number of persons (disaggregated by target group) reached with correct HIV/AIDS prevention messages through community outreach events.

Key Targets and Performance Indicators for BCC Activities (previous BCC Strategy for Reference)

KEY TARGETS BY THEME	*PERFORMANCE INDICATORS**
Impact level targets (Prevalence)	
1. Reduction in the rate of spread of HIV among women by 25% by 2015	Percentage of blood sample taken from pregnant women aged 15 to 24 years that test positive for HIV during routine sentinel surveillance at selected ANC clinics (UNAIDS, 2000)
2. Reduction in syphilis prevalence among pregnant women	Percentage of blood sample taken from pregnant women aged 15 to 24 years that test positive for syphilis during routine sentinel surveillance at selected ANC clinics (UNAIDS, 2000)
3. Reduction in the rate of spread of HIV among the Most At Risk Persons (MARP) including FSW, injecting drug users, LDDs etc.	Percentage of blood sample taken from MARPs that test positive for HIV during routine sentinel surveillance.
Outcome level targets (Behaviour)	
1. An increase in abstinence (or in delay of sexual activity) as a means of HIV prevention among those not yet sexually active	Percentage of young people 15-24 yrs reporting that they abstain as a means of HIV prevention of all young persons 15-24 years. NARHS 2003.
2. Reduction in higher risk sex in the last one year.	Percentage of respondents who have had sex with a non-marital, non-cohabiting sex partner in the last 12 months of all respondents reporting sexual activity in the last 12 months. UNAIDS 2000.
3. An increase in condom use among those engaging in non-spousal, non-cohabiting sex	Percentage of respondents who said they used a condom the last time they had sex with a non-marital, non-cohabiting partner in the last 12 months of all respondents reporting sexual activities in the last twelve months. UNAIDS 2000.
4. Increase in consistent condom use during commercial sex.	Percentage of sex workers reporting consistent condom use in the last one week of all sex workers reporting sex with clients in the past one week. National Behavioural Survey 2 (NBS2)
5. A reduction in the number of non-marital sexual partners	Percentage of sexually active men and women (15-49 years) reporting reduction in number of non-spousal, non-cohabiting sex partners in the last one year. (including young people 15-24 year olds)
6. A reduction in IDUssharing unsterilised sharp objects	Percentage of IDU sharing sharp / piercing object
7. Increase in men and women receiving appropriate treatment for STIs.	Percentage of men and women who reported symptoms of STIs who have been treated in a health care facility / pharmacy in the last one year whose providers have been trained in STI care in a population based survey of all people who reported symptoms. UNAIDS 2000.
8. An increase in the number of people requesting an HIV test, having a test and receiving test results.	Percentage of people aged 15-49 surveyed who voluntarily requested an HIV test, had the test, and received their result in the last 12 months. UNAIDS 2000.
9. Increase in pregnant women counselled and tested for HIV.	Percentage of pregnant women at public antenatal clinics offered counselling and voluntary testing for HIV by trained staff or referring to VCCT services by all pregnant women attending antenatal clinics. UNAIDS 2000.
10. A reduction in percentage of people who stigmatise HIV and PLWH	Percentage of respondents agreeing to the statement that PLWH should be discriminated against. NARHS 2005.
11. Increase in HIV positive women provided with anti retroviral therapy in pregnancy	Percentage of women testing positive at a selected ante-natal clinics in the last 12 months who are provided with a complete course of ARV to prevent MTCT according to national guidelines by all women who tested positive at selected ante-natal clinics.

KEY TARGETS BY THEME	*PERFORMANCE INDICATORS**
	UNAIDS 2000.
12. Increase in HIV positive people receiving ART.	Percentage of people with advanced HIV infection receiving anti-retroviral combination therapy. UNAIDS 2000.
Enabling environment (Advocacy)	
1. Work place policies	Percentage of large enterprises/companies that have HIV and AIDS work place policies and programmes. UNAIDS 2000.
2. Health facility policy regarding HIV and AIDS	Percentage of health care facilities having an HIV and AIDS policy regarding HIV and AIDS discrimination divided by all facilities surveyed. Redefinition of UNAIDS indicator.
3. Health care setting with guidelines and practices for prevention of accidental HIV transmission.	Percentage of facilities in a facility survey that has guidelines to prevent medical transmission of HIV: adequate sterilization procedures and surgical gloves in stock of all facilities surveyed. UNAIDS 2000.
4. Adequate funding approved and available for full implementation by stakeholders and partners	Amount of money allocated in national accounts for spending on HIV prevention and care programmes, per adult aged 15 to 49. UNAIDS 2000.
5. Improvement on the AIDS Programme Effort Index	The average score given to a programme by a defined group of knowledgeable individuals asked about progress in over 90 individual areas of programming grouped into 10 major components.
Knowledge (Information and Motivation)	
Knowledge	
1. An increase in the knowledge of prevention of HIV/AIDS to 99% of the general population	Percentage of all respondents who, in response to prompted questions, say that a person can reduce their risk of contracting HIV by using condoms and having sex only with one faithful uninfected partner. UNAIDS 2000.
2. Increase in the knowledge that a healthy person can be HIV+	Percentage of 15 to 49 years old who know that a healthy looking person can be HIV positive over laa respondents aged 15 to 49 in the survey. UNAIDS 2000.
3. An increase in personal risk perception of those populations most at risk	Percentage that can adequately assess personal risk (personal risk perception) of contracting HIV based on their reported sexual behaviour divided by population most at risk. NARHS 2003.
4. Increase in the knowledge of prevention of mother to child transmission of HIV.	Percentage of men and women who correctly respond to prompted question about preventing mother to child transmission through anti-retroviral therapy and avoiding breastfeeding. UNAIDS 2000.
Social and Community Support	
1. Improved parent-child communication around life skills, values and RH	Percentage of respondents reporting discussion on HIV and reproductive health with children / parents in the last three months preceding the survey divided by all respondents. NARHS.
2. Reduction in stigma expressed towards PLWH by families, peers and faith based organisations	Percentage of respondents disagreeing to the statement that PLWH should be discriminated against divided by all respondents. NARHS.
3. Greater family care and support for PLWH	Percentage of PLWH reporting that they enjoy care and support from their family divided all PLWH surveyed.
4. Active involvement by majority of FBOs in advocacy and community action to support for greater	Number of FBOs involved in HIV and AIDS education, advocacy, and care and support activities.

KEY TARGETS BY THEME	*PERFORMANCE INDICATORS**
compassions and care around HIV	
5. Increased training for TBAs and volunteer health workers on modes of transmission, prevention, referral, care and support and positive living	Number of TBAs and Volunteer health workers trained
Access to and Quality of HIV Related Services (Ability to act)	
Condom access	Easy, affordable condom access in every community in Nigeria especially at high risk communities
Work place policies and programmes	Effective HIV workplace policies and programmes in every major corporation in Nigeria
Access to ARV by PLWH	Increased access to inexpensive or free ARVs and drugs for opportunistic infections and palliative care for those who meet international criteria

Part 2:

Priority Audience BCC Strategies

Contents:

Chapter 1: Female Sex Workers

Chapter 2: Health Workers

Chapter 3: Injecting Drug Users

Chapter 4: Men who have Sex with Men

Chapter 5: Orphans and Vulnerable Children

Chapter 6: People Living with HIV

Chapter 7: People with Disabilities

Chapter 8: Transport Workers and Other Men who Travel

Chapter 9: Women and Men of Child Bearing Age

Chapter 10: Young People

Chapter 1:

Working with Female Sex Workers (FSWs)

1

Working with Female Sex Workers: Background

1. Key Issues:

Grace's story represents the needs of female sex worker in a brothel based setting though many women (like Bessie) live and work outside of a brothel based setting as well.

- With over 30% of all FSW infected with HIV, female sex workers have been identified as the sub-population most affected by HIV/AIDS in Nigeria.
- At state-level, the worst affected FSW are those working in FCT and Kano, where FSW on average had been selling sex for longer than in other states and prevalence levels approached 50% in three of the four groups surveyed.
- While syphilis was quite low, about 20% of FSW reported experiencing an unusual genital discharge in the past 12 months.
- *Although condom use in commercial sex is reported to be high*, condom use with boyfriends and casual partners is considerably lower, and FSW have enough of these types of sexual partnerships to identify this as a potentially significant bridge for HIV to move from these networks to the general population.
- Most FSW did not perceive themselves as being at risk of HIV and the proportions of FSW receiving HIV counseling and testing, and education from peer or outreach workers was quite low, particularly among the FSW of Lagos.
- Alcohol abuse is rife within the sex worker community with one quarter or more FSW consuming alcohol on a daily basis.
- Because their work is illegal, it is difficult to reach FSWs, particularly outside the brothel setting, and protect their fundamental rights.

2. Problem Behaviours

Unsafe SRH Behaviours

- FSW do not use condoms consistently with all paying clients
- FSW do not use condoms with non-paying boyfriends and casual partners.
- FSW drink alcohol daily which impairs decision regarding safe sex
- Three percent of brothel-based FSW and seven percent of non-brothel based FSW had anal sex with a client in the past 12 months.
- CSW use oil based lubricants (which affects efficacy of condoms)
- FSW share skin piercing and body cutting instruments.

Unreliable Health Seeking Behaviours

- FSW do go for HIV testing to know HIV status
- FSW self medicate e.g. use antibiotics for prevention and treatment of STIs
- FSW do not access other key SRH/HIV related services (PPTCT and ART).

3. Key Behavioural Outcome Objectives

- Reduce the number of multiple concurrent partners.
- Increase correct and consistent condom-use among paid and *nonpaid* sexual partners.
- Practice safe piercing and cutting.
- Reduce alcohol and drug use among FSWs.
- Increase uptake of family planning methods to prevent passing HIV on to children.
- Increase demand and uptake of STI treatment, HIV testing and HIV treatment services.
- Improve quality of provider client interaction and adherence to treatment protocols
- Develop supportive legal environment and accessible health delivery system.

4. Key Strategic BC Communication Objectives for Interventions

Level of Intervention	Key BCC Objectives	Key Interventions.
Individual Level	• Increase personal risk perception • Develop culturally and gender responsive appropriate life skills • Reduce myths and misconceptions	• **Media communication** on key themes using all channels • **Peer/mentoring** with life skills
Community Level	• Increase community dialogue • Reduce reported stigma and discrimination • Reduce reported gender inequalities • Modify high risk cultural practices • Strengthen peer and community support groups	**Community transformation** (communities, workplaces, places where people meet) to address stigma, harmful cultural and gender norms, and strengthen community response for referral and service delivery.
System Level	• Strengthen positive provider-client interactions • Increase access to condoms and family planning • Increase number of HIV related service sites • Increase referral to HIV related services including ART.	**Increasing access to quality products and services** by strengthening provider –client interactions for education and adherence, positioning key products where clients can reach them easily, and increasing visibility of quality services through branding.
Policy Maker Level	• Increase friendly workplace policies • Increase supportive legislation	**Advocacy to address the wider policy environment** that determines access, protects fundamental rights, and fosters linkages between sectors.

2 Working with Female Sex Workers: Grace's Story

Grace is a young woman who earns her living by having sex with men. While she has heard about HIV, she is fairly confident about her own health, because the brothel she works in is pretty good about insisting on condom use with men who come there. Most of the time, they even protect her when clients get a bit too rough. But, she worries about getting pregnant, since that would mean the end of her income. Most of the girls use charms to protect themselves from pregnancy, or take things to stop the pregnancy from sticking. She sometimes gets some unusual discharge as well but the others say this is normal when you have a lot of sex. It doesn't hurt… It's lucky that the girls support each other in giving information, and don't compete so much for clients.

Bessie meets her sexual partners in a few places in town – the disco is her favourite place because she doesn't have to drink so much – quite costly if you are waiting for someone to pick you up- and can dance and dance. She loves the independence though her boyfriend often acts as her manager. She doesn't mind. She knows he loves her very much and that the money she brings in is helping to make a home for the two of them.

Like the other girls at the brothel, she has a boyfriend who she met at a bar one night when she wasn't working. He doesn't know what she does for a living, which is fine. When she makes enough money, she will stop anyway, and perhaps she will settle down with someone like him. She imagines that with his good looks, he has other women, but he seems to care quite a bit about her –treats her well, even buys her things to wear. She would never suggest using a condom when they have sex because he might suspect that she sells sex and leave her. Condoms are for people who are promiscuous and not for a possible "love" relationship like they have. He travels quite a bit, so when she is lonely, she sometimes meets other men at clubs, or even restaurants. They make her feel like a normal person, not an object, and she enjoys having 'normal' sex with them as well.

Because of her secret illegal life, she doesn't feel there is any safe place for her to go for support or for regular health care. From the girls, she knows of a good traditional and herbal practitioner who gives her different medicines and never asks questions. She tells herself it is too expensive to go for health care, and she really doesn't have that much time. But, secretly she fears that if she went to a health facility, the provider might realise what she did for a living, and say terrible things to her; perhaps even refuse to treat her. Worse, if it got around in her community about her illegal sex work, she would face discrimination and abuse. The police already treat sex workers very badly, harassing and even raping them from time to time. It can be very dangerous. She wishes she could have a normal life like other people, but what can she do?

What can we do as program planners to help?

Step 1

Know the problem behaviours that affect female sex workers in your area and the circumstances in which they take place.

Checklist to Consider

Are there unsafe sexual and reproductive health practices taking place?

- Do sex workers have more than one non-paying sexual partner they are seeing at the same time?
- Do sex workers use condoms consistently and correctly with all paying clients? Do they use condoms when having anal sex as well?
- Do sex workers use condoms consistently and correctly with non-paying boyfriends and casual partners?
- Do they drink alcohol, inject drugs, or use other substances daily which impairs decision regarding safe sex?
- Do they use water based lubricants that won't damage the condoms?
- Do they share skin piercing and body cutting instruments?

Are there unreliable health seeking behaviours?

- Do sex workers go for regular HIV testing to know their HIV status?
- Do they routinely get screened for STIs, and/or go for early treatment when symptoms are noticed?
- Do they access other key SRH/HIV related services (such as PPTCT and ART)?

You need to **keep in mind the context in which sex is being exchanged.**

Are they….

- Working out of a brothel
- Selling sex through bars, entertainment centres, or on the streets?
- Are they exchanging sex for gifts, rent, etc. for economic reasons as well (and still classify as having many multiple partners?)

Where sex is transacted **determines who the gatekeepers are and how sex workers can best be reached for interventions.**

Grace's problem behaviour

Grace may use condoms within the brothel for paid sex but does not use condoms with her boyfriend or other casual partners. This is very risky, because while Grace is at high risk for HIV for having many multiple partners, it is likely that her boyfriend and other casual partners also have multiple partners as well.

We don't know if Grace is aware that condom use is necessary during anal sex as well, or if she uses safe lubricants.

Step 2

Find out which barriers make it difficult for female sex workers to take more positive action to protect themselves.

Checklist to Consider

What are the most important barriers to consider in Grace's situation?

- Does Grace **feel personally at risk for contracting HIV,** not only in her paid sex relationships but also from her boyfriend and other casual partners where condom use is low?
- Does she have the **confidence and skills** to negotiate safe sex in the context of these informal (as well as paying) relationships?
- Is **Grace's boyfriend likely to be supportive** of her asking for condoms during sex? Are paid clients supportive of using condoms in paid sex?
- Are there **friends, gatekeepers in at the brothel that she can talk to**? Who will protect her from clients who do not follow "brothel rules" regarding consistent condoms use?
- Does **stigma within the community affect everyone's beliefs** about who gets HIV and how they should be treated? Who uses condoms?
- Are **there cultural norms that encourage girls to have transactional sex** (ie. exchange sex for gifts, rent, etc.) **and encourage men to have multiple sexual partners?**
- **Is there friendly support from the existing health providers** in her area?
- **Are support services there** to help her within her community?
- **Who would the gatekeepers** be if Grace was not working in a brothel?
- **What type of community** do these types of sex workers live in?

BCC Interventions will need to address the context of sex work:

- Brothel based FSW
- Nonbrothel based FSW
- Risks for all young women, widows, to engage in transactional sex due to cultural and gender norms.
- Male risks and responsibility
- Partners of FSW as bridge populations.

Barriers Grace Faces

Individual level:

- *Grace does not feel personally at risk for HIV because of high condom use in the brothel.*
- *Nevertheless, her other concurrent [1]sexual partners – boyfriend and casual partners also put her and themselves at high risk for HIV transmission because they are having sex at the same time, may have other sexual partners, and do not use condoms regularly in these relationship.*
- *She also does not realise that STIs increase her risk of getting HIV.*
- *We do not know if she has anal sex with clients as well, and if this is considered high risk "sex" where condoms are important to use as well.*
- *She also doesn't know much about the importance of protecting herself from unwanted pregnancy, and preventing passing HIV to a child through pregnancy, by using modern contraceptive methods and/or may have misconceptions and fears about how these methods work in the body.*

Community level:

- *Grace's paid and unpaid sexual partners are unlikely to support condom use.*
- *Grace's community is the brothel. She seems to have support from the madam/brothel owner who tries to implement 100% condom use among clients who come there, and even provide some protection against violence.*
- *They don't seem to play as much of a role in helping her access family planning to prevent unwanted pregnancy, or making sure she has access to routine STI screening.*
- *The other girls seem to be in the same situation as she is in, and they are an important source for information and emotional support.*
- *Grace's paid and unpaid male sexual partners are from the general population. There is a strong cultural norm that encourages men to have multiple sexual partners, because they are "naturally promiscuous", and need sex.*
- *There are also cultural norms that discourage condom use, because of widely held misconceptions around condom efficacy, and stigma around condom use in "love" relationships.*
- *Gender inequalities make it difficult for someone like Grace to negotiate safe sex, and seek other opportunities besides paid sex work to survive.*

Health System level:

- *The health provider is not perceived as being friendly to sex workers, nor accessible in terms of cost, or time involved.*
- *The alternative is the high patronage of quacks and in most cases fake drugs.*
- *We don't know if the health system actively discriminates against FSWs in this story..*

Policy maker level:

- *Because sex work is illegal, there is little support or protection that Grace, and other sex workers, can get in the places where they work.*
- *Some law enforcement officers, rather than protect the rights of all citizens, use their positions of power, and the illegal environment in which sex workers find themselves, to exploit FSWs through rape and harassment.*
- *It may also be difficult to target tailored health interventions or income generation programmes to known places where sex workers stay because of the illegal environment.*

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[1] People who are partners of the person at the same time, not one after the other.

Identify existing opportunities to help address Grace's and other FSWs' needs.

Checklist to Consider:

- Does Grace have **key values** that would be a benefit **to address her own risk for HIV?** What are those values?
- **Does the brothel see incentives to protect girl's health** by providing condoms, water based lubricants, contraceptives and supporting links for routine STI screening?
- Are there **networks to support nonbrothel based FSWs**?
- **Does the community have traditional values and structures** that can address men's desire for multiple sexual partners and that inadvertently encourages girls to find partners based on exchange of material goods (ie. Traditional laws re: property rights, wife inheritance, beliefs regarding women's rights to education or work, dowry)?
- Are there **female** and **male role models** that could be a meaningful example for Grace?
- Are there **examples of good community materials** that could be used to facilitate community dialogue?

Examples of opportunities:

- Positive beliefs that emphasise importance of health
- Most brothels already have a No Condom, No Show policy.
- Access to media
- PEP Plus developed for Sex Workers
- Established brothel-based FSW structure.
- Trained peer educators for FSW exist
- Brothel owners/madams' are key influencers and are receptive to ideas that will ensure well being of their "girls"
- Traditional rulers are increasingly more educated and willing to address norms that encourage gender inequalities, including early drop-out of girls from school.
- Market place, entertainment and other drinking establishments, do have organised structures and could be mobilised as interested gatekeepers.
- Condoms (and water based lubricant?) are easily available and affordable
- Availability of formal training settings that can incorporate IPCC and other HIV related training in health provider curriculum
- Involvement of police in intervention among sex workers as model.
- STI treatment and VCCT currently a strong component of many interventions among FSW
- Availability and accessibility of HIV services e.g PMTCT, HCT
- Increased NGO activities in the field which could serve as models for all states.

Choose your doable actions at each level.

What can *Grace* do?

- Grace could keep condoms on her at all times to use consistently with her paying and non-paying partners.
- She could find ways to make condom use sexy and fun.
- Grace could try the female condom as an alternative which is possible to put on in advance.
- Grace could talk with the other girls to come up with an agreed upon strategy together about how to deal with clients who don't want to use condoms, including enlisting the bar owners, brothel owners, etc. on their important role to educate clients on benefits of safe sex.
- She could set a limit to alcohol intake, choosing other non-alcoholic drinks instead, and/or watering them down for her good health and beauty.
- She could use only water-based lubricants in all sexual encounters, including anal sex.
- Grace could use modern contraceptives to prevent unwanted pregnancy.
- Grace could seek prompt and proper treatment for all infections including STIs.
- Grace could go for regular HIV counselling and testing services to know her HIV status, perhaps go with a good friend.
- If she is found HIV positive, she could find someone she trusts to share her concerns, fears and hopes.
- She could get support from a close buddy to seek assessment and care for HIV if she is found to be HIV positive.

*Nigeria's **PEER EDUCATION PLUS Toolkit** has been developed for sex workers and girls who are out of school. They are using trained peer sex worker educators to help women organise to protect themselves and each other from risk sex.*

*In Australia, CS used a **life skills** approach taking advantage of times when all the girls fold towels to conduct informal educational sessions.*

What can the *community* do?

- Grace's friends could support each other to practice 100% condom policy in brothel based settings emphasising the benefit of having safety for all girls): Life skills approach for sex work.
- They could also protect each other from clients who don't obey safety rules by having an agreed upon strategy (like blowing a whistle or banging on a drum) to let the owners, gatekeepers, know what is happening.
- Brothel owners institute 100% condom policy and routine STI screening in establishment (highlighting safety of sex, pleasure without pain as a marketing tool for clients).
- The community could have a "neighbourhood watch" concept that protects the safety of all those in that community, with full participation of sex workers and their support groups
- Bar and entertainment centre owners, and market place groups could take responsibility to educate men about the benefits of protected sex, and provide condoms at cost
- Clients could take responsibility for their health by always carrying condoms, and reducing the number of partners they have sex with.
- Clients could demand 100% condom use with paid sex.
- Faith and traditional leaders speak to community members about cultural norms that put all girls at risk for sex based on exchange of material goods – pressure men to have additional partners.

- Communities could support widows and divorcees by linking them to income generation opportunities, protecting their inheritance rights,
- Community leaders should emphasise the importance of supporting girl children to go to school and recognise the achievements of girls who do well/complete their education.
- Faith based groups could demonstrate compassion and non-judgemental by integrating sex workers into community activities.

What can the *health system* and *workplace* do?

- Health providers could provide friendly, non-judgemental health care services to all people who come for STI, HIV and RH related services.
- Mobile services that reduce stigma could be put in place for FSWs and their partners
- Police work together with the FSW community to discuss and stop harassment of FSW and focus on protection of their rights.
- Companies whose employees travel a lot could put into place workplace policies and programmes to promote the reduction of multiple concurrent sexual partners and the importance of condom use.
- Companies could supply staff with free condoms.

What can *policy makers* do?

- Policy makers could develop legislation to provide greater protection of sex worker's fundamental human rights (ie. Prosecute police officers who are found to rape sex workers, provide protection from discrimination within formal health care system, etc.)
- Policy makers within health could link with law enforcement agencies, educating them about sex work and how they can help to create a better environment for HIV prevention programmes.

Cross Rivers State passed legislation making it mandatory for all hotels, etc. to have condoms available.

- Policy makers could make condoms widely available in public establishments like hotels, bars, entertainment centres, etc.
- Policy makers could ensure that the legal system and traditional law supports widow's rights to inheritance, and divorced women's right to some form of compensation like alimony payments.
- Policy makers need to ensure legislation is in place to protect the girl child from early and forced marriage.
- Policy makers could set up outreach integrated health care in areas where prevalence of HIV is high to encourage screening for STIs, HIV testing, access to family planning to increase Grace's access to supportive health care on a regular basis.
- ,Policy makers need to invest more in girl child education and establish economic empowerment programs for women,

Choose your minimum package of strategic interventions based on your identified barriers at different levels.

Guiding Principles for a Minimum Package of Strategic Interventions for FSWs

Effective strategic interventions for FSWs should:

- **Address Grace's needs at individual, community, system and enabling environment levels.**
- **Be driven by FSWs** to identify needs, doable actions, and approaches, and real stories.
- **Have a strong peer mentoring component** focusing on building 'culturally appropriate and feasible" life skills for their specific setting (ie. brothel, non brothel based)
- **Draw on the strengths of the "community" gatekeepers** (including workplace for clients)
- **Focus on community cultural and gender norms** to address male responsibility and risk to reduce multiple concurrent partners and increase safety of sex.
- **Address the wider policy environment** including protection of fundamental rights, and access to 'culturally relevant" RH and HIV related products and services.
- **Focus on doable actions on all four levels.**

Behavioural Objectives

- Reduce the number of multiple concurrent partners
- Increase correct and consistent condom-use among paid and nonpaid sexual partners.
- Increase uptake of family planning methods to prevent passing HIV on to children.
- Increase demand and uptake of STI treatment, HIV testing and HIV treatment services.
- Improve quality of

Minimum Package of Strategic Interventions:

Level of Intervention	Strategic Interventions	Ideas and Resources to Support Do-able Actions for Each Level
Individual Level Barriers • Low risk perception among sex workers and their sexual partners • Lack of life skills among sex workers	**Media communications** focus on **the reduction of multiple concurrent sexual partners and 100% condom use for safe sex** in hot spots (ie. markets, bars, eating establishments, entertainment centres, etc.) where men and women meet for sex. **Peer education among sex workers** in brothels and hot spots focus on building culturally appropriate life skills **Highlight benefits** for men and women in hot spots to get early treatment for STIs and know their HIV status. Emphasise that everyone is at risk, so everyone should know.	• **Use personal stories of sex workers** drawing on experiences of existing PEP Plus CSW networks (highlight different contexts in which sex is exchanged and the importance on developing skills to address risks with casual partners and boyfriends as well. Ensure that doable actions identified are really perceived as doable by them. • **Incorporate stories into existing PEP Plus for CSW toolkit to support problem solving** around what she can do differently: identify "culturally appropriate life skills to practice doable actions to negotiate safe condom use, deal with violence, strategies for accessing RH and HIV services for FP, regular STI screening, HIV testing – PMTCT. • **In hot spots, use personal stories that focus on couple's strategies**. "We protect each other". • Focus also on **places for where sex workers meet like beauty salons** to reach them. • **Why Wait? Campaign to encourage early STI treatment** for men and women (reinforce with print that focus on different key benefits using humor: STIs are easy to treat, services confidential, protects from infertility, HIV transmission, etc.)
Local Community Level Barriers • Lack of peer and local community support for FSW in all settings.	**Community mobilisation target 'local' gatekeepers** to promote safe sex for all: protecting girls, protecting clients:– through 100% condom use, family planning and regular screening for STIs,	**Brothel owners /managers and chairladies** • Advocacy/ action dialogue for No condom No sex policy. • Brothel-based counselling and testing? Consequences? • Build linkages to STI screening/treatment centers • Provide male and female condoms and water-based lubricants at brothels • Training on HIV prevention and transmission **Non-brothel based hot spots**

Level of Intervention	Strategic Interventions	Ideas and Resources to Support Do-able Actions for Each Level
		• Target bar, entertainment, market owners and organisations to identify ways to increase access to condoms, communicate about reduction of partners, refer to STI and HCT services. • Targeted sensitization activities in identified hot spots • BCC materials (Billboards, posters etc)display in and around hotspots **Police** • Advocacy/ action dialogue to reduce FSW harassment, • Link with existing uniformed networks to identify models that have led to decreases in HIV prevalence in their employees.
Wider Community Level Barriers • Risky cultural and gender norms that put men and women at risk for multiple concurrent partners, unsafe sex without condoms. • Community norms and traditional laws put widows, divorcees, and girl child at risk for transactional sex.	**Wider community mobilisation** targets all men **through community traditional and faith leaders**, **to address cultural and gender norms** that encourage multiple concurrent sexual partners among men and women and undermine women's security.	• Mobilise traditional rulers, and community members to dialogue around cultural practices that foster gender inequalities, gender norms related to masculinity that put men at risk. • Work through traditional leaders and courts to address inheritance rights for women (use tools like African Transformation which highlights this problem). • Mobilise faith leaders and structures to speak out about gender inequalities, risks for girls for transactional sex, property rights of women.
Workplace Level Barriers	**Advocacy and community mobilisation within workplaces** to sensitise men regarding risks of	.**Clients/boyfriends** • Mobilise employers in high risk areas to establish workplace programmes. • Workplace programmes address

Level of Intervention	Strategic Interventions	Ideas and Resources to Support Do-able Actions for Each Level
• Lack of community support to reduce multiple partners, and support condom use.	multiple partners, need for 100% condom use.	men's low risk perception around multiple partners, myths and misconceptions and stigma around condom use. • Make condoms available for staff • Increase access to STI treatment and HIV testing.
Health System Level Barriers • Lack of access to RH products and friendly services.	**Increase access to male and female condoms and water based lubricant** in brothels and hot spots through peer to peer support. **Strengthen provider/client interaction** to increase demand for RH and HIV related services. **Increase access to quality RH and HIV related services** by exploring outreach service delivery to most at risk populations	• Advocacy for the inclusion of IPCC training in all health provider training curricula (formal and informal) to support friendly health service delivery. • Integrate HIV related information and services into broader RH needs for FSWs. Benefits: Special coupons for free services….one stop and shop RH service to reduce stigma - provide related services like EC, family planning, PMTCT, ART, PEP when available…..) • Increase CSW access to male and female condoms: ensure that new methods, like female condoms, have educational component to strengthen correct use: brainstorm on how to deal with possible reuse of female condoms in safe manner.
Policy Maker Level Barriers • Lack of protection for FSWs • Lack of protection for widows, and divorcees	**Expand access to male and female condoms** where people meet. **Address legal environment** to protect rights of sex workers, and protect women's rights to inheritance, property, etc.	• Advocacy for improved working conditions for health providers, highlight and reward best practices by facilities and states that are providing quality care to all populations in need. • Advocate to develop related legislation to provide greater protection of sex worker's fundamental human rights (ie. Prosecute police officers who are found to rape sex workers, provide protection from discrimination within formal health care system, etc.) • Advocacy for locating literacy/skills development programmes in areas where FSW can be accessed during off hours. • Advocacy to policymakers to make condoms available at all hotels, and entertainment centers.

Chapter 2:

Working with Health Care Workers

1 Working with Health Care Workers (HCWs): Background

1. **Key Issues:**

Irene represents the needs of health workers. Health workers are critical to address because of the need to prevent medical transmission of HIV, to provide friendly, nonjudgmental services, to improve access to most at need populations in society, to improve their role as models to reduce stigma and discrimination, and finally, to strengthen effective, integrated service delivery in both facilities and within communities.

- Much of the country lacks basic health care services, including essential supplies, drugs and equipment. This makes it difficult to introduce HIV related services, particularly prevention of parent to child transmission services, which also relies on a strong maternal and child health service delivery.
- Where HIV related testing and treatment are available, the numbers are few, and difficult for most of the population to access.
- Attitudes of health care providers, particularly towards PLWHs, are also highly stigmatizing making it difficult to motivate people to use the limited services available.
- Confidence in health care services is low. There are hidden costs in accessing health care. Not only are services and products not free for many Nigerians who cannot afford to pay, but opportunity costs such as travel and time lost in work must be factored in when people access health care.
- Because of the low quality of public health care available, most Nigerians seek private care, use local pharmacies and traditional healers with a very wide range of knowledge, skills, training and legitimate interest in public health.
- Medical transmission of HIV is also critical to address with this group. HCWs do not always handle blood and blood products safely, re-use injection needles, and lack safe disposal of blood products and needles.

2. **Problem Behaviours:**

- HCWs are seen as being unfriendly and judgemental towards key vulnerable groups including young people, PLWH, FSWs, clients presenting with STIs, poor people.
- HCWs do not provide accurate information and basic counselling for HIV prevention, treatment and drug adherence or refer clients to needed services.
- HCWs do not provide condoms and family planning methods when requested by some groups (e.g. youth)
- HCWs may not respect clients' confidentiality.
- HCWs do not prevent medical transmission of HIV by using gloves, new needle/syringe for all procedures, disposing needles and blood products safely.
- HCWs do not go for HIV testing and related services
- HCWs do not take PEP if exposed to HIV risk.

3. **Key Behavioral Outcome Objectives:**

- Strengthen positive provider-client interaction
- Support client access to RH products (condoms, family planning methods)
- Support client adherence to STI and HIV related treatment.
- Support client access to other needed care and support services through referrals.
- Reduce risk of transmission of HIV through injection and blood safety:
- Reduce stigma and discrimination in health care settings.

4. **Key Strategic BC Communication Objectives for Interventions:**

Level of Intervention	**Key BCC Objectives**	**Key Interventions.**
Individual Level	• Increase personal risk perception • Develop culturally and gender responsive appropriate life skills • Reduce myths and misconceptions	• **Media communication** on key themes using all channels • **Peer/mentoring** with life skills
Community Level	• Increase community dialogue • Reduce reported stigma and discrimination • Reduce reported gender inequalities • Modify high risk cultural practices • Strengthen peer and community support groups	**Community transformation** (communities, workplaces, places where people meet) to address stigma, harmful cultural and gender norms, and strengthen community response for referral and service delivery.
System Level	• Strengthen positive provider-client interactions • Increase access to condoms and family planning • Increase number of HIV related service sites • Increase referral to HIV related services including ART.	**Increasing access to quality products and services** by strengthening provider –client interactions for education and adherence, positioning key products where clients can reach them easily, and increasing visibility of quality services through branding.
Policy Maker Level	• Increase friendly workplace policies • Increase supportive legislation	**Advocacy to address the wider policy environment** that determines access, protects fundamental rights, and fosters linkages between sectors.

2 Working with Health Workers: Irene's Story

Irene is a clinical nurse working in a general hospital in Zaria. Irene is overwhelmed by the number of people who troop in for her services every day. She works under tight conditions with no regular medical supplies and equipment to do her job properly. Often, there are no gloves to deliver the many babies, demands for injections for every kind of illness without enough new needles/syringes available, limited drugs for treatment, and not enough nurses to relieve her from duty once in a while. Irene is visibly under stress, and it shows clearly with the permanently etched lines on her forehead!

She sometimes finds herself yelling at the clients in her frustration. Why don't they come as soon as they know they are sick? Why don't they have to have money prepared in advance to pay for the services? Why don't they understand what they are supposed to do to take care of themselves? When will it end?

Secretly, she fears, being exposed to HIV. How can she protect herself if PLWH come to see her? Irene does not like that she sometimes deliberately avoids HIV + clients, or limits her contact with them. She is afraid of infection, and her little technical understanding, competence and knowledge of the HIV is insufficient to guarantee a feeling of certainty and protection. She has heard of PEP for HIV prevention, but her own facility does not have such tablets available. Even if they did, how can she be sure she is really safe?

Her friends, the other nurses in the hospital don't take the work as seriously as she does. They suggest that she lets the clients wait, while they enjoy their long tea breaks and gossip.

Her boss also yells at her for having so many people waiting in queues. But her boss doesn't provide her with the support she needs as well – short breaks and reasonable hours of work. Last week, she was requested to work night shifts as well! Added to this, there are endless demands from highly placed persons from the community for preferential treatment. Irene's hands are already full as it is, but who can dare turn back the wife of the LGA Chairman, or ask her to cue up in waiting like other clients?

At home, she also has her own problems. Her husband complains that he never sees her, and she suspects that he may have found a mistress elsewhere. Her four young children routinely complain about their mother's perpetual absence from home!

What can we do as program planners to help?

Step 1

Know the problem behaviours that affect health workers in your area and the circumstances in which they take place.

Checklist to Consider

What are the key issues affecting health workers in your area?

Do health providers interact with clients in a manner which supports their access to needed RH products, HIV testing, care and support services and adherence to treatment?

- Do health workers treat clients in a respectful, non-judgemental and friendly manner regardless of their age, sexual preference, disability, HIV status, occupation and gender?
- Do they provide accurate information and basic counselling for HIV prevention, treatment and drug adherence?
- Do they provide clients with condoms and family planning methods when requested and support their correct use?
- Do they refer their clients' to key HIV prevention, treatment, care and community support services available (especially for HIV testing)?
- Do they treat all clients' needs and concerns in a confidential manner by not disclosing personal information to other people?
- Do they know their own HIV status?
- Do they role model safe sexual and prompt health seeking behaviour by also using condoms, family planning, reducing sexual partners, getting tested for HIV, and seeking prompt health care when ill?

Do health providers practice medicine in a manner that does not put themselves or clients at further risk of HIV?

- Do they use gloves when handling blood and blood products?
- Do they use a new needle /syringe every time they provide injections to clients?
- Do they dispose of used sharps including needles and blood products safely?
- Do they take PEP if exposed to HIV risk?
- Do they know when they have been exposed to risk of HIV?

Do health providers stigmatise and discriminate against PLWHA?

- Do health care workers maintain confidentiality about the status of clients living with HIV?
- Do health care workers avoid or shun people living with, or suspected to have HIV and AIDS?
- Do health care workers shout and intimidate clients who come for HIV and AIDS care and treatment or testing services?
- Do they treat clients living with HIV in a positive, compassionate manner?

Irene's Problem Behaviours:

Irene does not always treat clients who seek her guidance for help in a friendly, respectful manner and sometimes avoids any contact with PLWH.,

She may not provide her clients with needed information and counselling to support their ability to prevent HIV transmission adhere to drug treatment or meet their RH needs more holistically. She does not refer clients to other needed HIV or RH services through health facilities or within the community.

Irene does not use safe injection and disposal procedures which protect her from medical transmission of HIV, and can infect others. She does not take PEP if exposed to HIV.

Irene, like any other person in the general population, may not protect herself from risk of HIV transmission from non-medical transmission (ie. husband) but as a health provider, may be seen as a role model for others in her community.

Irene may also been seen as one of the key sources of stigma, as a provider who is intimidated and confused about HIV.

Step 2

Find out which barriers make it difficult for health workers to take more positive action to support clients in a friendly manner.

Checklist to Consider

What are the most important barriers to consider in Irene's situation?

- Does Irene **feel personally at risk** for HIV due to her work environment and as a member of the general population?
- Does Irene **have the knowledge, self confidence and skills** to treat clients with respect, kindness and offer key information and services needed, including positive prevention and drug adherence counselling? Advocate for her right to PEP, and a safe working environment to protect herself and her peers from HIV infection? Negotiate for safe sex with her own husband?
- **Does she have a supportive group of work peers** who help each other to avoid burn out and stress by working as a team in providing services? Support positive and professional treatment of all clients who come in for services?
- **Does her boss ensure that all health workers obey guidelines,** protocols and standards for HIV prevention, care and treatment services, **and hold them accountable** when they are not performing their duties as required? Do they **advocate for needed health equipment, supplies and drugs** to protect the team from work related risks, and provide quality services to the best of their ability?
- **Do the community leaders support prompt health seeking behaviour** among their community members and seek dialogue with health facilities to improve quality of care? **Do they provide related services within the community** as part of ongoing care and support**?** **Encourage safe RH practices** that protect community members from HIV risk?
- Is there **stigma and discrimination within the community** that reinforces Irene's fear of people living with HIV?
- Are there widely held **community norms and values which indirectly lead to judgment** around other members of the community's right to health care services? (ie. Young people, people with disability, men who have sex with men, sex workers, etc.)
- Do **policy makers provide needed opportunities to develop health providers' capacity** and skills to deliver quality of care services for Nigeria's diverse community needs? Provide **needed tools and equipment** to support service delivery? **Recognise excellence** in service delivery and reward it?

Barriers Irene Faces

Individual level:

- *Irene knows a little about HIV and AIDS, but not enough to give her the kind of confidence and skill to feel at ease about her ability to prevent infection in the course of her work with clients who are HIV positive. She may not recognise that HIV cannot be transmitted through casual contact with PLWH.*
- *While she knows there can be HIV transmission through her workplace, Irene does not feel personally at risk of HIV from non-medical causes, as a member of the community.*
- *Irene lacks the skill and confidence to provide effective counselling for clients around HIV prevention, treatment, care and support, or related RH services. She also may not be aware of services available to help clients in need for appropriate referral.*
- *Irene wants to be able to show compassion and love to her clients, but the pressure on her does not allow her that luxury of being nice all the time.*
- *Irene may have low morale and motivation due to lack of recognition, support, and a professional environment to work in.*

Community level:

- *Irene's workplace peers do not support her to provide professional, timely and friendly services, nor pull their weight in providing their highly demanded service.*
- *Her boss does not provide her with a supportive environment to work in, and may indirectly encourage preferential treatment by influential members of the community. He does not recognise good work efforts, penalise her peers for not working based on guidelines, or ensure that basic drugs, supplies and equipment are available to offer quality of care services and protect workers and clients from work related risks.*
- *There is stigma and discrimination of PLWHA within the health facility and within the community that reinforce Irene's fear of HIV. (including by community and faith leaders)*
- *There may be commonly held community norms and values that lead to refusal to service other members of the community including young people, sex workers, people with disabilities, men who have sex with men, etc.*
- *There may be community norms that increase HIV risk within the community, or encourage delays to prompt health care.(e.g., scarification of the new born, hot water bath for new mothers, female genital mutilation, non medical circumcision , or discourage husbands of pregnant women to attend ANC for PPTCT).*
- *There may be a lack of strong community linkage with the heath facility management to ensure that health care services are relevant to community needs and that community plays a role in strengthening service delivery, referrals and, follow-up*
- *It may be that community self help groups do not intervene at facility level to complement government efforts at providing regular hospital supplies as this is perceived as government responsibility.*
- *NGOs that offer HIV services may rarely come down to the facilities to support effective linkages and referrals between facilities and community level CBO provided services.*
- *Health care services are generally perceived as providing low quality of care which further contributes to Irene and her peers' demoralisation. This is both a community-level services level issue.*

Health system level:

- *Irene's health facility is not well equipped with necessary drugs, supplies and equipment to provide the services they offer, and protect workers and others from medical transmission (ie. PEP, appropriate colour coded receptacles safety boxes, safety needles/syringes) to facilitate adherence to standards and protocols, etc.*
- *The LGA authorities, LACA levels structures are in most cases weak or nonexistent, and may not be able to help Irene much in terms of supplies.*
- *Due to high stigmatisation, the health facilities around may not offer confidential services to Irene. Irene in turn may not go for HIV testing because she cannot afford to be seen as HIV Positive. If she is found positive, who would let her inject their child, for example?*
- *High levels of stigma within facilities may not allow Irene to advocate for greater compassion for PLWH.*
- *The Union of Health Workers to which Irene belongs is occupied with bargaining for salaries and other allowances with government and have no time, due to conflicting demands, to lobby government to provide regular supplies.*
- *The low quality of Care and Treatment services sometimes contribute to the low patronage of HIV services in the communities.*
- *Facilities are often situated at long distances and remote sites, while cost of transportation alone may deter clients from regular, follow up or first time visits. It is possible that cost of services also makes it difficult for clients to arrive on time.*
- *The extensive number of unchecked private health facilities, pharmacies and non medical providers of health care delay prompt health seeking and further undermine Irene's morale as a professional.*
- *Lack of referral sites for HIV related services (PPTCP, ART, HCT) also make it difficult for Irene to serve her clients well.*

Policy maker level:

- *Policy makers do not ensure regular provision of supplies and consumables to health facilities.*
- *Policy makers have not yet passed the Anti Stigma Bill; the law against stigmatisation and discrimination of PLWH by health care workers.*
- *Service protocols, guidelines and standards for most services have not been disseminated to many clinics, so health workers cannot be held to any violations of such guidelines.*
- *Health care workers are not regularly trained in basic HIV services to boost their confidence in handling HIV cases. It is unclear whether HIV has been included in the HCP training curriculum.*
- *There are no HIV workplace policies implemented in many health care institutions*
- *There are no standards for quality interpersonal communication counselling services within and outside health care facilities, so everyone determines his own standards of counselling services.*
- *There is insufficient funding to match political commitment by leadership.*
- *There is no appropriate M&E framework to guide private sector health operations.*

Identify the existing assets and opportunities to help address Irene's and other health workers' needs.

Checklist to Consider:

- **Does the health care community have key values** that would be a benefit to address HIV related stigmatisation and discrimination of PLWH in health care facilities? (The Hippocratic Oath, for example?)
- Are there **existing HIV and AIDS workplace prevention programs** for health care Workers within facilities?
- Are there **platforms for health care workers that could be used to mobilise health workers** for stigma reduction in health care settings
- Are there **role models** that could be used to promote and model adherence to the provision of HIV services in accordance with national guidelines and standard operating procedures and protocols?
- Are there **community structures on the ground that could support the supply of hospital equipment and tools**, either by philanthropy or through regular contributions from community members?
- Are there **regular communication opportunities within health care facilities** that could be used for dialogue around HIV stigma reduction, and prevention of HIV among health care workers?

Examples of opportunities:

- The Nigerian caring spirit could be used to mobilise health care workers and communities to take responsibility for health care delivery together.
- Most health care facilities have professional associations guided by principles and standards of practice. These Professional Associations could be used to assert professional values and standards of practices on health care workers. These core values and standards usually frown at stigmatisation of people with chronic diseases including HIV and AIDS.
- Regular platforms for communication between and amongst most healthcare workers, such as daily ward rounds, teaching sessions for medical students, administrative meetings etc, could be used to communicate about HIV issues to health care workers.
- Many support groups of PLWHAS which provide counselling services to HCT clients in HCT centres could be scaled up and institutionalised to provide support to facility staff, who are often overwhelmed with clients.
- There are many NGOs within the community proving HIV services in the community which could be formally linked with health care facilities in their domain to strengthen referrals, networking and linkages for health care delivery.
- Some health facilities are becoming noted for friendly health service provision, in some cases, some of those are also privately run by Individuals or groups. Other health care workers could explore experience-sharing opportunities with some of these facilities.
- Community members usually have high regard for health care workers, their opinions, and recommendations on good health strategies. This makes them vehicles for information dissemination, makes the source more credible and the messages more believable.

- Other health quality recognition initiatives (like QAR on PATHS) in the DFID states can help to create more supportive environment internally and externally.
- Integration of ISS (integrated supervision and support), which is beginning to take place in PATHS states, provides an opportunity to monitor HIV services at the same time, increasing the notion of integrated single-stop services.
- Where they exist, facility health committees (FHCs) which have membership from both the community and the services, can also monitor community issues and provide liaison and feedback between the two.
- High literacy and willingness to serve among health care workers remains a key asset. There are also an enormous amount of skilled untapped human resources in the country.
- Increasing number of HIV related services, including care and support.
- The National HIV/AIDS Workplace Policy is in place and could be domesticated for the health care sector.
- There is strong political commitment and multi-sectoral partnerships in place for collaborative HIV prevention and mitigation.
- *The availability of the National Health Insurance Scheme could be extended to the general public to increase demand for health services.*
- *HIV/AIDS has been mainstreamed into the HCP training module?*

Choose your doable actions at each level.

What can *Irene* do?

- Irene could treat all clients, regardless of their age, sexual preference, disability, living with HIV, occupation, and gender, in a respectful, non-judgemental and friendly manner.
- Irene could provide information, services and referral for HIV prevention, treatment adherence and access to care and support services to all clients.
- Irene could practice medicine in a manner that does not put herself or clients at further risk of HIV. (ie. use of gloves, safe injecting and disposal practices).
- Irene could seek out more information about the causes, transmission, prevention, care, support and treatment for HIV through training programs, independent efforts at accessing and reading HIV related medical and other literature, keeping up to date information on developments around HIV issues .to help her reduce stigma.
- Irene could first go for HIV testing to know her own status and to develop the necessary confidence to counsel other clients to go for HCT.
- Irene could join a support group of people living with HIV if she turns out to be positive and model a positive living lifestyle as a role model in the community.
- Irene could organise regular fora with her colleagues to educate them on the impact of stigmatisation on the lives of PLWH and the facility in general.
- Irene could mobilise community volunteers to work with influential people in the community to generate donations from philanthropic individuals and organisations, to organise events for income generation, and to advocate for increased political commitment and health budgetary allocations for supply of drugs and other consumables from politicians, government agents, and private sector.
- Irene could advocate with her boss to put in place fair working practices including reasonable hours, clearly defined break times, and clear supervision guidelines.
- As a member of the community, Irene could advocate with community leaders to address community norms which affect prompt health seeking behaviour, and increase risks for HIV transmission, and encourage the establishment of a community-health committee to work closely with her local health facility.
- Irene could initiate dialogue with her husband around safe sex for both of them.
- Irene could remind herself and others that everyone is at risk for HIV and maintain a positive and open attitude towards PLWH.

What can the *community* do?

- Irene's colleagues could initiate a peer education approach to educate their peers about HIV prevention, care and treatment.
- Irene's boss could put into place clear guidelines on a code of conduct for all health workers, supervise workers on a regular basis, and reward/penalise workers based on service delivery practices.
- The hospital authorities could use community outreach as a channel of communicating anti stigma and HIV preventions messages on a regular basis.
- The Hospital Workers Union, medical associations, etc. could ensure that health workers are continually guided by standards, protocols and procedures for provision of medical care in Nigeria.
- Irene's husband could work with Irene to advocate for support to the health care facility from philanthropic Individuals,

> *Health Community Feedback Committees have been done in Nigeria through the PATHs*
>
> *In Botswana, peer mothers who are HIV positive support health care workers to provide HIV counselling to mothers within the PMTCT programme.*

government, and private sector. Rather than keep a mistress outside the home, Irene's husband could actually become a change agent in the community.

- The Hospital Workers Union could recruit and train community volunteers who could relive the burn out and stress arising from long hours of working without relief or duty shifts.

What can the *health system* do?

- The health facilities could engage the community more actively to obtain feedback and use such feedback to improve service delivery in the community this is where the FHCs (see above--used in the PATHS states) could have a vital role in feedback and liaison between community and services
- The health systems could organise capacity building activities for all staff in the area of HIV prevention, care, support, treatment and impact mitigation. This will increase knowledge and confidence of the staff to deal with HIV related issues without fear or stigmatisation.
- The health facility could ensure that PLWH support groups are linked and integrated with the facility in terms of service delivery. Meaningful involvement of PLWH will ensure higher prospect of success for prevention, care and treatment programs.
- The health facilities could recruit, train and utilise volunteer staff from catchment communities to relieve permanent staff from burnout and stress.
- The health facility could ensure strict adherence to standard operating procedures, proper and up to date licensing of medical staff and availability and use of service guidelines in all consulting rooms and hospital units.
- The health facilities could ensure that job aids are made available to health care workers. In particular, flipcharts, recorded tapes, TV spots, etc are available to support staff –client communication.
- The health facilities could provide health care workers with up to date and regular anti HIV stigma training.
- The facility could ensure free distribution of supplies such as condoms, and water based lubricants, as well as fresh syringes, gloves etc to aid adherence to HIV prevention protocols
- The facilities could ensure regular supply of hospital consumables and other supplies; and eliminate stock outs of relevant drugs.
- The health systems could provide education on PEP to all health care workers, and make PEP available to all staff that might need it.
- The health systems could advocate through media, or interpersonal channels increased budgetary allocation to health and the facilities in particular.

> *Malawi's health sector has developed a Provider- Client Charter which is posted outside health facilities, explained and promoted.*
>
> *Branding of Quality Care Health Facilities and outstanding teams with a symbol that has cultural importance (ie. gold star, blue circle, flower, etc.) has been done in many countries to increase the visibility of reproductive health care services, and establish a standard of excellence.*

What can *policy makers* do?

- Policy makers could facilitate the passage into law the anti HIV stigmatisation and discrimination bill.
- Policy makers could ensure the domestication and implementation of the National HIV Workplace Policy and prevention program within health care facilities.
- Policy makers could increase budgetary allocation to health facilities with particular emphasis on HIV and AIDS.
- Policy makers could explore ways to increase open dialogue around HIV and AIDS prevention, care and treatment between health facility staff and members of the communities.
- Policy makers could explore making relevant laws that empower professional medical associations to de-license health care workers found with stigmatising and discriminating attitudes and behaviours towards clients with HIV and AIDS.
- Policy makers could brand health facilities that provide quality care services, highlight health care teams that are providing exceptional service, and reward them.
- At state and LG levels of government, there should be communication steering or coordinating committees with membership across sectors, so issues can be more fully coordinated, monitored, and implemented at all those levels. Services thereby become more responsive to other community initiatives.

Choose your minimum package of strategic interventions based on your identified barriers at different levels.

Guiding Principles for a Minimum Package of Strategic Interventions for Health Workers

Effective strategic interventions for health workers should:

- **Address Irene's needs at individual, community, system and enabling environment levels.**
- **Be driven by health care workers** to define needs, best approaches to reach them and highlight positive role models/personal stories.
- **Recognise the cultural context** in which work is done, the nature of health work and the context of HIV service delivery in Nigeria.
- **Consider urban vs. rural differences** in terms of location of service facilities, literacy levels, access to information, and ability to refer to available HIV services to ensure that education and service provision is relevant to needs of communities.
- **Consider the different circumstances, challenges**, **and constraints** in which health care workers deliver HIV services

Behavioural Objectives

- Strengthen positive provider-client interaction
- Support client access to RH products (condoms, family planning methods)
- Support client adherence to STI and HIV related treatment.
- Support client access to other needed care and support services through referrals.
- Reduce risk of transmission of HIV through Injection and blood safety:

- **Critically analyse community cultural and gender values and beliefs** that encourage poor health service delivery, HIV related stigma and discrimination of PLWH, etc.
- **Reinforce rights of people living with HIV and AIDS** to non stigmatisation and non discrimination**.**
- **Address the wider policy environment** including the need for an effective and integrated service delivery system.
- **Focus on doable actions on all four levels.**

Minimum Package of Strategic Interventions:

Level of Intervention	Strategic Interventions	Ideas and Resources to Support Doable Actions at Each Level
Individual Level Barriers • Myths and misconceptions around HIV transmission • Low personal risk perception regarding medical and non-medical transmission • Lack of confidence and skills to provide quality counselling/communication with clients.	**Media communications** target health workers as professionals to develop knowledge, skills, confidence on HIV issues and reduce fears and stigmatisation using interactive radio programming. **Develop job aids in key areas around facility based client education and counselling** and support take home materials (particularly to strengthen adherence and provider-client communication).	• Develop entertaining/interactive format for radio programme which highlights personal stories of outstanding health teams, positive faces of PLWH, identifies new initiatives in HIV treatment, adherence, prevention, models skills and innovative approaches to providing care, builds skills of HCWs in an educative/interactive manner of different issues of prevention, treatment adherence, care and support. Use listener groups (if possible) to reinforce learning. • Ensure that all media around HIV also include professionals like health workers' own risk for HIV as members of the general population –reinforce that we are all in this together! • Develop simple step by step job aids in key areas around facility based client education and counselling and support take home materials (particularly to strengthen adherence and provider-client communication). All materials should focus on real people's positive experiences.

Level of Intervention	Strategic Interventions	Ideas and Resources to Support Doable Actions at Each Level
Community Level Barriers • Lack of positive peer support within facilities	**Strengthen peer support through professional organisations** and development of peer support groups for prevention, care and support among HCW.	• Mobilise health unions and other professional associations to develop skills, support updated information is included in HCP curriculum, support development and dissemination of guidelines, protocols, etc. • Strengthen positive peer support through professional associations – develop team spirit, morale for profession • Initiate a peer education program for HCWs to reduce HIV risks and increase adoption of preventive behaviours both at work and at personal levels • Establish support groups for HCW living with HIV.
• Lack of wider community involvement in health care delivery. • Stigma and Discrimination • Cultural norms that delay prompt health seeking behaviour and undermine rights of all community members to receive care without judgement.	**Community mobilisation** with traditional and cultural leaders **to foster community dialogue and advocate for increased support to health facilities** through volunteerism, philanthropy, etc. **Increase the visibility of PLWH leadership within health care delivery** through involvement in community feedback committees.	• Establish or strengthen health – community feedback committees (which include PLWH members) to strengthen quality of health care delivery in facility and community level and address resource mobilisation needs. • Highlight effective committees within the HCW radio programme. • Link CBOs, PLWH, youth and disability networks with local facilities to explore how lay groups can support health care delivery by taking on more of a education/counselling role. (Particularly in HCT). • Community feedback committees could be watchdogs for health care providers not practicing within existing standards, (private sector as well as public sector),

Level of Intervention	**Strategic Interventions**	**Ideas and Resources to Support Doable Actions at Each Level**
Health Systems Level Barriers • Lack of supportive supervision and enforcement of guidelines/protocols • Lack of supplies, equipment and drugs to prevent HIV transmission, and support quality of care delivery. • Lack of supportive work environment for HCW living with HIV.	**Promote stigma reduction** through increased capacity building on HIV prevention, care and treatment for health workers and by including established PLWH groups, CBOs as part of the health care delivery team. **Domesticate National HIV Workplace Policy for Health Care Settings** to ensure that HCW have access to preventive education, measures (condoms, PEP, gloves, new needles/syringes, and appropriate colour coded receptacles), confidential testing, support for PLWH in the health profession. **Strengthen supportive supervision of HCW and recognition** for outstanding HC team work.	• Professionalise health care workers by providing them with easy to use/fun job aids which build confidence and skills to provide effective communication and counselling with clients. • Establish routine group education sessions as part of service delivery which reduce individual counselling time and increase relevance of one on one communication. • Explore possibility of providing media based education within facilities through VCRs, radio. • Establish or strengthen provider-client charter and ensure visibility at health facilities, within radio programmes, through all media so that clients and providers know what to expect from service delivery. and their rights. • Ensure that there are mechanisms to complain about service providers that violate charter. • Integrate PLWH in service delivery as planners and lay counsellors. • Provide routine supportive supervision and acknowledge health care teams that deliver services based on guidelines and for excellence through clearly displayed certification. • Ensure that pre-service

		HW training integrates the latest HIV guidelines, protocols, and skills development, particularly in IPPC. • Ensure that HIV related issues are integrated into routine in-service training of HCW, particularly in IPPC. • Brand quality care facilities and outstanding health care teams, linked to health care/community management committee approval. Promote centres of excellence through clear signage outside facility, etc.
Level of Intervention	**Strategic Interventions**	**Ideas and Resources to Support Doable Actions at Each Level**
Policy Maker Level Barriers • Lack of supportive policies in place within health sector to ensure effective service delivery based on guidelines/protocols, anti-stigmatisation of specific clients, and protection of HCW living with HIV. • Lack of sufficient HIV related services for appropriate referral • Lack of sufficient budget to address huge gaps in delivery of the essential health package (delivery of essential drugs, supplies and equipment).	**Advocacy to policy makers** to pass the anti stigma bill, implement HIV and AIDS workplace policy and program, and ensure increased budgetary allocation to health facilities. **Advocacy to establish clear Provider-Client Charter** for all health care facilities **Community Mobilisation** to garner the support of community leaders for increased advocacy efforts to government, private sector and philanthropic individuals and organisations for increased support to health facilities.	• Prepare an advocacy plan for the health sector based on policy issues • Develop and implement an advocacy strategic action plan with all stakeholders including the media. • Hold regular community dialogue around policy issues with institutional leaders and members of the community in active participation • Ensure national guidelines, protocols are disseminated to all states, LGAs, and have teeth for implementation. • Establish public private sector initiatives to increase funding for health service delivery and ensure that private sector delivery adopts national guidelines, and protocols in delivery of care. • Consider certification of private health care sites if they meet national standards of excellence.

Chapter 3:

Working with Injecting Drug Users (IDUs)

1 Working with Injecting Drug Users (IDUs): Background

1. Key Issues

Samson's story represents the needs of injecting drug users.

- IDUs had the third highest HIV prevalence after FSW and MSM in Nigeria.
- IDUs are considered at higher risk of contracting and spreading HIV primarily through the sharing of needles and syringes, as well as practicing unsafe sex.
- IDUs, particularly those in Kano, reported highly risky injecting behaviour, and were more likely to share needles/syringes than IDUs in other states.
- IDUs were reported to be very sexually active with both girlfriends and with FSWs. Many female IDUs sell sex, as well, increasing the risk of HIV spreading into the general population through their clients.
- Because of their behaviour is illegal, it is difficult to reach IDUs with appropriate information, condoms, services, and harm reduction measures including access to safe needles and rehabilitation services.
- In general, very low proportions of IDU had received HIV counseling and testing or had received HIV interpersonal communication or services in the past 12 months.

2. Problem Behaviours

Unsafe SRH Behaviours

- IDUs sharing unsterilised needles.
- IDUs have multiple concurrent partners (some IDUs sell sex)
- IDUs have unprotected sex with women, including with FSWs.
- IDUs' use of drugs impairs effective decision-making about safe sex.

Inconsistent health seeking behaviours

- IDUs do not access HIV testing services or disclose their status.
- IDUs do not get treated for STIs or notify their partners for early treatment as well.
- IDUs who are HIV positive, do not access HIV treatment related services.

3. Behavioural Outcome Objectives

- Reduce sharing of needles among IDUs
- Reduce the number of multiple concurrent partners
- Increase correct and consistent condom-use among paid and nonpaid sexual partners.
- Increase demand and uptake of STI treatment, HIV testing and HIV treatment services.
- Improve quality of provider client interaction and adherence to treatment protocols
- Develop supportive legal environment and accessible health delivery system to address special needs of IDUs. (access to clean needle exchange, methadone or other safer drugs, and drug rehabilitation programmes).

4. Key Strategic BC Communication Objectives for Interventions

Level of Intervention	Key BCC Objectives	Key Interventions.
Individual Level	• Increase personal risk perception • Develop culturally and gender responsive appropriate life skills • Reduce myths and misconceptions	• **Media communication** on key themes using all channels • **Peer/mentoring** with life skills
Community Level	• Increase community dialogue • Reduce reported stigma and discrimination • Reduce reported gender inequalities • Modify high risk cultural practices • Strengthen peer and community support groups	**Community transformation** (communities, workplaces, places where people meet) to address stigma, harmful cultural and gender norms, and strengthen community response for referral and service delivery.
System Level	• Strengthen positive provider-client interactions • Increase access to condoms and family planning • Increase number of HIV related service sites • Increase referral to HIV related services including ART.	**Increasing access to quality products and services** by strengthening provider –client interactions for education and adherence, positioning key products where clients can reach them easily, and increasing visibility of quality services through branding.
Policy Maker Level	• Increase friendly workplace policies • Increase supportive legislation	**Advocacy to address the wider policy environment** that determines access, protects fundamental rights, and fosters linkages between sectors.

2 Working with Injecting Drug Users: Samson's Story

Samson is ill and isolated. He was first introduced to heroin at a friend's party two years ago when he was twenty two. The high was so great; it was hard to get enough. He felt like he was on top of the world - even the sex was better. And with group of friends he was with, it was easy to find lots of willing females to have sex with. Now, he can't seem to stop, even though he wants to. If he doesn't shoot up, the sickness inside him is terrible. And his friends would stop being his friend if he stopped. He couldn't bear the loneliness. They are his only family since his own parents won't have anything to do with him.

It's hard to get good stuff where he lives, but he and his friends manage to get whatever they can find. They don't have access to clean needles, they are too expensive anyways, but he and his friends take care of each other and always share the needles and the drugs they have.

He has a special girlfriend, who also uses drugs. She has to sell her body to make enough money for them to buy the drugs they need. He feels bad about it, but they both have to do their part to survive. There is also a lot of pressure for him to do illegal things. The local gangsters know his weakness, and use him and his friends to steal, and pretty much anything they want by threatening to turn them in. It's difficult to see a way out.

Lately he and his girlfriend are both starting to get more and more ill. He wonders if it could be that disease of the city, HIV, which he has heard about. There isn't much they could do if it was. He takes traditional medicine that his friends recommend but it doesn't seem to help much. He can't go to a health facility for help. He knows what people think about people like him and his girlfriend. Anyways, it is too much money to go for health care, even buy condoms, and dangerous if anyone knew he was doing drugs. The health care providers might report him to the police, and then what….?

What can we do as program planners to help?

Step 1

Know the problem behaviours that affect men and women who use injecting drugs in your area and the circumstances in which they take place.

Checklist to Consider

Are there unsafe sexual and reproductive health behaviours taking place?

- Do they share unsterilised needles with other people who use intravenous drugs?
- Do they have more than one sexual partner at the same time?
- Do they use condoms consistently and correctly with all their sexual partners?
- Do they drink alcohol daily which also impairs decision regarding safe sex?

Are there unreliable health seeking behaviours?

- Do they go for HIV testing to know their HIV status? If they are HIV positive, do they disclose to all their sexual partners?
- Do they go for early STI treatment when symptoms are noticed? Do they notify all their sexual partners so that they can get treatment as well?
- Do they access other key SRH/HIV related services (ART and PPTCT)?

You need to **keep in mind the context in which drug use takes place**

Are they….

- Living on the streets?
- Meeting in hotspots to take drugs?
- Living in cities or in rural villages?
- In schools?
- Married?
- Selling sex?

Samson's Problem Behaviours

Samson shares unsterilised needles with other people who use intravenous drugs.

He has multiple sexual partners, and doesn't use condoms, partly because of cost and access, but it is likely that drugs would affect his ability to have safe sex anyways. His steady girlfriend, who also shares needles, is a female sex worker which increases both of their risk as well. .

Step 2

Find out which barriers make it difficult for injecting drug users to take more positive action to protect themselves.

Checklist to Consider

What are the most important barriers to consider in Samson's situation?

- Does Samson feel **personally at risk for transmitting HIV** from sharing needles? Having multiple sexual partners? Having sex without a condom?
- Are there **myths and misconceptions** that affect his willingness to learn more about how HIV could affect him?
- Does he have the **confidence and skills** to try to seek help for his drug addiction? Take his health and future seriously? Use condoms? Access needed health care?
- **Are** Samson's **sexual partners likely to be supportive** of him asking for condoms during sex? How is Samson's girlfriend's situation different from his in terms of her own risky behaviour and ability to negotiate safe sex?
- **Are** Samson's **friends, supportive of him stopping drug use**? Reducing his sexual partners? Using condoms during sex?
- Is Samson **isolated from his family and community**?
- Does **stigma** associated with drug use fuel judgemental attitudes among healthcare providers? Among the community at large?
- Are there **cultural norms** that encourage men like Samson to have multiple sexual partners? Delay access to needed health services?
- **Are there accessible and friendly health services** where Samson can go for information, condoms, counselling and services?
- **Are accessible support services there** to help him access sterilised needles? Address his drug addition? Deal with his HIV status?
- Do **law enforcement agencies insist on no drug use/illegal drug approach** rather than risk reduction around settings?

Barriers Samson Faces

Individual level:

- *Samson does not feel personally at risk for HIV because of his sharing needles, having multiple sexual partners or not using condoms.*
- *He doesn't have the confidence, skills or power to deal effectively with peer pressure to take drugs and have multiple partners, because he is likely to be physically addicted to the drugs he takes now, and can't make good decisions due to the drugs he takes.*

Community level:

- *Samson's peers encourage him to continue his risky behaviour, and to continue his isolation in order to be a part of his "new family".*
- *The wider "local community" of gangsters offers no safety or comfort at all – and make it difficult for them to have power to say no to illegal work due to violence, or legal consequences.*
- *His own family and community stigmatise people who use drugs and further reinforce their isolation.*

Health system level:

- *The health provider is not perceived to be safe, because of the stigma they face as drug users, nor are the services accessible to them due to cost.*
- *There are no services available to deal with their drug addition, if they choose, or choose safer options like sterile needles, or free condoms.*

Policy maker level:

- *Because drug use is illegal, it is difficult for Samson to access health care or social support services.*
- *He has very little protection at all, even in the face of illegal activities of gangsters that form part of his community.*
- *There are no policies to support Samson's reduction of risk or deal with his drug addiction in a positive manner.*

Identify existing assets and opportunities to help address Samson and other IDUs needs?

Checklist to Consider:

- Does Samson have any **values** that would be a benefit **to address his own risk for HIV?** Take more control over his life?
- Does the wider "**community' have traditional values** that can positively address notions of masculinity which encourage Samson to take risks?
- Are there "community" **structures** that could be mobilised?
- Are there **male and female role models** that could support Samson to behave differently?
- Are there **examples of good community materials** that could be used to facilitate community dialogue?
- Are there **examples of innovative ways of delivering health and social support services to IDUs from other countries in the region or internationally?**

Examples of opportunities:

- Many sex workers who may also be IDUs have been exposed to some HIV interventions and could strengthen a peer led approach.
- Many IDUs experience isolation. Targeting them with an intervention could restore confidence and self efficacy.
- IDU are a closed hard to reach communities. Models of peer mentoring programmes, like PEP plus, could be adapted to work with IDUs.
- Parental support could easily be mobilised
- Community level traditional and faith based structures exist who could be mobilised and empowered to intervene.
- Presence of CSOs across many Nigerian communities could be mobilised to target IDUs.
- ARN that works with MSM networks and CSOs working with sex workers could integrate IDUs.
- Politicians have a captive audience in IDUs and other drug use and could serve as channels of communication
- Availability of HIV and other STIs services, counselling, Condoms, referrals, etc
- Stigma reduction interventions are ongoing in some healthcare settings
- There are opportunities for integrating IDU specific needs into HIV and AIDS services at all levels
- Police and healthcare workers can assist program planners with more supportive policies and services
- National Drug Law enforcement Agency could be mobilised for more supportive policies and interventions targeting IDUs

Choose your doable actions at each level.

What can *Samson* do?

- Samson could build his self-confidence by educating himself and his friends about their risk for HIV and develop risk reduction strategies.
- Samson could reduce the number of casual and paid sexual partners he has.
- Samson could keep condoms on him at all times to use consistently and correctly.
- Samson could talk to a friend that he trusts and respects around his fears about HIV.
- Samson could ask a friend to go with him to access HIV counselling and testing services (if he felt assured of confidentiality).
- Samson and his friends could limit the amount of alcohol they drink to keep them strong and fit.
- Samson could access clean needles (if needle exchange program was available) and dispose used sharps correctly.

What can the *community* do?

- Samson and his friends could go together to CSO/ network that works to support individuals in a illegal environment (like MSM/FSW networks) to request help in terms of information and access to supportive and relevant health care services.
- Samson and his friends could support each other to reduce sexual partners, and use condoms consistently.
- Families and communities could show understanding and support to their children who use drugs, help them to access relevant health and support services and avoid stigmatising attitudes and behaviours.
- Traditional and faith leaders could speak out on the dangers of drug use, before young people are exposed to drugs, and address stigma that puts everyone at risk. They could teach more about compassion, and take the lead in establishing programmes to support drug rehabilitation programmes, community based support for drug users.
- CSOs with experience working with substance users could target injecting drug users for an intervention.

What can the *health system* do?

- Providers could provide friendly, non-judgemental health care services to IDUs
- Health care facilities could tailor STI and HIV services according IDU needs
- Health care workers should not judge, stigmatise and discriminate against IDUs
- Health providers could offer mobile counselling and testing services at hot spots and joints where IDUs , like Samson frequent.

The Asian Harm Reduction Network (ARHN) has developed a strategy for prevention HIV among problem drug users. They advocate for provision of harm reduction kits to IDUs. These kits include: disposable syringes and needles, antiseptic solution and cotton, condoms, culturally appropriate information on health and hygiene, advice on safer injection, safe disposal of injecting equipment, vein care, sterilising and dressing infections and abscesses.

Harm Reduction Strategy for IDUs and HIV?AIDS Prevention in Afghanistan (2005)

What can *policy makers* do?

- Policy makers could train health providers on the needs of especially vulnerable and hard to reach groups like IDUs.
- Policy makers could establish clean needle exchange programmes in areas where sharing needles is common.
- Policy makers could design an IDU Rehabilitation scheme based on models that work.
- Community structures including the police, could work together towards reduction in criminal activities, gangsters, etc.
- Police could be trained to help IDUs access services rather than adopt punitive measures.
- Policy makers could strengthen links between organisations working with sex workers, MSM to address IDU needs as well
- ‘Policy makers within education could strengthen education on dangers of drug use within schools starting at primary level.

Step 5 Choose your minimum package of strategic interventions based on your identified barriers at different levels.

Guiding Principles for a Minimum Package of Strategic Interventions for IDUs.

Effective strategic interventions for IDUs should:
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- **Address Samson's needs at individual, community, system and policy maker levels.**
- **Be driven by IDUs** to identify needs, best approaches to reach them, and identify role models from within the group.
- **Have a strong peer mentoring component** focusing on building 'culturally appropriate and feasible" life skills for IDUs to reduce partners, and use condoms.
- **Draw on the strengths of existing CSOs and networks working with vulnerable populations** at risk whose activities are illegal.
- **Focus on community cultural and gender norms** to address male responsibility and risk to reduce multiple concurrent partners and increase safety of sex.

Behavioural Objectives

- Reduce sharing of needles among IDUs
- Reduce the number of multiple concurrent partners
- Increase correct and consistent condom-use among paid and nonpaid sexual partners.
- Increase demand and uptake of STI treatment, HIV testing and HIV treatment services.
- Improve quality of provider client interaction and adherence to treatment

- **Address the dangers of drug use and develop life skills** through all channels before young people experiment, and become addicted to drugs.
- **Address the wider policy environment** to promote access to clean needle exchange, methadone or other appropriate drug access, and drug rehabilitation programmes for drug addiction.
- **Focus on doable actions on all four levels.**

Minimum Package of Strategic Interventions:

Level of Intervention	Strategic Interventions	Ideas and Resources to Support Do-Able Actions at Each Level
Individual Level Barriers • Low personal risk perception around shared needles, multiple partners, and unprotected sex. • Low personal risk perception and life skills around drug use.	**Communications and peer mentoring approaches** targeting IDUs to increase their sense of personal risk around shared needles, multiple partners and unprotected sex.	• Map out IDUs through CSOs and networks working with vulnerable populations. • Highlight vulnerability of IDUs through stories that could be aired on radio, put into peer education materials, refer them to "safe" places for information, clean needles, where needed, and access to friendly health services. • Integrate substance abuse education into peer education materials for FSW and MSM and referrals for clean needles, and services
	Media communications highlight general risks around drug use and addiction with increased risk practices targeting young people.	• Media Campaigns to target the risks around drug use and multiple partnerships for young people. • Integrate substance abuse prevention life skills education into FLHE content for formal education and through anti AIDS club, youth organisations, peer networks targeting both in and out of school youth.
Community Level Barriers • Lack of peer and community support for IDUs • Lack of wider community support for IDUs	**Establish "safe places" for IDUs** to access information, safe needles and health related services.	• Establish a peer led team that would educate IDUs and provide options for risk reduction and link them to related health services using PEP model.
	Community mobilisation to explore community roles to prevent substance abuse and create community based programmes for IDUs and other vulnerable groups.	• Community dialogue on how to strengthen programmes for young people to prevent initiation of hard drugs • Community dialogue on links between any substance abuse with risky sex practices. • Provide income generating activities at community level
Level of Intervention	**Strategic Interventions**	**Ideas and Resources to Support Do-Able Actions at Each Level**
Health System Level Barriers • Lack of access to	**Increase IDU access to health products and services**	• Provide condom use skills and make condoms available to all IDU hotspots • Organise stigma reduction training for healthcare workers • Provide BCC materials for health care settings targeting stigma

products and friendly services		reduction • Integrate needs of specially vulnerable groups into HCT counsellor training.
Policy Maker Level Barriers • Lack of supportive policy environment	**Advocacy with policy makers** to establish needed services for IDUs, and strengthen links between key sectors for referrals.	• Advocacy to gain policy makers and stakeholders support for IDU issues • Establish a needle exchange program that substitutes used needles with sterile ones. Encourage safe disposal of used needles • Facilitate links with other services, such as a program for IDUs that substitutes harmful drugs with methadone or other appropriate drugs. • Advocate for capacity building of health care workers to integrate IDU programs within mainstream, HIV and AIDS services • Advocate for the provision of needles and condoms at service delivery points • Police and other law makers should enforce the child rights act which prohibits underage marriages, forced marriages and early marriages which lead promote adoption of sex work later in life. • Advocate for police to support IDU access to needed information and services

Chapter 4:

Working with Men who have Sex with Men (MSM)

1 Working with Men who have Sex with Men (MSM): Background

1. Key Issues:

Thomas' story represents the needs and issues of men who have sex with other men.

- After FSW, MSM recorded the next highest HIV prevalence rates within Nigeria with 13.5%.
- According to the IBBS (2008), HIV prevalence was highest in Lagos (25%) followed by Kano (10%), and Cross River (3%).
- MSM represent a diverse group of people, who may engage in sex for different reasons – sexual preference, economic benefit, and sexual assault.
- MSM are generally a young population with 3/4 under 25.
- They are also an educated population with the majority completing secondary education (79%), among whom 15.5% had completed tertiary education.are educated with the majority completing secondary education, and highly mobile.
- Because of cultural taboos and lack of legal protection, they are also a highly stigmatized population with limited access to relevant information and services appropriate to their needs.
- Exposure to interventions among MSM was reportedly very low, with only around one quarter receiving safe sex education from peer or outreach workers.
- Nevertheless, because of stigma, they are likely to be difficult to reach, and often may be married to women, with children, increasing the risk of HIV spreading into the general population.

2. Overview of Problem Behaviours:

Unsafe SRH Behaviours

- MSM have unprotected anal sex with other men.
- MSM have multiple partners at the same time (some sell or pay for sex, others are non-paying)
- MSM are having unprotected sex with women (up to 50% in each state also had sex with women), including FSWs.
- MSM use alcohol and marijuana which impair their ability to have protected sex.

Unreliable Health Seeking Behaviours

- MSM do not access HIV testing services
- MSM do not get treated for STIs or notify their partners to treat themselves as well.
- MSM do not access other HIV related services including ART.

3. Behavioural Outcome Objectives:

- Reduce the number of multiple concurrent partners.
- Increase correct and consistent condom-use among paid and nonpaid male and female sexual partners.
- Reduce reported alcohol and drug use.

- Increase demand and uptake of STI treatment, HIV testing and HIV treatment services.
- Improve quality of provider client interaction and adherence to treatment protocols
- Develop supportive legal environment and accessible health delivery system.

4. Key Strategic BC Communication Objectives for Interventions

Level of Intervention	Key BCC Objectives	Key Interventions.
Individual Level	• Increase personal risk perception • Develop culturally and gender responsive appropriate life skills • Reduce myths and misconceptions	• **Media communication** on key themes using all channels • **Peer/mentoring** with life skills
Community Level	• Increase community dialogue • Reduce reported stigma and discrimination • Reduce reported gender inequalities • Modify high risk cultural practices • Strengthen peer and community support groups	**Community transformation** (communities, workplaces, places where people meet) to address stigma, harmful cultural and gender norms, and strengthen community response for referral and service delivery.
System Level	• Strengthen positive provider-client interactions • Increase access to condoms and family planning • Increase number of HIV related service sites • Increase referral to HIV related services including ART.	**Increasing access to quality products and services** by strengthening provider –client interactions for education and adherence, positioning key products where clients can reach them easily, and increasing visibility of quality services through branding.
Policy Maker Level	• Increase friendly workplace policies • Increase supportive legislation	**Advocacy to address the wider policy environment** that determines access, protects fundamental rights, and fosters linkages between sectors.

2

Working with Men who have Sex with Men: Thomas' Story

Thomas feels alone. He has known that he is attracted to men for a long time. But, coming from a small village and a very religious family, he knew that he had to keep his feelings a secret and pretend to like girls as much as his friends. Things changed when he came to Lagos, got his university degree, and was finally able to meet other men like himself. He was free.

In the big city, it is easy for him to meet other men and have sex. But because it is illegal, they have to be very careful and hide their feelings, and their behaviours. He is still young, only 25, and feels like his whole future is ahead of him. Of course, he would love to eventually find someone to fall in love with and have a long-term relationship but it is only a dream. His family are already pressuring for him to marry a nice girl, and they even try to introduce him to different women when he sees his family. He has tried to have sex with one or two women but it feels like a lie. But he is afraid of being honest with his family. There is so much stigma, discrimination and abuse of men who are openly gay, or transgendered, that he knows that he will never be able to have a proper relationship with another man, and it is likely his family would never speak to him again if they knew.

Everything around him denies his right to exist. Although he knows about HIV, the condoms advertisements are targeted towards men and women so it is difficult for him to convince the men he is with that they should use condoms and a water based lubricant as well. They seem to think that if you have anal sex, you cannot get HIV.

While he could go into any health facility for care as a man, he knows he could not be really honest with a health provider regarding his sexual preference, and health needs. He doesn't think it would make any sense to have an HIV test, because there are no services to help someone like him anyways. Better not to know. Like so many other men he knows, he will probably get married at some point and continue his secret life.

What can we do as program planners?

Step 1

Know the problem behaviours that affect men who have sex with men in your area and the circumstances in which they take place.

Checklist to Consider

What are the key issues affecting men who have sex with men?

Are there unsafe sexual reproductive health practices taking place?

- Do men have more than one sexual partner at the same time?
- If so, do they know their HIV status?
- Do they always use condoms, and water based lubricant to protect each other from HIV?

Are there unreliable health seeking behaviours?

- Do they go for early STI treatment, and notify all their partners?
- Do they know their HIV status?
- Do they disclose their HIV status to someone they trust?
- If they are HIV+, do they access treatment, care and support services?
- If they are HIV+, do they live positively with HIV?

Consider the different circumstances in which men have sex with other men:

- Is it a sexual preference?
- Are there economic incentives for sex?
- Is it rape?
- Is it happening under unusual circumstances (ie. prison)

Thomas's Problem Behaviours:

Thomas has more than one sexual partner at the same time. He does not use condoms consistently or correctly, with water based lubricant, when he has sex with other men, or with women.

Thomas does not access health care services such as HIV testing, STI screening, etc.

Find out which barriers make it difficult for men who have sex with other men to take more positive action to protect themselves.

Checklist to Consider

What are the most important barriers to consider in Thomas's situation?

- Does Thomas **feel personally at risk** for HIV?
- Does Thomas have the **self confidence and skills** to negotiate his right to safe sex with other men or access to protective health services as a man who has sex with other men?
- **Does he have a supportive group of family and friends** to advocate for his right to be open about his sexual preference, have safe sex and access to condoms, lubricants, and HIV/RH related services?
- **Does his family pressure him to continue to live a dual life** by encouraging him to have female sexual partners?
- **Do Thomas's sexual partners** support his desire for safe sex? Would a female partner support him if he asked to use a condom when they had sex?
- **Does the community talk** about the risks of anal sex for both men and women? Support use of condoms?
- Do the **community's cultural norms, beliefs and practices** about real men and multiple partners influence Thomas's desire for multiple male partners? Encourage him to live a secret life?
- Is there **stigma** within the community which would affect Thomas' ability to openly have committed loving relationships with other men? Affect his willingness to get tested for HIV? Use condoms for safe sex?
- **Are 'gender' appropriate information and health services available** for Thomas to get information he needs to protect himself from HIV and other STIs through anal sex? Prevent passing it on to women? Provide proper counselling and support to him if he were found to be HIV+?
- **Do policy makers ensure that** men who have sex with other men's **fundamental rights are protected?**

Barriers Thomas Faces

Individual level:

- *Thomas has heard about HIV, and may even feel a bit at risk but doesn't have information targeting him and his peers.*

Community level:

- *Thomas has many male (and a few female) partners. The male partners don't support condom use during sex because they don't feel personally at risk for HIV through anal sex. Female partners are likely to resist condom use because condoms are associated with paid sex, and lack of trust.*
- *All the men and women of the community believe that men are supposed to have multiple partners, and men must marry to be a part of the community. This forces Thomas to live two lives – one where he pleases his family and community by having a female partner, and perhaps family – and one where he continues to have multiple sexual partnerships with other men. This puts him, his future wife, and future children at great risk for HIV.*
- *General stigma in the community around men who have sex with men, HIV and condom use makes it difficult for Thomas to get any helpful information or support from his community.*

Health systems level:

- *The health facility is not seen as accessible to Thomas – although he seems to have money and education, he does not see the services as meeting his health and social needs.*
- *Stigma around men who have sex with men and HIV by health providers also affect Thomas's access to friendly HIV related services.*

Policy maker level:

- *Sex between men is illegal which reinforces secrecy, silence and continued vulnerability by Thomas and his peers.*
- *Illegality of sex between men and stigma means that needed information and health services to protect themselves from HIV are difficult to access for Thomas and his peers.*

Identify existing opportunities to help address Thomas' and other MSM's needs.

Checklist to Consider:

- Does the 'MSM" community have key values that would be a benefit to address cultural beliefs and practices that put men at risk for multiple partners?
- Does the 'MSM' community have networks that could be mobilised to address community norms and practices that put Thomas and other men at risk
- Are there male role models within 'MSM' communities that could be used to promote community awareness and dialogue around new ways that men could protect each other from HIV? Build positive support networks for MSM living with HIV.
- Are there examples of good "MSM' community materials from the region or internationally that could be used to facilitate dialogue among peer groups and networks, and places where MSM meet?
- Are there opportunities within the wider Nigerian community to address exploitative circumstances in which men have sex with other men (ie. rape of boys, sex within prisons, paid sex work) and develop appropriate strategies to address their needs as a starting point to begin a positive dialogue around this group's needs?

Examples of opportunities:

- Many MSM are young and so have the energy, enthusiasm and ability to adapt like other young people their age.
- Many MSM are very educated and have access to high tech information like internet and mobile phones
- Current existence of MSM networks in Nigeria for information on meeting locations etc. – can be mobilised for peer education.
- Alliance Rights of Nigeria (ARN) works with MSM and are currently (2008) conducting a formative research on MSM group to guide interventions with this group.
- Cross-Rivers State has had great success in recruiting MSM for HIV testing.
- Increased interest of implementing partners, including by national level policy, to begin to tackle the needs of MSM.

Choose your doable actions at each level.

What can *Thomas* do?

- Thomas could use condoms and water based lubricant every time he has anal sex with a man, even with paying partners.
- Thomas could reduce the number of sexual partners he has to protect himself from HIV.
- Thomas could stop having sex with women, or use condoms when he has sex with a woman.
- Thomas could seek prompt treatment of STIs
- Thomas could reduce his intake of alcohol and hard substances to ensure that he always takes care of his health.
- Thomas could go for an HIV test, perhaps with the support of an MSM network, to get needed information, confidential HIV testing and appropriate support services for his needs.
- Thomas could find a buddy who he trusts, to accompany him for HIV testing, and be a support if he is found to be HIV positive.

What can the *community* do?

- Thomas's peers could support each other to get informed about HIV and protecting the 'community' through 100% condom use with water based lubricant when they have sex.
- Thomas' peers could support each other to get tested for HIV, and taking a positive stance towards prevention, through existing MSM networks.
- MSM networks could work with NGOs or private sector to get services that are not stigmatized—testing, treatment, education
- MSM networks could advocate for MSM rights to 'culturally appropriate" information, and services (eg. access to trained counsellors through hotlines, HIV testing sites, etc.)
- Thomas's family could support Thomas to protect himself from HIV.

In Abia State, a radio programme was aired which shared real stories of MSM and the issues they face. The radio programme called for interested MSM to meet two times a week for support. The group is growing through word of mouth and many MSM are accessing the support available.

What can the *health system* do?

- The health provider could provide friendly health care to Thomas and his peers.
- Public and donor funded health services could train providers on services for MSM, particularly in testing and treatment sites

What can *policy makers* do?

- Policy makers could open a wider policy dialogue to address how to protect MSM from stigma, discrimination, and physical abuse.
- Policy makers could explore innovative ways to increase MSM access to information and services.
- Policy makers could focus on dangers of unprotected anal sex
- Policy makers could look to separating men from young boys in prisons to protect them from unwanted sex, provide condoms in prisons? STI screening?, educational programmes.

Choose your minimum package of strategic interventions based on your identified barriers at different levels.

Guiding Principles for Minimum Package of Strategic Interventions for MSMs:

Effective strategic interventions for MSM should:

- **Address Thomas's needs at individual, community, system and enabling environment levels.**
- **Be driven by men who have sex with other men to** define needs, best approaches to reach them, and highlight positive role models' personal stories.
- **Recognise the cultural context** in which men who have sex with other men live in as well as their own "culture".
- **Consider urban vs. rural differences** in terms of access to information, key services and literacy.
- **Consider the different circumstances** in which men have sex with other men or children.
- **Address risks to both men and women** around anal sex.
- **Have a strong peer mentoring component** focusing on building 'culturally appropriate and feasible" life skills for MSMs.

Behavioural Objectives

- Reduce the number of multiple concurrent partners
- Increase correct and consistent condom-use among paid and nonpaid male and female sexual partners.
- Reduce reported alcohol and drug use.
- Increase demand and uptake of STI treatment, HIV testing and HIV treatment services.
- Improve quality of provider client interaction and adherence to treatment protocols

- **Draw on the strengths of the "community" gatekeepers** (including places where men meet).
- **Critically analyse community cultural and gender values** and beliefs that encourage multiple partners.
- **Reinforce rights of men living with HIV** who have sex with other men to have positive but safe sexual relationships.
- **Address the wider policy environment** including protection of fundamental rights, and access to HIV related products and friendly services.
- **Focus on doable actions on all four levels.**

Minimum Package of Strategic Interventions:

Level of Intervention	Strategic Interventions	Ideas and Resources to Support Doable Actions at Each Level
Individual Level Barriers • Low risk perception • Lack of life skills • Lack of peer support	**Communications and peer mentoring approaches** targeting MSM through networks focus on reduction of multiple concurrent partners, dangers of unprotected anal sex, and promote access to friendly MSM services where available.	▪ **Utilise Alliance Network or other existing networks** in your state to identify positive personal stories regarding protection, support. ▪ **Map out hot spots** where MSM meet through existing networks, including FSW networks. ▪ **Use peer education/peer promotion within networks of MSM** to highlight doable actions and build life skills for MSM to negotiate safe condom use, and access needed services (recognise that male sex may have unequal power relationships as well that needs to be addressed) ▪ **Utilise radio and share personal stories**, focus on doable actions in states where it is possible. ▪ **Address secrecy by utilising small A5 size cards** with key information and telephone numbers of support networks available (hopefully within the same state) ▪ Identify positive resources through the internet ▪ **Integrate messages about the dangers of unprotected anal sex** into all existing communications targeting both men and women in a non judgemental/stigmatising way ▪ **National hotline** could include MSM friendly counsellors who can address MSM questions, health needs in a supportive and non-judgemental manner and be able to refer MSM to MSM friendly services where available. (promotion of hotline services could be done through networks and small cards rather than draw national attention to MSM services).
Community Level Barriers	**Community mobilisation** to strengthen support networks for MSM.	• **Build capacity of existing MSM networks** to make them more responsive to MSM issues

Level of Intervention	Strategic Interventions	Ideas and Resources to Support Doable Actions at Each Level
• Lack of positive community support • High risk cultural norms and practices		• **Set up support networks for MSM** in states where there are none drawing on FSW networks that are more established.
	Community mobilisation to highlight risks of anal sex for both men and women, reduction of multiple partners, and address vulnerability of boys and young men for unwanted sex.	• **Include information around risks of anal sex** in all materials where risk factors are addressed • **Integrate risks of unwanted sex for boys** in community interventions which address community action to combat rape.
Health Systems Level Barriers • Lack of access to needed products and services	**Increase access to male condoms and water based lubricant**	• Utilise existing MSM peer networks to **identify places where condoms and lubricant should be made available**.
	Increase access to MSM friendly STI services	• Integrate needs of MSM into existing training on IPPC for health providers
	Increase access to MSM friendly HCT	• Provide outreach testing in hotspots or through MSM Networks , FSW Networks
	Increase access to HIV related treatment and support services.	• Ensure that MSM networks can provide referrals to existing HIV related services • Establish MSM friendly PLWH groups
Policy Maker Level Barriers • Lack of an enabling policy environment	**Advocacy** among policy makers at state and local level for MSM friendly information and health services	• **MSM networks use advocacy to put into place MSM friendly information and health services** (hotlines, and incorporate needs into HCT counsellor training, health provider training)
	Advocate for protection of boys and men against unwanted sex	• **Advocacy within prison systems** to separate boys and men • **Advocacy to ensure legislation around sexual assault** addresses sex with boys as well as girls and women.

Chapter 5:

Working with Orphans and Vulnerable Children (OVCs)

1 Working with Orphans and Vulnerable Children (OVCs): Background

1. Key Issues:

Rosaline's story represents the needs of orphans and vulnerable children. The number of children affected and infected by HIV is increasing rapidly in Nigeria. OVCs are a diverse young population who, in addition to dealing with the stress of losing parents and/or living with HIV, are at great risk of poverty, sexual abuse and dropping out of school. They are a difficult group to reach because they may be marginalized by living on the streets, trafficked or otherwise facing exploitation. Like other children, they often have no voice but are put in the difficult position of having to care for other siblings, often with no means to provide for them. They may have little control over their sexuality, livelihood or have access to education, health, social services, and protection of fundamental rights.

2. Problem Behaviours:

Unsafe SRH behaviours

- OVCs may be subjected to early land unwanted sex through sexual abuse and child marriages.
- OVCs may not be able to have protected sex to prevent HIV transmission.

Unreliable health seeking behaviours

- OVCs may not be able to access needed health care including nutrition, HIV testing, care and support services.
- OVCs who are HIV positive may not be able to access paediatric treatment
- OVCs may not be able to adhere to treatment protocols, and live positively with HIV.
- OVCs may not have access to psychosocial support, social protection or basic education and livelihoods training.
- OVCs may be caring for other OVCs.

3. Behavioural Outcome Objectives:

- Reduce early and unwanted sex through sexual abuse and child marriages.
- Increase OVC's access to HIV testing, nutrition, paediatric treatment, care and support services.
- Increase adherence of children to HIV treatment protocols
- Ensure that more orphans and other vulnerable children have access to psychosocial support and social protection programmes at family and community levels.
- Reduce stigma and discrimination that affect children living with HIV and their families.

4. **Key Strategic BC Communication Objectives for Interventions**

Level of Intervention	Key BCC Objectives	Key Interventions
Individual Level	• Increase personal risk perception • Develop culturally and gender responsive appropriate life skills • Reduce myths and misconceptions	• **Media communication** on key themes using all channels • **Peer/mentoring** with life skills
Community Level	• Increase community dialogue • Reduce reported stigma and discrimination • Reduce reported gender inequalities • Modify high risk cultural practices • Strengthen peer and community support groups	**Community transformation** (communities, workplaces, places where people meet) to address stigma, harmful cultural and gender norms, and strengthen community response for referral and service delivery.
System Level	• Strengthen positive provider-client interactions • Increase access to condoms and family planning • Increase number of HIV related service sites • Increase referral to HIV related services including ART.	**Increasing access to quality products and services** by strengthening provider –client interactions for education and adherence, positioning key products where clients can reach them easily, and increasing visibility of quality services through branding.
Policy Maker Level	• Increase friendly workplace policies • Increase supportive legislation	**Advocacy to address the wider policy environment** that determines access, protects fundamental rights, and fosters linkages between sectors.

4.

2 Working with Orphans and Vulnerable Children: Rosaline's Story

Rosaline is seven years old and feels all alone. After both her parents died, she was put into her uncle's house. But she doesn't feel safe there. They also have quite a few children of their own, and they have made it very clear that they are doing her a favour by letting her stay there. Because her parents died of HIV related illnesses, they even seem to be a bit afraid of her, as if she could pass the virus onto her just by eating at the same table or breathing the same air.

They say they don't have enough money to send her to school, so she helps her aunt sell vegetables in the market. While she doesn't mind the work so much, she is led to believe that this is temporary, and they are already making plans to marry her off to someone who can pay them some money. She is afraid of her uncle because he has also begun to look at her in strange ways, and has hinted that it would be good for him to know if she is of "marriageable" quality, when they are alone together.

She doesn't know who she can go to for help. The community is also afraid of families who have been affected by HIV, and children are not taken seriously by adults.

The health services and school are also far away, and since she is poor, she imagines they would not listen to her either.

Ibrahim's grandmother worries about her six years old grandchild, Ibrahim who is living with HIV. He got the virus while being born but both his parents are dead now. He has been going for treatment but his grandmother doesn't explain to him why, and certainly doesn't tell anyone else in the community for fear that they would insist on keeping him out of school, and he would have no friends to play with. They might even avoid her as well. She finds it hard to remember to have him take his tablet 2 times a day and costly to take him every month for his check up. She also wonders who will take care of him when she is too old and needs help herself?

What can we do as program planners to help?

Know the problem behaviours that affect orphans and vulnerable children in your area and the circumstances in which they take place.

Checklist to Consider

Do orphans and vulnerable children have unsafe SRH behaviours?

- Are they being sexually abused?
- Are they being trafficked for sex?
- Are they being married off as children?
- Are they having sex for their economic survival?

Do orphans and vulnerable children have unreliable health seeking behaviours?

- Do children at risk know their HIV status?
- If they are HIV positive, do they access HIV related treatment, including cotramoxizole?
- If they are HIV positive, do they live positively with HIV, including have access to school, play, social support, and protection?
- Do they access other key health products and services to prevent and manage opportunistic infections?

You need to **keep in mind the context in which children are at risk.**

Are they….

- Orphans (lost one or two parents?)
- Children with inadequate access to educational, health and other social support
- Children which have a chronically ill parent (regardless of whether the parent lives in the same household as the child);
- Children who live in a household with terminally or chronically ill parent(s) or caregiver(s);
- Children who live with old/ frail grandparent(s) or caregiver(s)
- Children who live outside of family care, i.e. live with extended family, in an institution or on the streets;
- Children who are infected with HIV.
- Children with physical or mental disabilities
- Sexually abused
- Neglected
- In conflict with the law
- Exploited "Almajiri"
- Child beggars, destitute children and scavengers
- Children from broken homes
- Destitute children/child beggars
- Child laborers, including domestic child labourers
- Children in child-headed homes
- Internally displaced children
- Children hawkers
- Trafficked children
- Children of migrant workers such as fishermen, nomads.

Step 2

Find out which barriers make it difficult for orphans and vulnerable children to take more positive action to protect themselves.

Checklist to Consider

What are the most important barriers to consider in helping Rosaline?

- Does Rosaline feel **personally at risk for HIV? For sexual abuse?**
- Are there **myths and misconceptions** that affect his willingness to learn more about how HIV could affect him?
- Does she have the **confidence and skills** to deal with stigma in her family and community? Her own risk for sexual abuse? Her desire for a normal life as a child?
- Is Rosaline's adopted family **likely to be supportive** of her demanding her rights to education, her right not to be abused? Or married off?
- Does Rosaline have **friends,** who can support her
- Does **stigma within the community affect everyone's beliefs** about who gets HIV and how they should be treated? Who uses condoms?
- Are there **cultural norms** that encourage men to have sex with children? (ie. child marriages?)
- **Are there accessible and friendly health services** where Rosaline can go for information, HIV counselling and testing and paediatric HIV services?
- **Are accessible support services there** to help her if she were found to be HIV positive?
- Is there a legal **and policy framework for the protection of vulnerable children** in the country?

Consider what would be different if Rosaline was living on the streets? If she were disabled? If she were in a situation of conflict?

Would "community" barriers would be different? The same? Would services be available to her?

Rosaline's Problem Behaviours

- *Rosaline is an orphan and working as a child labourer.*
- *Rosaline does not know her HIV status, even though both her parents died of HIV related illnesses.*
- *She at risk for sexual abuse by her uncle and likely to be married off (or trafficked) even though she is only seven years old.*

Barriers Rosaline Faces

Individual level:

- *Rosaline knows she is at risk, even though she may not understand much about HIV, sex or marriage.*

Community level:

- *Rosaline's uncle and aunt do not support Rosaline's rights as a child, and directly put her at risk for early, unwanted and risky sex because of her uncle's desire for sexual satisfaction and money earned for the family if she is sold into marriage.*
- *They also have myths and misconceptions about HIV and directly stigmatise her because of her family and HIV.*
- *The community also stigmatises PLWH and have cultural norms and values that put Rosaline, as a girl child in particular, at risk for early and unwanted sex through child marriages and denying her rights….*

Health and educational system level:

- *We don't know if the health system is accessible to Rosaline from the story. We can imagine that there are few services available specifically targeting the need for child protection, children's sexual and reproductive health needs, or paediatric HIV treatment and support services for children and their guardians.*
- *Hidden costs for health care also may make it difficult for Rosaline to get care when she needs it.*
- *The educational system is likely to have hidden costs for children which acts as a barrier to her access to "free education", or develop her life skills to protect herself from risky situations.*

Policy maker level:

- *The rights of the child are unlikely to be well understood or implemented at state and community level to protect children like Rosaline.*
- *Wider poverty makes it difficult for families to protect children like Rosaline rather than exploit them.*

Identify existing assets and opportunities to help address Rosaline and other OVC's needs.

Checklist to Consider:

- Does Rosaline have **values** and qualities that would be a benefit **to address her own risk for HIV?**
- Does the **community have traditional values** that can positively address rights of OVCs and unequal gender norms?
- Does the community have **traditional structures** that could be mobilised?
- Are there **male and female role models** among children and within the community to strengthen community action?
- Are there **examples of good community materials** that could be used to facilitate community dialogue?
- Are there **examples of social /economic programmes** that could support Rosaline's right to relevant information, education and social services?
- Are there **examples of innovative ways of delivering health care to children**

Consider the following assets/opportunities:

- Children have boundless energy, enthusiasm, inner strength, and trust in life that helps them to learn quickly and take action.
- African cultural value that a child belongs to the community and not to one family, is a strong way to motivate community responsibility and action.
- There is a National Plan of Action for OVCs.
- The consultative process undertaken in developing the plan of action has already brought together greater coordination across government and civil society and has raised awareness and commitment.
- Donors are ready to commit resources to a coordinated and comprehensive plan of action.
- Lobbying for issues of exclusion in access to health and education services can ride on government, UN and donor commitment towards meeting the Millennium Development Goals.
- Communities and children themselves provide the greatest opportunity and hope for ensuring orphans and other vulnerable children are protected, cared for and supported to realize their rights to survival, life and development.

Choose your doable actions at each level.

What can *Rosaline* do?

- Rosaline could seek out an adult she does trust (perhaps in the market) who could help her address her fears about her uncle's sexual intentions, and the planned early marriage/trafficking.
- Rosaline could organise with other children to talk to adults (traditional or faith leader) as a group regarding their rights and needs.
- If Rosaline is found to be HIV positive and eligible for treatment, she could remember to take her medicines daily by having a song to sing, or using her daily routine to remind her.
- If Rosaline is HIV positive, she could play like other kids, go to school and study, eat well, and tell a guardian she trusts when she feels unwell and needs to see a doctor.
- Rosaline could have dreams and hopes and develop her confidence and skills to take control over her life.

What can the *community* do?

- Other children could watch over each other to make sure that all children are treated as normal and get help from safe adults even when vulnerable children are afraid to ask for themselves.
- Caregivers could make sure that OVCs receive health care when required, including HIV testing and access to paediatric treatment and support services available.
- Concerned adults in the community could organise a child welfare and protection committee to establish guidelines on fundamental rights of all children and map out where OVCs are who might need help.
- Traditional and faith leaders could speak out bout the special risks to OVCs to encourage unity members to take action to support them.
- Traditional courts could set rules within the community regarding universal education for all children, and sanctions for sexual abuse of children.
- Community leaders could organise an assessment with families/caregivers of OVCs and children themselves to identify appropriate community interventions.
- Community leaders could educate family members on the rights and needs of children with special needs.
- Community based organisations could establish inclusive programmes for all children to support their development, play, and participation in community activities.
- CBOs could establish early intervention programmes, with caregiver families, to strengthen their capacity to protect, care and support the needs of OVCs.
- Community leaders could educate the community members about the dangers of stigma and discrimination against adults, and children, living with HIV.

What can the *health and educational system* do?

- Teachers could teach all children from an early age life skills to protect themselves from risky situations and develop their self esteem to participate in decision-making.
- Schools could work together with community networks for OVCs to put in place community based recovery schemes to cover costs of OVC's school expenses.
- Health providers could provide child friendly and empowering health care services including HIV testing, treatment and care.

- Health workers could strengthen capacity for accessible community based and differentiated services along a continuum of care including psychosocial support for OVC, their primary caregivers and families.
- NGOs, CSOs and FBOs could deliver quality psychosocial support (PSS) and protection services to OVCs, families and communities.
- Local health workers could provide strong support for community-oriented actions for health promotion and disease prevention for OVCs.
- Health workers could provide quality community based counselling, incorporating HCT, to reach OVCs and their families.
- Health providers could provide friendly care for HIV infected mothers enrolled in PPTCT service and the infants of mothers living with HIV, and ensure that they are linked to community based programmes for ongoing support for themselves and their children.
- Health workers could support caregivers and CBOs to provide home-based care (HBC).

Malawi's Ministry of Health developed a story based flipchart about children on treatment for guardians to learn about needs of children with HIV. With guidance of a children's support group, a small low literate friendly booklet story, was also developed. On every page, there was a checklist to remind the guardian and child to take their daily treatment in the morning and night, a tablet guide for the monthly dosage, and a homework assignment that the provider and child could discuss during their monthly visit to the clinic.

What can *policy makers* do?

- Health and educational policy makers could work with community structures to identify locally determined solutions to increase OVC's access to essential health, nutrition and educational services.
- Policy makers could provide forums in which OVCs and their guardians participate in making decisions that affect their well-being and future.
- Policymakers could pass the Child Rights Act in all states and ensure that it is implemented at all levels.
- Policy makers could finalise the National Policy for the Child.
- Policy makers could improve budget allocation and resources to OVC programmes at all levels.
- Policy makers could enforce the Universal Education Act to ensure that all OVCs have access to education and remain in school (establish community based funds to pay for basic education costs for OVCs).
- Policy makers could link with the private sector to increase OVC's access to quality vocational and livelihood skills.
- Policy makers could increase funding and capacity support to CBOs to strengthen community based programmes for OVCs with special needs to remain cared for in their homes or communities of origin, as much as possible, rather than put them into Institutional care.
- Policy makers could mainstream OVC issues into macro-economic policies and programmes.
- Policymakers could highlight and share "best practice" programmes which have identified locally determined solutions and resources in an effort to increase sustainability, reduce dependency and empower children and communities.
- Policy makers could advocate for greater financial support for programmes to increase OVC's access to basic health and educational services, and support more community empowered safety net programmes (link with private sector to determine opportunities to support vocational skills development with community service programmes targeting OVCs).

Choose your minimum package of strategic interventions based on your identified barriers at different levels.

Guiding Principles for a Minimum Package of Strategic Interventions for OVCs.

Effective strategic interventions for OVCs should:

.

- **Address Rosaline's needs at individual, community, system and policy maker levels.**

- **Be driven by the orphans and vulnerable children** to identify needs, best approaches to reach them, and identify role models from within the group.

- **Have a strong peer mentoring component** focusing on building 'culturally appropriate and feasible" life skills for children themselves and for their caregivers.

- **Draw on the strengths of the "community" gatekeepers** (including community based organisations, parent groups, and community structures).

- **Focus on community cultural and gender norms** to address gender inequalities that increase the risk of sexual abuse for both girls and boys.

- **Address wider policy environment** including protection of fundamental rights, and access to child friendly health and educational services.

Behavioural Objectives:

- Reduce early and unwanted sex through sexual abuse and child marriages.
- Increase OVC's access to HIV testing, nutrition, paediatric treatment, care and support services.
- Increase adherence of children to HIV treatment protocols
- Ensure that more orphans and other vulnerable children have access to psychosocial support and social protection programmes

Minimum Package of Strategic Interventions:

Level of Intervention	Strategic Interventions	Ideas and Resources to Support Do-able Actions for Each Level
Individual Level Barriers • Lack of self esteem and age appropriate life skills	**Media communications focus on** raising awareness and increasing knowledge of **orphans and other vulnerable children's risk for HIV** among policy/decision makers and the general population at all levels.	• FMWA to develop advocacy plan for the national response in tune with the campaign on Children and AIDS. • Develop and pre-test advocacy materials along thematic areas, e.g. enrolment in pre-primary schools, girl child rights, inheritance, increased access to services by OVC, etc. • Finalize and distribute advocacy kits • Develop and produce radio jingles, translate into relevant languages • Launch mass media campaign through phone-in-programs, TV/radio talk shows, soap operas, meetings with electronic and print media executives • Develop theatre for development/drama through grants to NGO, CBOs and private theatre companies
Level of Intervention	**Strategic Interventions**	**Ideas and Resources to Support Do-able Actions for Each Level**
Community Level Barriers • Lack of peer and family support. • Lack of community awareness and support for OVCs. • Cultural norms and practices that put OVCs at risk for child marriages (sexual	**Wider community mobilisation targets community traditional and faith leaders**, **to address cultural and gender norms** that encourage child marriages, sexual abuse of children, **and stigma**, and **facilitates the development of community driven solutions** to ensure that all children have access to essential health, education and social protection services.	• Undertake community-based advocacy visits to LGA Chairmen, religious, opinion, traditional, women, youth leaders, etc., to mobilize community about OVC issues • Promote children/ family, community, government and CSO dialogue on protection, care and support • Strengthen the capacity of civil society organizations to effectively design, monitor and evaluate Programmes, involving the most vulnerable children • Reduce stigma and discrimination around HIV/AIDS, particularly children affected by HIV and AIDS, through community dialogue and action planning • Train OVC Committee members and other community health workers on relevant health promotion and disease prevention strategies/ programmes on various aspects of health promotion and disease prevention for OVC

abuse)		• Implementation of serialized educational and skills building programmes on various aspects of health promotion and disease prevention OVC Committee at the community levels • Promote formation of support groups for OVC focused actions and child monitoring at community level • Advocate and mobilize for resources for community nutritional support, (and other needs) to support very vulnerable household • Advocate through social mobilization to increase demand.
Educational system level Barriers • Lack of access to life skills education for OVCs.	**Strengthen life skills education to include the needs of OVCs**, advocate for inclusion of OVCs in schools.	• Review the FHLE curricula to ensure that issues around sexual abuse are addressed. • Advocate through PTA to develop schemes to assist OVCs with school related fees that keep them outside of school, and/or lead to early dropout.
Level of Intervention	**Strategic Interventions**	**Ideas and Resources to Support Do-able Actions for Each Level**
Health System Level Barriers • Lack of access to RH products and friendly services.	**Strengthen provider/client interaction** to support children living with HIV and their caregivers ability to take care of their health, and positive living. **Increase OVC at risk's access to quality HIV testing, treatment, care and support including nutrition** for children.	• Provide outreach activities from a health post or LGA facility, and establish a linkage between communities and NGOs. • Hold sensitization workshops for Primary Health care coordinators (at LGA level) for social mobilization on OVC issues at community level • Strengthen referrals of HIV-infected mothers to ARV, TB services, and other needed treatment services • Train peer counsellors at already-established VCT centres at community level to support OVC in facilities for counselling • Develop family and child friendly educational flipchart regarding the needs of children on treatment, and child driven adherence materials to help them remember to take their medicine, and facilitates friendly provider – child dialogue. •
Policy Maker Level Barriers	**Advocate for enabling policy environment** to increase OVC's access to essential health, education,	• Massive advocacy and social mobilization at all levels, especially in endemic regions, to create awareness on the jeopardy of

• Lack of supportiv e policy environm ent to address the needs of OVCs.	social protection services.	children deprived of protection and care • Review existing policies to mainstream OVC issues, including: Education Policy; Health Policy, HIV/AIDS Policy; Adolescent RH Policy, National Policy on Child Labour, Social Welfare Policy, NEEDS, SEEDS, • Advocate for PEP for children who are sexually abused.

Chapter 6:

Working with People Living with HIV (PLWH)

1

Working with People Living with HIV: Background

1. Key Issues:

Kabiru's story represents the situation of PLWH. PLWH are afraid to disclose their status for fear of stigmatisation, discrimination and in the case of women, violence and abandonment. This is critical to address because many couples are discordant. PLWH need to learn about prevention in the context of living positively, to protect themselves from OIs, and protect partners from HIV. PLWH also have wider reproductive health needs that should be addressed. PLWH are a very diverse group representing children, young people, men and women (some pregnant or breastfeeding), and vulnerable individuals who may face additional barriers to accessing related information and services.

2. Problem Behaviours:

Unsafe SRH behaviours

- Some men and women who are HIV+ still have multiple concurrent partners.
- Men and women who are HIV+ do not disclose their HIV status to their partners.
- Discordant couples do not use condoms to prevent HIV transmission to their partners.

Unreliable health seeking behaviours

- PLWH don't live positively (eat well, rest, avoid alcohol/drugs, seek social support, prevent OIs, prevent transmission of HIV to others, practice dual protection)
- PLWH don't seek early treatment for OIs or if eligible, for ART (Key to focus on STI management and malaria – particularly for pregnant women).
- PLWH don't adhere to ART consistently (if on treatment).

3. Behavioural Objectives:

- Reduce multiple concurrent partners.
- Increase the number of PLWH who disclose their status and seek social support.
- Increase correct and consistent condom-use.
- Increase uptake of family planning and PPTCT services
- Increase uptake and adherence to ART for PLWH who are eligible.
- Increase number of PLWH who access health services for OI prevention and early treatment of OIs
- Improve quality of provider client interaction and adherence to treatment protocols
- Reduce number of PLWH reporting stigma and discrimination
- Develop supportive legal environment for PLWH and accessible health delivery system.

5. Key Strategic BC Communication Objectives for Interventions

Level of Intervention	Key BCC Objectives	Key Interventions
Individual Level	• Increase personal risk perception • Develop culturally and gender responsive appropriate life skills • Reduce myths and misconceptions	• **Media communication** on key themes using all channels • **Peer/mentoring** with life skills
Community Level	• Increase community dialogue • Reduce reported stigma and discrimination • Reduce reported gender inequalities • Modify high risk cultural practices • Strengthen peer and community support groups	**Community transformation** (communities, workplaces, places where people meet) to address stigma, harmful cultural and gender norms, and strengthen community response for referral and service delivery.
System Level	• Strengthen positive provider-client interactions • Increase access to condoms and family planning • Increase number of HIV related service sites • Increase referral to HIV related services including ART.	**Increasing access to quality products and services** by strengthening provider –client interactions for education and adherence, positioning key products where clients can reach them easily, and increasing visibility of quality services through branding.
Policy Maker Level	• Increase friendly workplace policies • Increase supportive legislation	**Advocacy to address the wider policy environment** that determines access, protects fundamental rights, and fosters linkages between sectors.

2

Working with People Living with HIV: Kabiru's Story

Kabiru is anxious about his future. He began to worry about his HIV status because of ill health and recently went to have an HIV test. He was found to be HIV+. He hasn't told his wife about his HIV test result, because he fears what her family will say, and if they will tell her to pack up the children and leave him to die alone. Nevertheless, he suspects that his wife would feel pressured to stay and care for him when he becomes very ill. This is because of the dowry he has paid to her family, and the children they have had together. He thinks perhaps the easiest thing to do is not tell her about his HIV status, and continue as normal. After all, she is likely to have HIV as well no?

He will never be able to share his fears about his health and family's future security with his friends or even his Imam because HIV is feared. Others who are known to be HIV + are treated very badly – thrown out of his faith, and even excluded from community activities.

He can't tell his boss because he suspects that they would fire him immediately, and who would take care of his family then?

Even though he has heard something about treatment for HIV, he doesn't know where he can find these special drugs and wonders if they are very expensive to take. He also worries about how he will be treated at the health facility – what if people see him and know why he is going there? How will the health provider act towards him?

Perhaps he should just give up….?

What can we do as program planners to help?

Fatima had an HIV test when she went for routine ANC services and found out she was positive. She doesn't know how to tell her husband since she is afraid he will blame her (even though she has never had any other sexual partner but him). She will be kicked out of the house, and perhaps the community as well. She can't imagine how she can keep this a secret but is afraid to seek help in case someone she knows should see her….

Ibrahim's grandmother worries about her six years old grandchild, Ibrahim who is living with HIV. He got the virus while being born but both his parents are dead now. He has been going for treatment but his grandmother doesn't explain to him why, and certainly doesn't tell anyone else in the community for fear that they would insist on keeping him out of school, and he would have no friends to play with. They might even avoid her as well. She finds it hard to remember to have him take his tablet 2 times a day and costly to take him every month for his check up. She also wonders who will take care of him when she is too old and needs help herself?

Step 2

Know the problem behaviours that affect men, women, young people and children living with HIV in your area.

Checklist to Consider

- Do men and women living with HIV **disclose their HIV status** to their partners and family members?
- Do they **know their HIV status as a couple** or family?
- Do guardians **tell children that are HIV +** their HIV status?
- Do men, women, young people and children who are on ART, **take their medication consistently**?
- Do they **live positively** with HIV? (ie. eat well, prevent OIs, go for early OI treatment, seek social support?)
- If they are sexually active, do they **use condoms to prevent HIV**, particularly if they are discordant (ie. one who is not HIV+)?
- Do PLWH **use family planning methods to prevent unwanted pregnancy** or space children?
- Do PLWH **access health services to prevent passing HIV on to their children**?

Kabiru's Problem Behaviour

Kabiru is afraid to disclose his HIV status to his partner, family, friends, community and workplace. This may put his wife at risk for HIV as well, since he does not know her HIV status, and may not have infected her yet. It could also affect the health of his future children if he decides not to use a condom when having sex with his wife to avoid suspicion.

He may decide not to go for HIV related services for fear of stigma, including prevention of parent to child transmission services.

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Fatima is also afraid to disclose her HIV status to her husband and access related HIV health and support services. There is fear that she may be sent packing from her matrimonial home.

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Ibrahim's grandmother does not disclose Ibrahim's HIV status to Ibrahim, other family members, or people who could help support him and her as his only guardian.

She needs to make sure that Ibrahim takes his ART treatment consistently and is seen by a doctor every month. He also needs to go to the health centre whenever he has health problems.

Step 2

Find out which barriers make it difficult for PLWH to take positive action to protect themselves.

Checklist to Consider

What are the most important barriers to consider in Kabiru's situation?

- Does Kabiru **know enough about HIV** to address his, and other's questions about **living positively with HIV, discordance with his wife, and what health and support services can provide** for him and his family?
- Does Kabiru have the **confidence and skills** to deal with stigma, and discrimination he may face by his family, friends, community, mosque and workplace?
- Is Kabiru's **family likely to be supportive** of him?
- **If Kabiru's wife was HIV +** instead, would he and the family treat her differently?
- Are there **people in his community that he can talk to**?
- Does **stigma within the community affect everyone's beliefs** about who gets HIV and how they should be treated?
- **Friendly support from the existing health system** to address prevention and management of opportunistic infections such as malaria, STIs, TB, etc? Is ART treatment available and accessible to him when he meets the medical criteria?
- **Are the support services there** to help him within his community? In his workplace?

Barriers Kabiru Faces

Individual level:

- *Kabiru does not have relevant information about how HIV will affect his health, and what he can do to live positively, including seeking early assessment for possible HIV treatment. He also does not know that it is possible for his wife to be HIV negative, and that she needs to be tested as well, so that she and the children are protected.*

Community level:

- *Kabiru's wife and family may not be supportive of him. The community stigmatises people living with HIV, and discriminates against them in even within their faith.*
- *In his workplace, PLHWH are also discriminated against, and he is afraid of being fired. (As a woman, Fatima, would be afraid of being kicked out of her matrimonial house and sent packing.)*

Health system level:

- *The health providers may treat him differently because he is HIV positive. The HIV services might also be too visible so that everyone knows why he is there.*

Policy maker level:

- *ART and support services are not widely available. Workplace policies that would protect Kabiru from being fired from his job may not be in place.*

Step 3

Identify existing assets and opportunities to help address Kabiru and other PLWH's needs.

Checklist to Consider:

- Does the community have **key values** that would be a benefit **to address stigma** and discrimination?
- Does the community have **traditional structures** that could be mobilised?
- Are there **male and female role models** within communities that could be used to promote community awareness and dialogue around the rights of PLWHs or offer examples of positive community action?
- Are services, drugs and support services for PLWH available?
- Are there **examples of good community materials** that could be used to facilitate community dialogue?

Examples of opportunities:

- Extended family system reinforces care and support for PLWH.
- Disclosure and factual information about HIV transmission helps to tackle stigma.
- Role models are there of people living positively with HIV as couples, families and communities.
- Support groups are increasing/culture of group organisations.
- Radio Diaries about PLWH are already developed.
- Strong religious values among many Nigerians and the existence of influential faith leaders can be used to mobilise communities around compassion and support.
- FBOs and some religious institutions are already involved in HIV issues.
- Active support groups already exist that can be used as a platform to help PLWH
- Existence of CSOs and Government and other agencies working on gender issues.
- NGOs and CBOs already involved in HIV/AIDS issues.
- There are trained peer educators who can correctly disseminate information (Peer Education Trainers for Youth Corpers)
- Special groups of people already trained on HBC and basic skills on HIV.
- There are supportive programmes and income generation activities planned for PLWH by NAPEP (National Poverty Eradication Program).
- Kaduna, Benue, and Cross River States have domesticated the National Workplace Policy could be models for other states to draw on.
- There is a National Anti Stigma Bill awaiting reading at the National Assembly. Some States have already passed the anti stigma bill at state level including Kaduna. Cross River, Kwara and Plateau States.
- Some States have already developed Islamic and Christian policies on HIV to mobiise FBO actions.
- The media is sensitized and mobilised on HIV issues.
- NIBUCAA is there to access private sector on HIV.
- There is a pool of trained health workers available.
- The Family Life Health Education curriculum is now being adapted for teachers to reach young people.
- FGN has channelled many resources into ART.
- Drug regulatory agencies exist.
- The National Policy on HIV/AIDS and National Workplace Policy to prevent discrimination against PLWH.
- Legislation currently in process to prevent sacking of PLWHs from workplaces.

Choose your doable actions at each level.

What can *Kabiru* do?

- Kabiru could find one person he trusts to talk about his HIV status.
- He could find a local PLWH support group that could help him deal with his HIV status, and support him to disclose his HIV status to his wife.
- Kabiru could go with his wife for HIV testing and counselling together so that both of them get the facts about transmission, protection, care and support. He could support her to also know her HIV status.
- Kabiru could seek referral for assessment of ART and learn what he could do to live positively with the virus and protect his family.
- If Kabiru is eligible for ART treatment, he could identify a treatment buddy to remind him to take his medicines everyday, and support him to go to the health facility when he is ill, or for his monthly check-up.
- Kabiru could use condoms when he has sex to prevent passing HIV to others and protect himself from further infection.
- Kabiru could go with his wife to learn more about prevention of parent to child transmission services, including the use of regular family planning.
- Kabiru could live positively with HIV and work and live normally.

"Reach Out, Show Compassion" for PLWH is the second phase of the high profile "Stop AIDS Love Life" multimedia communication campaign that has been running since February 2000. With the cooperation of Muslim and Christian leaders in Ghana, the new campaign aims to increase the number of religious organizations, congregations, and humanitarian groups advocating for and engaged in care and compassion activities in communities. Training for 900 clergy, imams, and other religious leaders is being organized and conducted throughout the country to establish compassion and support programs. Television and radio spots also incorporate quotes directly from the Bible or the Koran that demonstrate compassionate behaviour.

www.popline.org/docs/279060

What can the *community* do?

- Kabiru's wife could go with Kabiru for HIV testing to know her own HIV status.
- Kabiru and his wife's family could support them as a couple to live positively with HIV in the family and educate others on the dangers of stigma (advocate for the protection of their rights).
- Friends could socialise normally with Kabiru and his family.
- Friends could recognise that everyone is at risk for HIV, and go for HIV testing to learn their own HIV status.
- Faith and traditional leaders could educate their community members on the importance of compassion, inclusion and treating everyone in the community the same way.
- Faith and traditional leaders could support communities to ensure gender issues are addressed in the extended family system, create mechanisms to protect women who are HIV positive from violence and abandonment.
- Faith and traditional leaders could advocate for establishing or strengthening support groups within the community for families living with HIV – offer couples counselling, support home based care initiatives.
- Faith and traditional leaders could advocate for increased access to affordable and locally available HIV related services for families living with HIV.

Christian Aid and the African Network of Religious Leaders Living with or Personally Affected by HIV have come up with the concept of SAVE as a comprehensive approach to HIV prevention. Their concept is Be Safer, Get What's Available, Get Tested Voluntarily, and Get Educated under the anti stigma motto "HIV is a virus, not a moral issue".

- Faith and traditional leaders could promote HIV testing for all community members recognising that everyone is at risk – they could take the lead by being the first to get tested for HIV.
- Empower PLWH to have access to support groups and other organisations to seek help (eg FIDA, NCWS etc).

What can the *health system* and *workplace* do?

- Kabiru's health provider could offer supportive, friendly health care services to Kabiru and his family, referring Kabiru to HIV specific health care and support services including ART assessment where available.
- Kabiru's doctor could involve his family in his treatment and counsel them all on drug adherence in order for the family to support Kabiru with his treatment
- Kabiru's doctor could also link up Kabiru with a CHBC NGO where Kabiru could also help with mobilising care and support for other PLWHs
- Kabiru's workplace could have an HIV policy to protect employees living with HIV.
- Kabiru's boss could promote HIV testing for all employees and ensure that RH and HIV information is readily available.
- Kabiru's workplace boss could link employees with available health care services, to either provide services within his office, and/or be able to refer employees for needed care and support services. (including access to condoms for all employees).

PLWH need to have social and health needs addressed in a holistic fashion. In many places, they are supported to find a treatment buddy to help them take their medicines daily. Adults also need access to family planning methods, malaria prevention like insecticide bed nets and cotramoxizole as prophylaxis. This requires great synergy between primary health care services and HIV related services.. Examples of integrated approach?/ prevention for positives?

What can *policy makers* do?

- Policy makers could institutionalise couple counselling at all health care facilities.
- Policy makers at national level could establish private-public sector partnerships through NiBUCCA to ensure that all companies have a workplace HIV policy and programmes.
- Policymakers could formalise role of PLWH groups to provide lay counselling/testing at health facilities and within communities.
- Policy makers could encourage stakeholder partners to provide other support services in the facility free – reward states that have come up with innovative solutions to address stigma.
- Policy makers could link states with faith based HIV policies with other states.
- FGN could ensure there is no stock out of ARTs at all levels
- NAFDAC regulation of all ARTs to make sure no substandard drugs are in circulation
- Encourage CBOs to become involved in HBC

Kaduna State has domesticated the National Workplace Policy and disseminated it to all relevant stakeholders, including the private sector. The Police College in Kaduna recruited police officers and two weeks after their passing the exam, they were mandated to take and HIV test. 26 were found to be HIV positive and were dismissed. The SACA, NEPWHAN and CISNAN wrote a memo, signed by the SACA chairman to the police authority stating that they had been wrongfully dismissed under the State Workplace Policy. While they have yet to be recalled, the police have agreed in principle to do so.

Step 5

Choose your minimum package of strategic interventions based on your identified barriers at different levels.

Guiding Principles for a Minimum Package of Strategic Interventions for PLWH.

Effective strategic interventions for PLWH should:

.

- **Address Kabiru's needs at individual, community, system and policy maker levels.**
- **Be driven by men, women, young people and children living with HIV** to identify needs, best approaches to reach them, and identify role models from within the group.
- **Recognise that stigma affects men and women differently** and address gender inequalities **in peer mentoring life skills programmes and community transformation interventions** developed.
- **Consider urban vs. rural differences** in terms of access to information, key services and literacy.
- **Address the special needs of young people and children on treatment**, and issues around disclosure
- **Address the need for treatment literacy in communities at large**, and the importance of adherence.
- **Reinforce rights of PLWH to have positive but safe sexual relationships** and needs for wider reproductive health information and services.

Behavioural Objectives

- Reduce multiple partners.
- Increase the number of PLWH who disclose their status and seek social support.
- Increase correct and consistent condom-use.
- Increase uptake of family planning and PPTCT services
- Increase uptake and adherence to ART for PLWH who are eligible.
- Increase number of PLWH who access health services for OI prevention and early treatment of OIs
- Improve quality of provider client interaction and adherence to treatment protocols

- **Use positive images and stories of hope**, showing different types of people who are affected (older, younger, urban, rural, men, women, children, pregnant women, etc) looking warm, full of energy, to address myths and misconceptions about who gets the virus and that HIV is a death sentence.
- **Address the wider policy environment** including protection of fundamental rights, and access to 'culturally relevant" RH and HIV related products and services.
- **Focus on doable actions on all four levels.**

Minimum Package of Strategic Interventions:

Level of Intervention	Strategic Interventions	Ideas and Resources to Support Do-able Actions for Each Level
Individual Level Barriers • Difficulties to disclose HIV status to partner and family members • Inadequate knowledge about discordance . positive living and treatment options.	**Media communications address stigma by highlighting** positive experiences from PLWH, **that everyone who doesn't know their HIV status is at risk,** and the benefits of HCT for all. Increase **spousal communication and disclosure** and treatment literacy.	• Address stigma and fear among population about an HIV+ result, highlight real individuals who live positively with the virus, emphasise different groups affected (ie. Women, men : urban and rural), pregnancy, couples, children, : emphasise different modes of transmission, benefits of knowing your HIV status. • Link with HIV testing…. Focus on everyone is affected by HIV, • Use HIV + role models to develop mass media materials which can be used to address issues of disclosure and positive living (PABA role models): to talk openly about how they dealt with HIV in their families • Replicate radio dairies on national radio stations such as FRCN. • Highlight national/community responsibility: Break the Silence Campaign (community and faith leaders working hand in hand with PLWH, young people….) • Treatment Literacy radio series to address all aspects of living with HIV.
Level of Intervention	**Strategic Interventions**	**Ideas and Resources to Support Do-able Actions for Each Level**
Community Level Barriers • A dialogue on stigma and gender related risks. • Inadequate number of support groups or referral mechanism s for PLWH. • Insufficient	**Community mobilisation** with traditional and religious leaders to break cultural silence, stigma, call for community action to support PLWH, and protect their fundamental rights. **Communication action** to establish and/or strengthen support groups for men, women, couples and young people living with HIV. **Community mobilisation to encourage traditional and faith leaders to promote themselves as**	• Involve FBOs to support the PLWH in the community • Explore a wide variety of traditional information sharing networks • Involve community gate keepers in stigma reduction in their communities • Explore a wide variety of traditional information sharing networks • Involve community gate keepers in stigma reduction in their communities • Promote PABA role models in their communities • Build capacity of key people in the community to handle issues of HIV and gender based violence • Strengthen referral network and

Level of Intervention	Strategic Interventions	Ideas and Resources to Support Do-able Actions for Each Level
role models/leaders to address fear and stigma by publicly going for an HIV test, and addressing myths and misconceptions.	**models** for their community by going for an HIV test, publicly working with PLWH networks, and addressing myths and misconceptions.	support groups • Community tool for treatment literacy to support education at community level (other models: Bridge PMTCT Kit and Male responsibility, AT Package has story about discordance…). • Build capacity among support groups
Health System Level Barriers • Stigma and discrimination • Lack of friendly health care	**Strengthen capacity to deliver friendly and supportive health care** to PLWH of all ages. Ensure that treatment includes strong **adherence counselling component**, **and that wider RH needs of PLWH** are addressed.	• Training and retraining of health workers on IPCC on ART treatment • Develop adherence related counselling and take home materials for adults and children on treatment. • Refer all PLWH on ART to one of the support groups • Provision of free support services
Level of Intervention	**Strategic Interventions**	**Ideas and Resources to Support Do-able Actions for Each Level**
Workplace Level Barriers • Insufficient supportive workplace policies and programmes for PLWH being implemented.	**Implement workplace policies across all sectors and all levels** and establish workplace programmes that support wide needs of PLWH.	• Institutionalise the National Workplace Policy into workplace. • Involve NIBUCAA more in HIV programs in the work place • Ensure that NIBUCAA has state chapters in all states to spearhead workplace response. • Promote male and female condoms in the workplace, pharmacies, through peer education, SDP, and all places where people meet. • Use NEPWHAN network to guide supportive programmes and IGAs planned by NAPEP.
Policy Maker Level Barriers • Lack of legal protection for PLWH through national policy framework.	**Advocacy to pass and disseminate the National Anti-Stigma and Discrimination Bill** and ensure its domestication within all states. **Advocacy to establish watch dog organisations** at national and state level to ensure that passed	• Advocate to legislators to pass the National Anti-Stigma and Discrimination Bill asap. • Ensure that all anti stigma and discrimination bills are disseminated to all the states so that they can be domesticated based on the positive example of Kaduna and Cross Rivers States. • Advocate for the establishment of community "watchdog" networks to

• Lack of supportive workplace policies and programmes implemented within the health care system for heath workers living with HIV.	legislation to protect PLWH is justly implemented at all levels and across all sectors.	monitor correct implementation of anti-stigma and discrimination bills at all levels. • Ensure that the Ministry of Health has domesticated the National Workplace Policy to protect health workers living with HIV.

Chapter 7:

Working with People with Disabilities

1 Working with People with Disabilities: Background

1. Key Issues:

Joshua represents the needs of people with physical disabilities. People with disabilities are among the poorest, least educated, and most marginalized populations worldwide. People with disabilities are also a diverse group who may have varying physical impairments that affect their access to needed information and services. They are often stigmatized because of their different abilities, and treated in ways that relegate them to an inferior position within society with little access to education, skills development, job opportunities or recognition of their sexual and reproductive health rights. Women who are disabled are particularly vulnerable to sexual abuse and need to have protection. Lami represents the needs of people with intellectual disabilities who are institutionalized. This is a difficult group to reach because they have little ability to advocate for their own rights or protect themselves from exploitation and abuse.

2. Problem Behaviours:

Unsafe SRH behaviours

- PWD have multiple concurrent sexual partners
- PWD do not use condoms consistently or correctly with sexual partners (in particular casual and paid sexual partners)
- Women and children are particularly vulnerable to sexual abuse.

Unreliable health seeking behaviours

- PWD do not go for HIV testing to know HIV status
- PWD do not access early STI treatment or notify all their sexual partners.
- PWD do not use family planning methods to space children or access PPTCT services.
- PWD do not access HIV treatment.
- PWD living with HIV do not live positively or access care and support services.

3. Behavioural Objectives:

- Reduce multiple concurrent partners.
- Increase correct and consistent condom-use among girlfriends, boyfriends, casual partners and paid sex.
- Increase uptake of family planning methods to prevent passing HIV on to children.
- Increase demand and uptake of accessible STI treatment, HIV testing and HIV treatment services.
- Improve quality of provider client interaction and adherence to treatment protocols in an accessible manner.
- Increase capacity of caregivers to provide appropriate, supportive, and correct care and advice to PWD

- Develop supportive legal environment for people with disabilities and accessible health delivery system.

4. **Key Strategic BC Communication Objectives for Interventions**

Level of Intervention	Key BCC Objectives	Key Interventions
Individual Level	• Increase personal risk perception • Develop culturally and gender responsive appropriate life skills • Reduce myths and misconceptions	• **Media communication** on key themes using all channels • **Peer/mentoring** with life skills
Community Level	• Increase community dialogue • Reduce reported stigma and discrimination • Reduce reported gender inequalities • Modify high risk cultural practices • Improve ability of caregivers to provide supportive and appropriate care • Strengthen peer and community support groups	**Community transformation** (communities, workplaces, places where people meet) to address stigma, harmful cultural and gender norms, and strengthen community response for referral and service delivery.
System Level	• Strengthen positive provider-client interactions • Increase access to condoms and family planning • Increase number of HIV related service sites • Increase referral to HIV related services including ART.	**Increasing access to quality products and services** by strengthening provider –client interactions for education and adherence, positioning key products where clients can reach them easily, and increasing visibility of quality services through branding.
Policy Maker Level	• Increase friendly workplace policies • Increase supportive legislation and budget allocations for PWD	**Advocacy to address the wider policy environment** that determines access, protects fundamental rights, and fosters linkages between sectors.

2a Working with People with Disabilities: Joshua's Story

Joshua's world is silent. He is seventeen years old and can't hear or speak. He left his family some years ago, because they couldn't understand what was wrong with him, assumed that he was dumb as well, and while he knew they loved him, he had no resources to help him. He was hidden away from others, in shame, and wasn't allowed to go to school – no point anyways because he couldn't communicate with his teacher, even though he knew he was as smart as any of them.

It was frustrating at times to let people know what he wanted and eventually, he gave up and ran away. He and his family are worlds apart from each other. Now, he stays with other people like himself. They find ways to communicate with each other in a basic sign language, and try to protect each other from the criminals out there who try to exploit them. There are other girls who are deaf as well, and they have a much harder time staying safe, because they are often attacked by men for sex – and can't make any noise to alert the others that they are in danger. He feels sorry for them, but even he has his sexual needs, and can't resist encouraging them to have sex with him as well.

There is little he knows of the world out there except what he can see, and understand from his other deaf friends. Since he never went to school, he can't read the billboards and posters out there, but likes to look at the pictures, and tries to make sense of the happy couples holding a small square in their hands, or standing outside health facilities. He understands from his more worldly friends that these pictures show something men wear during sex, but even if they are good to have, he can't afford them. He lives off the street, and doesn't have the means to buy anything except food and other basics to survive. (sometimes he has sex for money?). While he has many questions about having a family, and staying healthy, he doesn't go to a health facility because the health provider wouldn't be able to understand his questions, and probably doesn't think he has any need for information or services anyways. There is no place for him in their world.

Isa is unable to see the world she feels around her. Even though she is 25 years old, she stays within her very overprotective family. They don't let her go outside by herself, and laugh at her desire to find a husband, marry and have a family of her own. She would never be allowed to have a boyfriend like other girls who are even younger than herself. While she understands a great deal from what she hears on the radio about HIV, she knows that no one would ever expect her to need to protect herself and it angers her that people don't see her as normal like them. Even the girl down the road, who has mental problems, is known to have many sexual partners though she doesn't really understand what is happening to her. Isa is smart, but has never been able to go to school or will be able to hold a job. She feels like a burden.

What can we do as program planners?

Know the problem behaviours that affect people with disabilities in your area and the circumstances in which they take place.

Checklist to Consider

What are the key issues affecting men, women, young people and children with disabilities?

Are there unsafe sexual reproductive health practices taking place?
- Are they sexually active?
- Do men, women, young people and children have more than one sexual partner at the time?
- If so, do they use condoms and/or contraceptives to prevent STIs, HIV and unwanted pregnancy?
- Do they take hard drugs or alcohol which impairs decision making?

Are there inconsistent health seeking behaviours?
- Do they know their HIV status?
- Do they go for early STI treatment, and notify all their partners?
- Do they disclose their HIV status to someone they trust?
- If they are HIV+, do they access treatment, care and support services?
- If they are HIV+, do they live positively with HIV?
- Do they have caregivers or partners who understand their situation by "walking in their shoes"?

Consider the different circumstances in which people with disabilities have sex.
- Is it because of sexual violence/rape?
- Are there economic incentives for sex?

Consider that people with disabilities are of all ages, are both male and female and have many different types of disabilities which affect their ability to access information and services differently.

- Blindness
- Deafness
- Mental disabilities
- Physical disabilities

Joshua's Problem Behaviours:

Joshua has more than one sexual partner at the same time. He does not use condoms consistently or correctly, with water based lubricant, when he has sex with women or possibly with men.

Find out which barriers make it difficult for people living with disabilities to take more positive action.

Checklist to Consider

What are the most important barriers to consider in Joshua's situation…?

- Does Joshua **feel personally at risk** for HIV?
- Does Joshua have the **self confidence and skills** to negotiate safe sex, and access to friendly health services as someone with a hearing impairment?
- If Joshua were female, would her need for **self confidence and skills** be different? **In addressing issues of sexual violence and rape** against her as someone with a disability?
- **Does Joshua have a supportive group of family and friends** to advocate for his right to access information, products and HIV/RH related services in a manner he can understand, and support his desire to have safe sex and access to condoms?
- **Does his family stigmatise him** by excluding him from a normal life? **Educate him about the risks of unsafe sex?**
- **Do Joshua's sexual partners** support his desire for safe sex? Would a female partner support him if he asked to use a condom when they had sex?
- **Does the community talk** about the rights and needs of community members who have disabilities? Their special vulnerability to unwanted sex? Exclusion from education and a normal life?
- Do the **community's cultural norms, beliefs and practices** about people with disabilities and gender further exclude girls, in particular, from having safe and positive sexual relationships if they choose? Deny their rights to education further?
- Is there **stigma** within the community which would affect Joshua's and other men, women and children's ability to participate in the community like everyone else?
- **Are appropriate information and health services about 'disability' available** for Joshua to get information he needs to protect himself from HIV and other STIs? Prevent passing it on to others? Provide proper counselling and support to him if he were found to be HIV+?
- **Do policy makers ensure that** people with disabilities' **fundamental rights are protected?**

Barriers Joshua Faces

Individual level:

- *Joshua may or may not have heard about HIV from his friends but has little sense of personal risk because no information is available to him in a way that he can access.*

Community level:

- *Joshua's peers try to protect him from violence, but his female peers are very much at risk for rape/sexual violence by everyone.*
- *All the men and women of the community believe that people with disabilities have mental impairments as well which exclude their right to be part of the community as equal members, with rights and desires like everyone else.*
- *Few members of their families or in the community know what to do to help a PWD live a full life, and are intimidated by their inability to communicate effectively with PWD*
- *General stigma in the community around people with disabilities makes it difficult from his community.*

Health system level:

- *The health facility is not accessible to Joshua neither as a deaf person nor as a person living in extreme poverty. He cannot read nor communicate with the provider regarding his health needs.*
- *Stigma around people with disabilities by health providers also affects Joshua's access to friendly RH and HIV related services.*

Policy maker level:

- *There are no disability friendly HIV services available, nor are rights of people with disabilities addressed within a larger legal framework to protect them from violence, extreme poverty, access to education, work, special needs and rights of orphans/children with disabilities, inclusion.*

Identify existing assets and opportunities to help address Joshua and other PWD's needs.

Checklist to Consider:

- Does the **disability community have their own language, culture** which could be used to support Joshua and other people with disabilities' right for education and accessible info and health services?
- Does the **disability community have networks** that could be mobilised to address community norms and practices that put Joshua and other people with disabilities at risk
- Are there **role models within the diverse disability community** that could be used to promote community awareness and dialogue around rights of people with disabilities and special vulnerability? Build positive support networks for People with Disabilities
- Are there **examples of good disability community materials** from the region or internationally that could be used to facilitate dialogue among peer groups and networks?

Examples of opportunities:

- Disability networks exist within Nigeria and within Africa which bring together many positive role models of different types of men and women, young people with different disabilities.
- Models exist for reaching the Deaf community with "culturally appropriate" community tools, and services organised by the deaf.
- Braille materials are available and can be duplicated.
- Physical access is relatively easy to address within existing structures.
- Opportunities to mobilise disability advocacy organisations to take on disability and HIV related issues at policy maker level.
- NiBUCCA could be enlisted to sensitise private sector on disability needs, rights, and capacities for employment.
- Organisations working with OVCs could work more closely with disability networks to better address the needs of PWDs.

Choose your doable actions at each level.

What can *Joshua* do?

- Joshua could use condoms every time he has sex, even with paying partners.
- Joshua could reduce the number of sexual partners he has to protect himself from HIV.
- Joshua could seek prompt treatment of STIs
- Joshua could reduce his intake of alcohol and hard substances to ensure that he always takes care of his health.
- Joshua could go for an HIV test, perhaps with the support of a disability network, to get needed information, confidential HIV testing and appropriate support services for his needs.
- Joshua could find a buddy who he trusts, to accompany him for HIV testing, and be a support if he is found to be HIV positive.

People with visual impairments need audio tapes and Braille information for those who know Braille.

People with hearing impairments do not all speak the same sign language. Some sign language interpreters are uncomfortable using explicit signs around sexuality issues. There is a need for deaf counsellors.

Many buildings are not accessible to wheelchair users – so act as a barrier to their participation.

Parents don't want to discuss sexuality related topics with children with disabilities.

What can the *community* do?

- Joshua's peers could support each other to get informed about HIV and protecting the 'community' through 100% condom use when they have sex.
- Joshua's peers could support each other to get tested for HIV, and taking a positive stance towards prevention, through existing disability networks.
- Disability networks could advocate for rights for people with disabilities to 'culturally appropriate" information, and services (eg. access to trained counsellors through hotlines, HIV testing sites, etc.)
- Joshua's family could educate themselves on the rights and needs of people with disabilities and support Joshua to protect himself from HIV, and prevent unwanted pregnancy.
- Joshua's faith and traditional leaders could educate community members about the rights and needs of people with disabilities and establish support groups for them and their families, establish rules to promote accessible education for all, and protect children with disabilities from unwanted sex, and rape.

Liverpool VCT and Care Kenya opened up the first deaf VCT centre for the deaf run by the deaf in Africa. They now have three stand alone sites, do mobile testing and community mobilisation, have deaf support groups, developed their own IEC materials and peer education manuals for deaf people.

What can the *health system* do?

- The health provider could provide friendly health care to Joshua and his peers by hiring a deaf counsellor to assist in translation – link with deaf network to identify lay counsellors to support work with this community.
- Health facilities could build ramps for wheelchair users, and expand bathrooms for their access. They could make sure at least one room is wheelchair accessible.
- Workplaces could educate themselves on how to be more accessible to people with disabilities
- Vocational schools could set up programmes for people with different disabilities to build their skills and link to labour market.

What can *policy makers* do?

- Policy makers could make all health facilities accessible to wheelchair users.
- Policy makers could set up trainings for HIV and disability organisations to develop strategies together on how to best mainstream disability and HIV related issues into programmes.
- Disability Act exist at national level? State level? What rights does it entail in terms of access to workplace/issues around stigma and discrimination?
- Policy makers could link with vocational training institutions to develop disability friendly skills development programmes.
- Policy makers could enlist the support of NiBUCCA to sensitise private sector on needs and rights of PWDs and explore opportunities for livelihoods development for this group.
- Policy makers could link disability networks with OVC organisations to better support children with special needs.

Step 5

Choose your minimum package of strategic interventions based on your identified barriers at different levels.

Guiding Principles for a Minimum Package of Strategic Interventions for People with Disabilities.

Effective strategic interventions for people with disabilities should:

- **Address Joshua's needs at individual, community, system and policy maker levels.**
- **Be driven by people with disabilities** to define needs, best approaches to reach them, and highlight positive role models' personal stories.
- **Recognise the cultural context** in which deaf people live in as well as their own "culture".
- **Consider urban vs. rural differences** in terms of access to information, key services and literacy.
- **Consider the different circumstances** in which people with disabilities have sex.
- **Address risks to both males and females** around unwanted sex.
- **Draw on the strengths of the "community" gatekeepers** (including networks and community leaders).
- **Critically analyse community cultural and gender values and beliefs** that encourage rape and multiple concurrent sexual partners (particularly among men)
- **Reinforce rights of people with disabilities** to have positive but safe sexual relationships.
- **Have a strong peer mentoring component** focusing on building 'culturally appropriate and feasible" life skills for PWDs by other PWDs
- **Address the wider policy environment** including protection of fundamental rights, and access to disability friendly and accessible RH and HIV related information, products and services.
- **Focus on doable actions on all four levels.**

Behavioural Objectives:

- Reduce multiple concurrent partners.
- Increase correct and consistent condom-use among casual partners and paid sex.
- Increase uptake of family planning methods to prevent passing HIV on to children.
- Increase demand and uptake of accessible STI treatment, HIV testing and HIV treatment services.
- Improve quality of provider client interaction and adherence to treatment protocols in an accessible manner.

Minimum Package of Strategic Interventions:

Level of Intervention	Strategic Interventions	Ideas and Resources to Support Do-able Actions for Each Level
Individual Level Barriers • Lack of personal risk assessment for HIV.	**Media communications** to raise awareness about the relationship between HIV and AIDS and disability, issues around access and vulnerability.	▪ Draw from existing disability networks representing diverse disability needs (deafness, blindness, physical disabilities that affect access, etc.) to guide programming for their populations. ▪ Use the existing disability networks to identify personal stories of members who are successfully dealing with the virus. If no work has been done in this area, draw on role models from the region, where disability networks are more active. ▪ Highlight the personal stories in media communications on the radio, in accessible print formats for the deaf community, and/or use them in video format using sign language where appropriate.
Community Level Barriers • Lack of peer support for people with disabilities • Stigma against people with disabilities • Lack of understanding of the "real" life versus the perceived life of PWDs	**Community mobilisation** to establish disability networks and strengthen CBOs to design accessible materials and programmes for people with disabilities. Community mobilisation to **raise community awareness and action against sexual abuse** of people with disabilities.	• Develop peer education/peer promotion programmes within disability networks • Develop gender-sensitive and adapted/accessible resources for community HIV/AIDS workers to use when educating people with disabilities about HIV. • Work with networks for the blind to produce audio tapes that can be disseminated to blind people. • Have disability networks train CBOs and community leaders on needs and issues of people with disabilities to assist in identifying individuals in need of information and services within communities. • Work with community traditional and faith leaders to speak out against sexual abuse of PWD.

Level of Intervention	**Strategic Interventions**	**Ideas and Resources to Support Do-able Actions for Each Level**
Health Systems Level Barriers • Lack of accessible health services to meet needs of the disabled community.	**Strengthen health care workers and facilities ability to meet the needs of people with disabilities** with accessible information, and services.	• Link health facilities and health program planners at MoH with disability networks to identify ways to improve physical access to health facilities, access to information and related services in culturally appropriate manner. • Identify lay deaf counsellors to support HIV testing and service provision for the deaf community. • Consider developing HIV services specifically for deaf community.
Policy Maker Level Barriers • Lack of supportive policies and programmes to ensure people with disabilities have access to information and services, and participate as decision-makers in policies/programmes to meet their needs.	**Advocacy among policy makers** at national, state and local level to ensure that policies and practices aimed at stopping the spread of HIV include concerns affecting people with disabilities and their families.	• Establish a policy group of disability advocates and HIV advocates to work on the issue of HIV and disability. • Focus on priority issues including physical access to health care information and services. • Integrate disability needs with organisations working with OVCs, in particular. • Enlist support of NiBUCCA to sensitise the private sector on disability needs and rights. Explore ways in which they can support livelihoods training for this group.

2b Working With People with Psychiatric Disabilities (living in Institutions?)

Lami is a 27 year old woman who has been confined to a Psychiatric home for two years now. Lami used to walk the streets barefooted and unkempt. She was always on the move, gathering piles and piles of refuse dumps which she uses to make a home. Sometimes children follow Lami around singing and taunting her while she dances as she revels in their attention. Staff of the social welfare eventually picked Lami and took her to a psychiatric home, where she is now receiving treatment for her condition.

Lami has been severally raped by different categories of people. Sometimes, she is raped by facility staffs who take advantage of her being in captivity, and under their care, other times, by individuals who believed in the traditional myth that "having sex with a mad woman can make a man wealthy".

Lami has had miscarriages and premature deliveries while on the streets. Now she is pregnant again. Even within the facility, she walks around scratching and pulling at her pubic hair, all the time, but no one seems to notice. As her pregnancy has started showing, and in her condition, Lami does not have the mental capacity to either go to an ANC center or seek medication for her STI. Yet, she also needs a Prevention of parent to child transmission of HIV intervention.

Recently, Lami got into a violent and bloody fight with one of her peers and got a big gash on her forehead which was not stitched because no one dared approach her at the time of the injury. In turn Lami also bit the other lady on her forearm. Blood flowed freely. It took the intervention of several guards to separate the two women. Even the guards were not left out of the blood bath.

What can we do as program planners to help Lami?

Know the problem behaviours that affect persons in institutions and the circumstances in which they take place.

Checklist to Consider

What are the key issues affecting men, women, young people and children with in institutions?

Are there unsafe sexual reproductive health practices taking place?

- Are they sexually active?
- Do men, women, young people and children have more than one sexual partner at the time?
- If so, do they use condoms and/or contraceptives to prevent STIs, HIV and unwanted pregnancy?
- Are they exposed to forced sex?
- Do they take hard drugs or alcohol which impairs sexual decision making?

Are there unreliable health seeking behaviours?

- Do people in institutions know their HIV status?
- Do they go for early STI treatment when symptoms are noticed and notify all their partners when they have STIs so that they can get treatment as well?
- Do they disclose their HIV status to someone they trust?
- If they are HIV+, do they access other key SRH/HIV related services such as ART, and PPTCT?
- If they are HIV+, do they live positively with HIV?

Also consider the context in which people in institutions access healthcare or other sexuality issues:

- Are persons with disabilities institutionalized in rehabilitation centre or psychiatric homes?
- Does staff take sexual advantage of inmates within institutions?
- Are they challenged by economic resources, does this promote transactional sex, between PWD and other people in the community?
- Do they feel gratified when they are raped? Is there a problem of low self esteem?
- How does the myth that having sex with a “mad” woman can make a man wealthy promotes Lami’s vulnerability?
- For those outside institutions, where do they live?
- Are they living in cities or rural areas with their families or on the streets
- Are they young in school or out of school?
- Do they suffer from more than one type of disability? Mental and physical disabilities? Hearing or visual impairment as well?
- Are they exposed to drugs especially for those institutionalized in psychiatric homes?
- Are they given to violence and in fighting, and also physical struggle which exposes them to injuries and sharing of blood with other inmates?
- Can they be reached through media of communications? If not, what kind of media can be used to reach each category of persons with disabilities?

Lami's Problem Behaviors

Lami does not have the mental capacity to worry about her health conditions.

Her condition exposes her to multiple sexual partners, who often take advantage of Lami's state of mind to have unprotected sex with her. She does not have the mental capacity to understand any sign of any kind of physical illness let alone STI signs or symptoms. She has no knowledge of her HIV status, and would not know what to even if she did. Lami has no knowledge of PPTCT services, does not attend ANC services, and could not be bothered about the welfare of her unborn child.

Find out which barriers prevent people in institutions to take positive action to protect themselves.

Checklist to Consider

What are the most important barriers to consider in Lami's situation…?

- Does Lami **feel personally at risk** for HIV? Does she have the mental capacity to understand her personal risks?
- Does Lami have the **self confidence and skills** to negotiate safe sex, and access to friendly health services as someone with a mental disability? Is she offended or gratified by rape?
- **Does Lami have a supportive group of family and friends** to advocate for her rights and protection?
- **Do Lami's sexual partners** support her need for safe sex?
- **Does the community talk** about the rights and needs of community members who have disabilities? Their special vulnerability to unwanted sex? Exclusion from education and a normal life?
- Do the **community's cultural norms, beliefs and practices** about people with disabilities and gender further exclude girls, in particular, from having safe and positive sexual relationships if they choose? Deny their rights to education further?
- Is there **stigma** within the community which would affect Lami's ability to participate in the community like everyone else?
- Is the attitude of Health care providers supportive of Lami?
- Are there accessible and friendly health care services to help Lami access STI treatment, HIV related services?
- Is facility staff knowledgeable about Lami's risks and vulnerability to HIV and AIDS? Are they supportive of Lami to help her access PPTCT and other HIV services?
- **Do policy makers ensure that** people within institutions' fundamental **rights are protected?**

Barriers Lami Faces

Individual level:
- *Lami does not perceive her personal risk of HIV and AIDS, because she lacks the mental capacity to do so.*
- *She often feels that she is a "less privileged person" compared to normal people, and is "gratified" whenever "normal people" stoop to have sex with her, in spite of her status. This gives her a feeling of confidence and high self esteem.*
- *She has no capacity to understand the risks of her multiple sexual partnerships to her unborn child.*

Community level
- *Lami lives in an institution where her peers also experience similar challenges.*
- *There is often violence among the inmates which results in physical injuries.*
- *Like Lami, her peers lack the mental capacity to understand their own risks of HIV infection.*
- *Staff of the institution has often sexually abused Lami and hardly take notice of her new pregnancy, or the frequent itching and vaginal discharge.*
- *They are always quick to take away any new born babies within the institution, so Lami and her peers do not perceive the staff as friendly or supportive. In addition, they give them injections and do not allow them to go outside the institution; As far as Lami is concerned they are bad people.*
- *Family and relations have confined Lami to the psychiatric facility and rarely visit.*

Health system level:
- *Health workers are overwhelmed by inadequate facilities to deal with the high number of patients brought in on a daily basis.*
- *They lack adequate knowledge of HIV signs and symptoms, especially among those with intellectual or psychiatric disabilities.*
- *There is high level of stigma and discrimination against persons suspected of HIV infection or AIDS.*
- *They are often neglected and left to die without the necessary care.*
- *Sometimes they are sent back to their families.*
- *Access to HIV and AIDS services is very poor and often non existent.*
- *There are no support facilities to help inmates who are living with HIV, or to offer PPTCT services to the women who are pregnant.*

Policy maker level:
- *Because psychiatrist health facilities are often specialized, the type of services provided tend to be centred on psychiatry.*
- *HIV has not been effectively mainstreamed into this sector. HIV services, such as counselling and testing are often not sited within such facilities. Persons who are mentally challenged can not perceive their own risks, let alone make efforts to stay healthy; there is need for health workers within the facilities to help in making health decisions for them.*
- *This often does happen, as the health workers are busy trying to carry out their routine functions in an already overstretched health facility.*
- *HIV services are often cited in other clinics and locations, there is need for transportation and other incentives to motivate health workers to take on this additional responsibility.*

Identify existing assets and opportunities to help address Lami and other people with psychiatric disabilities' needs.

Checklist to Consider:

- Does the **wider community** hold **values** that frown at the practice of men having sex with people with psychiatric impairments in order to become rich? Can this be tapped into to encourage community sanctions on those who default?
- Are there **community structures** that could be mobilized to enforce rights of people with psychiatric disabilities against rape and sexual violence, especially within institutions?
- Are there **best practices in working with people within institutions** which could be adopted

Consider the following assets and opportunities:

- There are existing facility programs which could integrate HIV services for the inmates
- Many persons with disabilities are already in rehabilitations programs, and could be supported with HIV services within current rehabilitation programs.
- There is a National Public Sector Work Place Policy which can be domesticated within rehabilitation centres and institutions.
- Parental support could be mobilized to ensure that services are provided where government resources may be insufficient.
- Many community level traditional, cultural and faith based structures already frown at rape, and gender based violence, especially targeted at vulnerable populations such as persons with disabilities, therefore this can be used as basis for mobilizing community support to help abolish this practice
- Presence of CSOs willing to work with vulnerable groups is remarkable asset.
- There are laws against rape and gender based violence which could be used to deter persons who force other persons with disabilities to have non consensual sex with them
- Many health care workers are already undergoing stigma reduction trainings at various levels as part of the health sector response to HIV.
- Persons with disabilities are beginning to organize under recognized platforms to design economic empowerment projects. This can be extended to heath issues, especially HIV.

Choose your doable actions at each level.

What can *Lami* do?

Lami may not be in a position to do anything tangible to change her risky behaviors but should be engaged as much as possible to take responsibility for her health and well being.

- Lami should be introduced to an ANC facility for regular checks and for PPTCT
- Lami should access treatment for STIs
- Lami should have access to condoms at all times if she is able to understand how to use them properly.

What can the *community* do?

- Staff and peers should protect Lami to ensure that she has few if any sex partners.
- Other inmates could protect each other from sexual abuse by reporting incidences to trusted facility members.
- The psychiatrist facility staff could initiate a peer education approach among their staff to educate them about the dangers of unprotected sex and risks of multiple sexual partnerships/rape, etc.
- Facility management could take legal action against any staff member having sex with patients.
- The facility staff could also mobilize family well as community members to support inmates with care and treatment services.
- Faith based and traditional leaders could speak out against rape, gender violence, and enforce community penalties on defaulters.
- Traditional leaders could support facilities by making sure that drug peddlers are reported to the authorities immediately.

What can the *health system* do?

- Providers could ensure that there is reduced incidence of stigma and discrimination against inmates who are living with HIV or show sign of STIs.
- Health care providers at psychiatric homes could integrate HIV related services as part of a comprehensive care approach.
- Health care workers could seek the support of CSOs, especially FBOs, to provide peer education programs for facility based staff, especially non medical support staff within the institutions.
- Health workers could advocate for the placement of HIV testing and treatment centers within psychiatric homes to increase access.

What can *policy makers* do?

- Policy makers could provide training to psychiatric health providers on the HIV needs of their patients.
- Policy makers could ensure that HIV service sites are located within easy reach of persons with psychiatric disabilities, especially within such institutions.
- Policy makers could ensure that rape and gender based violence are adequately punished through relevant laws and statutes that will deter people from infringing rights of persons with psychiatric disabilities.
- Policy makers could increase resources devoted to HIV programming for people with psychiatric disabilities to ensure that all avenues for HIV transmission are blocked and that they can live positively with HIV.
- When persons with psychiatric disabilities are rehabilitated, they could be supported to work in organisations to help other persons with psychiatric disabilities with relevant HIV and AIDS services.

Choose your minimum package of strategic interventions based on your identified barriers at different levels.

Guiding Principles for a Minimum Package of Strategic Interventions for People with Psychiatric Disabilities (in Institutions)

Effective strategic interventions for people with psychiatric disabilities should:

- **Address Lami's needs at individual, community, system and policy maker levels.**
- **Engage persons with psychiatric disabilities** in the design and implementation of all programs,
- **Address the context of risk** for people with psychiatric disabilities.
- **Focus on community, cultural, and gender norms** to address male responsibility and reduce gender based violence against females with disabilities
- **Address the wider policy environment** within which disability issues are handled
- **Integrate and mainstream HIV effectively into routine services** provided to people with psychiatric disability

Behavioural Objectives:

- Reduce multiple concurrent partners.
- Increase correct and consistent condom-use among sexual partners.
- Increase uptake of family planning methods to prevent passing HIV on to children.
- Increase access to STI treatment, HIV testing, PPTCT and HIV treatment services.
- Improve quality of provider client interaction and adherence to treatment protocols in an

- **Draw on the strength of existing services provided**, within the facility, and by other CSOs working with vulnerable groups in the communities
- **Draw from best practices** in working with persons with psychiatric disabilities in other settings.
- **Address the wider policy environment** including protection of fundamental rights, and access to disability friendly and accessible RH and HIV related information, products and services.
- **Focus on doable actions at all levels.**

Minimum Package of Strategic Interventions

Level of intervention	Strategic interventions	Ideas and resources to draw on to support do-able actions.
Individual level barriers • Lack of risk perception, • Lack of relevant life skills and self-esteem.	**Develop life skills** for people with psychiatric disabilities through mentoring/support approach using individuals with strong counseling skills and relevant disability networks.	• Use peer group approach to address group risk for sexual abuse, and identify, together, workable strategies to protect themselves and each other from risk behaviours. • Develop self-esteem and rights of all people living with psychiatric disabilities.
Community level barriers • Lack of peer/caregiver support • Cultural norms/practices that put people with disabilities at risk for non-consensual sex, and stigma	**Media communications target cross-cutting issues of sexual assault** and vulnerable populations including people with psychiatric disabilities, emphasising male responsibility for risk behaviour. **Community mobilization targets caregivers within institutions and family members** regarding the risks of sexual abuse, and HIV.	• Provide peer health education programs among facility staff regarding risks and consequences of sexual assault of patients. • Community and traditional leaders to mobilize against gender based violence, rape, and sexual abuse. • Mobilise families to support institutionalized members, and ensure their rights are not infringed upon. • CSOs to focus on rights of persons within institutions particularly for those living with HIV.
Level of intervention	**Strategic interventions**	**Ideas and resources to draw on to support do-able actions.**

Health systems level barriers • Lack of supportive and accessible health services for people with psychiatric disabilities.	**Mainstream HIV related information and services into routine institutional health care services** for people with disabilities. **Build capacity of facility level staff in HIV** to reduce stigma and discrimination and increase the quality of services within the facilities	• Train healthcare workers on HIV mainstreaming for persons with psychiatric disabilities • Provide comprehensive condom programs that ensure access, condom use skills and harp on correct and consistent use. • Train healthcare workers on stigma reduction • Train healthcare workers on post exposure prophylaxis • Package information/BCC materials that are target specific and address the unique contexts of persons with disabilities living in institutions.
Policy level barriers • Lack of supportive policy environment to adequately mainstream unique needs of people living in institutions and protect them from sexual abuse.	**Advocacy to policy makers to develop comprehensive plan for mainstreaming HIV into "at risk" settings** like institutions for people with psychiatric disabilities. **Ensure legislation against sexual abuse is in place at all levels** and implemented effectively.	• Map Institutions for people with psychiatric disabilities and those in institutions. • Conduct in-depth formative assessments, analyze behavioral gaps, in relation to HIV and STI services, based on outcome, and design an intervention strategy. • Advocacy to gain policy makers and stakeholders support for persons with psychiatric disabilities and those in institutions. • Ensure linkages and referrals between services Design a capacity building strategy and plan for persons with psychiatric disabilities and their gatekeepers.

Chapter 8:

Working with Transport Workers & Other Men who Travel Often

1 Working with Transport Workers and other Men who Travel: Background

1. Key Issues:

James represents the needs of truck drivers and other men who travel. While army, police and transport workers returned HIV prevalence levels considerably lower than the 2005 general population estimates in the IBBS (2008), 30-40% of all three groups reported multiple sexual partnerships during the 12 months leading up to the survey. They also reported higher prevalence of STI symptoms including genital ulcers/sores and unusual genital discharge. Like female sex workers, condom use was far less likely to be reported in boyfriend/girlfriend relationships. While the focus is on truck drivers, there are other key groups to consider in this strategy including migrant workers, fishermen, men who work on oil rigs, areas of conflict, etc. This group is also critical to address because they reflect gender and sexual norms that encourage men to have multiple concurrent sexual partners.

2. Problem Behaviours:

Unsafe SRH behaviours

- Transport workers and other men who travel have multiple concurrent sexual; partners
- Transport workers and other men who travel have sex with commercial sex workers do not use condoms consistently or correctly.
- Transport workers and other men who travel do not use condoms with girlfriends or casual partners.

Unreliable health seeking behaviours

- Transport workers and other men who travel do not go for HIV testing to know HIV status
- Transport workers and other men who travel do not access early STI treatment or notify all their sexual partners.
- Transport workers and other men who travel do not go for HIV testing.
- Transport workers and other men who travel do not access other key SRH/HIV related services including HIV treatment.

3. Behavioural Objectives:

- Reduce the number of multiple concurrent sexual partners.
- Increase correct and consistent condom-use among girlfriends and casual partners.
- Increase demand and uptake of STI treatment, HIV testing and HIV treatment services (and notify partners for referral)
- Improve quality of provider client interaction and adherence to treatment protocols
- Develop supportive legal environment and accessible health delivery system.

4. Key Strategic BC Communication Objectives for Interventions

Level of Intervention	Key BCC Objectives	Key Interventions
Individual Level	• Increase personal risk perception • Develop culturally and gender responsive appropriate life skills • Reduce myths and misconceptions	• **Media communication** on key themes using all channels • **Peer/mentoring** with life skills
Community Level	• Increase community dialogue • Reduce reported stigma and discrimination • Reduce reported gender inequalities • Modify high risk cultural practices • Strengthen peer and community support groups	**Community transformation** (communities, workplaces, places where people meet) to address stigma, harmful cultural and gender norms, and strengthen community response for referral and service delivery.
System Level	• Strengthen positive provider-client interactions • Increase access to condoms and family planning • Increase number of HIV related service sites • Increase referral to HIV related services including ART.	**Increasing access to quality products and services** by strengthening provider –client interactions for education and adherence, positioning key products where clients can reach them easily, and increasing visibility of quality services through branding.
Policy Maker Level	• Increase friendly workplace policies • Increase supportive legislation	**Advocacy to address the wider policy environment** that determines access, protects fundamental rights, and fosters linkages between sectors.

2 Working with Transport Workers and other Men who Travel: James' Story

James has it made. He has been working as a long haul truck driver for a big company for some years now, has a bit of money, and a great life. He has two wives - one in the village where he comes from outside Kano, and another in Taraba State where he travels through every week for his deliveries. Sometimes he is sent to other places, and he's got enough money to buy as many women as he wants. They seem to just swarm over him!

He has heard about HIV through the radio, but doesn't really worry. He is pretty confident that his two wives are faithful to him, and if he doubts the cleanliness of the other girls he is with, he uses a condom. But most of the time, he meets more up class women in the bars, canteens or the market, and only rarely in the brothels where condoms are expected. He also suspects that HIV is transmitted by mosquitoes and doesn't know anyone who looks infected by HIV who could pass it to him.

He doesn't really like using the condoms, because he can't feel as much, and the girls he is with also seem to prefer the real thing. Anyways, he has heard from some of his friends that condoms are not really so effective, and can even spread HIV. Of course, with his wives, he won't use anything, because he wants to have a big family.

His friends think he is very lucky – they know he is becoming a big man and has the lifestyle to prove it. If he is around, he often pays for his friends' drinks and even women if he is feeling generous.

Ben is a police officer who suspects he may be HIV +. Like his peers, he has had lots of girlfriends, and station wives in places where he travels – particularly in places of crisis. He hasn't gone for an HIV test yet, because he knows that if he is seen there, it would be the end of his life. He is afraid to ask for advice from any of his workplace friends because men in the uniformed forces are supposed to be invulnerable to death. Secretly though, he knows that they fear HIV as much as he does. Others who were found to be HIV+ were kicked out of the forces, and struggle to get their basic rights protected. The uniformed forces have their own rules and only the strong are welcomed.

Although he has some unusual discharge and pain when he urinates, he doesn't have the time to go to the health centre. It is easier and far more effective to buy the drugs he needs at the local pharmacy. They all know what to do. Besides, he wouldn't feel comfortable going to the health centre. Everyone believes that strong men don't get ill – asking for help makes them weak like a woman.

What can we do as program planners to help?

Know the problem behaviours that affect truck drivers and men who travel a lot in your area and the circumstances in which they take place.

Checklist to Consider

Are there unsafe sexual and reproductive health behaviours taking place?

- Do men who travel **have more than one sexual partner** at the same time?
- Do they **use condoms consistently and correctly** with all their sexual partners?
- Do they **drink alcohol daily** which impairs decision regarding safe sex?

Are there unreliable health seeking behaviours?

- Do men who travel go for HIV testing to **know their HIV status**? If they are HIV positive, do they **disclose to all their sexual partners**?
- Do they **go for early STI treatment** when symptoms are noticed? Do **they notify all their sexual partners** so that they can get treatment as well?
- Do they access **other key SRH/HIV related services** (such as PPTCT and ART)?

Men who travel or spend a great deal of time away from their homes, have different occupations, levels of education, and access to wealth. You may need to also consider the risk behaviour of the following groups in your area.

- Other transport sector occupations including bus drivers, taxi drivers, motorboys (conductors), pilots
- police officers
- soldiers
- fishermen
- Migrant workers
- Any person who worked away from home for long periods of time

You need to **keep in mind the circumstances in which men who travel have their multiple sexual partners**

Do they have ….

- Station/Informal wives?
- Paid sex through brothels?
- Paid sex through bars, entertainment centres, markets, restaurants, or on the streets?
- Are they exchanging sex for gifts, rent, etc.

James' Problem Behaviours

James has many sexual partners at the same time – his village wife, city wife, and other women he meets when he travels.

He rarely uses condoms to prevent passing or getting HIV with any of his sexual partners.

He does not get treatment for his STIs, know his HIV status, or access other related services including family planning for his families.

He does not tell his sexual partners that they also need to get STI treatment, or go for HIV testing.

Find out which barriers make it difficult for truck drivers and other men who travel to take positive action to protect themselves.

Checklist to Consider

What are the most important barriers to consider in James' situation?

- Does James feel **personally at risk for transmitting HIV,** not only from his paid sexual partners, but also his casual partners, and wives? Does he feel he could pass it on?
- Are there **myths and misconceptions** that affect his willingness to learn more about how HIV could affect him?
- Does he have the **confidence and skills** to control the amount of alcohol he takes with his friends and use condoms with his sexual partners? Access needed health care? Discuss the importance of HIV testing for himself and his wives?
- Are James's **sexual partners likely to be supportive** of him asking for condoms during sex? What about his wives?
- Are James' **friends supportive** of him reducing his sexual partners? Using condoms during sex?
- Does **stigma within the community affect everyone's beliefs** about who gets HIV and how they should be treated? Who uses condoms?
- Are there **cultural norms** that encourage men to have multiple sexual partners? Delay access to needed health services?
- **Are there accessible and friendly health services** where James can go for information, counselling and services?
- **Are accessible support services there** to help him if he were found to be HIV positive?

Consider the different communities and gatekeepers available to men who live away from their homes for long periods of time (ie. In barracks, temporary communities for fishing, etc.)

Barriers James Faces

Individual level:

- *James does not feel personally at risk for HIV nor does he trust the efficacy of condoms.*
- *He believes his wives are faithful to him, and that his other casual partners are HIV free.*
- *While he feels confident in general, it is likely that he would not find it very easy to introduce condoms into many of his existing relationships.*
- *He also does not feel very confident about accessing health care as a man, nor discussing difficult issues with his regular partners.*
- *(He may feel invulnerable to HIV as a wealthy man, or fatalistic about death as a man who lives with the constant danger of car accidents).*

Community level:

- *James's peers support his risky behaviour because big men are believed to have many sexual partners, big families, and are too strong to get sick and need help. They also support each other to drink alcohol, perhaps use other drugs, which impairs their ability to negotiate safe sex with their partners.*
- *It is likely that community norms support these views about "being a real man" and reinforce stigma around condom use.*
- *It is also possible that certain cultural practices (e.g.* long postpartum abstinence, frequent informal divorces, and polygamy influence extramarital affairs.)
- *Temporary community settings, like barracks, can also promote the presence of hot spots where FSWs, MSM, alcohol and drug use are widely available.*

Health system level:

- *The health provider is not perceived as being convenient, nor is the health centre a place where strong men like James go unless they are very ill.*
- *There is also stigma of people who go for treatment of STIs by health workers.*
- *We don't know if condoms are widely available for James to access or if he would go to health facilities if they were less money, open when he is able to go.*

Workplace level:

- *His employer may not take responsibility for protecting the sexual safety of drivers like James – who travel a lot.*
- *We don't know if James' employer would protect his basic rights as someone living with HIV as, men, in other professions like the armed forces, have been dismissed from their job .*

Policy maker level:

- *Although the National Workplace Policy has been adopted, the transport sector has not yet domesticated it for implementation.*

Identify existing assets and opportunities to help address James' and other PWD's needs?

Checklist to Consider:

- Does James have **values** that would be a benefit **to address his own risk for HIV?** Take more responsibility for his own behaviour?
- Does the **community have traditional values** that can positively address notions of masculinity which encourage men to take risks?
- Does the community have **traditional structures** that could be mobilised?
- Can James's **workplace support** him to take fewer risks and access health care?
- Are there **male and female role models** that could support James to behave differently?
- Are there **examples of good community materials** that could be used to facilitate community dialogue?
- Are there **examples of workplace policies and programmes** that could support James's access to relevant information and services?
- Are there **examples of innovative ways of delivering health care to mobile populations?**

Examples of opportunities:

- Important values around masculinity, like strength, could be redefined to take preventive behaviours
- Traditional values in the community around male responsibility, leadership, protection of the family could be used to mobilise traditionally male groups around protection of the community's future children.
- Traditional leaders, courts play an important role in influencing male behaviour.
- Faith communities are strong and are willing to speak about HIV prevention.
- There is a highly organised transport system with a strong union and leadership structure (NURTW)
- Transport workers are highly networked and have a strong channel they use to pass information across to all members.
- Transport workers listen to the radio and enjoy programmes like 'Gari Muna Fata', Odejinjin'.
- Condoms are easily available and affordable, and
- There is a national workplace policy on HIV and AIDs that needs to be effectively domesticated for the transport sector and implemented across transport, and uniformed services organisations
- Promotion of VCCT and STI treatment to increase with increased donor funding
- PEP + for Transport Workers and Uniformed Services exists and is being implemented in many states. This could be used to identify positive experiences for other states.
- There is Increased NGO activities in the field among the uniformed services (AFPAC)
- There are examples of existing Private sector Workplace Programmes (ie. Afam Project: Shell Petroleum) which could support other employers who want to set up programmes in their area.

Choose your doable actions at each level.

What can *James* do?

> *Media messages and male peer educators in South Africa focus on the strength of men who take care of their health and protect their families using personal stories, and messages such as "my strength is for not hurting", I show my strength by getting an HIV test. (EngenderHealth)*

- James could reduce the number of casual and paid sexual partners he has (to at least one or two less).
- James could keep condoms on him at all times to use consistently with his paying and non-paying partners.
- James and his friends could limit the amount of alcohol they drink to keep them strong and fit.
- James could talk to a friend that he trusts and respects around his fears about HIV.
- James could go for HIV counselling and testing (with his long-term sexual partners) to prevent passing HIV on to their children.
- James could go to a health facility to get treated for his STIs (and encourage his partners to get treated as well).
- James could encourage his friends to take responsibility to protect their families as well, by reducing sexual partners.

What can the *community* do?

> *Nigeria's **PEER EDUCATION PLUS Toolkit** has been developed for transport and uniformed workers They are using trained peer transport workers as educators to help men organise to protect themselves and each other from risk.*

- James and his friends could support each other to reduce sexual partners, and use condoms consistently.
- Traditional leaders, courts, in hot spot areas as well, could be mobilised to address cultural and gender norms that encourage risky behaviour.
- Faith leaders, in communities and temporary settings, like barracks, could speak out on the dangers of masculinity norms that encourage multiple partners, and address stigma that affects everyone's ability to know their HIV status, and protect themselves from risk (rather than spread misconceptions about condoms)
- Community to set up a group to enforce rules by traditional leaders (based on what was written)

What can the *health system and workplace* do?

- James's employer could make HIV related information and condoms easily available to James and other employees.
- James's employer could support James's access to health care by setting up a formal agreement with a health facility to provide health care within the office.
- James's employer could have a workplace policy to protect all employees from HIV related stigma and discrimination and increase their access to testing and treatment.
- James workplace could support financial planning through collaborations with banks to encourage James to save money, acquire property and earn a pension on retirement.
- Health providers could provide friendly, non-judgemental health care services to all people who come for STI, HIV and RH related services.
- Health providers could offer tailored regular mobile counselling and testing services at hot spots and joints where James and other mobile groups frequent.

What can *policy makers* do?

- Policy makers could support the effective implementation of the workplace policy and programmes.
- Policy makers could explore making HIV testing and STI screening available in hotspots where people meet.
- Enforce and implement anti stigma policies and programs at all places.

Choose your minimum package of strategic interventions based on your identified barriers at different levels.

Guiding Principles for a Minimum Package of Strategic Interventions for Transport Workers and Other Men who Travel.

Effective strategic interventions for men who travel should:

- **Address James' needs at individual, community, system and policy maker levels.**
- **Be driven by the priority audience** (ie. transport workers, police, fishermen, migrant workers, etc.) to identify needs, best approaches to reach them, and identify role models from within the group.
- **Have a strong peer mentoring component** focusing on building 'culturally appropriate and feasible" life skills for men by men.
- **Draw on the strengths of the "community" gatekeepers** (including workplace and unions).
- **Focus on community cultural and gender norms** to address male responsibility and risk to reduce multiple concurrent partners and increase safety of sex.

Behavioural Objectives

- Reduce the number of multiple concurrent partners
- Increase correct and consistent condom-use among girlfriends and casual partners.
- Increase demand and uptake of STI treatment, HIV testing and HIV treatment services (and notify partners for referral).
- Improve quality of provider client interaction and adherence to treatment

- **Address the wider policy environment** including protection of fundamental rights, and access to male friendly RH and HIV related products and services.
- **Focus on doable actions on all four levels.**

Minimum Package of Strategic Interventions:

Level of Intervention	Strategic Interventions	Ideas and Resources to Support Do-able Actions for Each Level
Individual Level Barriers • Low risk perception among men who travel about risks of multiple partners, role of alcohol in risk, and importanc e of condom use.	**Media communications** focus on **the reduction of multiple concurrent sexual partners and 100% condom use for safe sex** in hot spots (ie. markets, bars, eating establishments, entertainment centres, etc.) where men and women meet for sex. **Highlight benefits** for men and women in hot spots to get early treatment for STIs and know their HIV status. Emphasise that everyone is at risk, so everyone should know.	• **Use personal stories of men** drawing on experiences of existing PEP Plus CSW networks (highlight different contexts in which sex is exchanged and the importance on developing skills to address risks with casual partners and boyfriends as well. Ensure that doable actions identified are really perceived as doable by them. • **In hot spots, use personal stories that focus on couple's strategies**. Such as "We protect each other". • **Why Wait? Campaign to encourage early STI treatment** for men and women (reinforce with print that focus on different key benefits using humor: STIs are easy to treat, services confidential, protects from infertility, HIV transmission, etc.) • **Promote HIV testing** through state led HIV testing weeks? Use special events, festivals, and armed forces days to increase access to HIV Testing Campaigns. • Target business men through communications through travel and telecommunications channels (ie. Interactive tools within national flights, within airports, etc.), strengthen links with telephone companies to link appropriate role models/messages with telephones (ie. "Nigerians Together: Keeping Our Community Strong" concept)
Level of Intervention	**Strategic Interventions**	**Ideas and Resources to Support Do-able Actions for Each Level**
Local Community /Workplace Level Barriers • Insufficient peer support. • Insufficient workplace support to	**Advocacy and community mobilisation within workplaces** to sensitise men regarding risks of multiple partners, need for 100% condom use and reduction of stigma.	• **Incorporate stories into existing PEP Plus for transport workers, uniformed forces toolkit to support problem solving** around what men can do differently: identify "culturally appropriate life skills to practice doable actions to address substance abuse, negotiate safe condom use, strategies for regular STI screening, HIV testing – PMTCT. • **Adapt PEP Plus to meet needs**

reduce multiple partners, and support condom use.		**of new groups identified** including motorcycle drivers, bus drivers, fishermen, men who work on oil tankers, etc. • **Establish workplace policies and programmes** to strengthen men's access to information, condoms, referral to related services, and addresses wider stigma around PLWHA and condom use. • Establish peer education clubs (parks, garages,) for intervention groups
Wider Community Level Barriers • Risky cultural and gender norms that put men and women at risk for multiple concurrent partners, unsafe sex without condoms.	**Wider community mobilisation** targets all men **through community traditional and faith leaders**, **to address cultural and gender norms** that encourage multiple concurrent sexual partners among men and **stigma.**	• **Mobilise traditional rulers, and community members to dialogue around risks of traditional notions of masculinity** and promote new positive norms for "strong" men. (Draw on examples of real men from African Transformation Toolkit as a starting point for dialogue) • **Establish/strengthen men to men peer education programmes** to develop 'male appropriate' life skills, and support. • **Address community level stigma against PLWHAs** that affects men's willingness to go for HIV testing, disclose their HIV status, and use condoms. • **Empower faith based and community leaders through capacity building** to mainstream RH and HIV issues into their routines.
Level of Intervention	**Strategic Interventions**	**Ideas and Resources to Support Do-able Actions for Each Level**
Health System Level Barriers Lack of access to RH products and friendly services.	**Increase access to male condoms** in places where men and women meet (e. brothels and hot spots) **Strengthen provider/client interaction** to increase demand for RH and HIV related services. **Increase access to quality RH and HIV related services** by	• **Link with private sector** to invest in condom vending machines so they are sustainable. • **Ensure workplaces provide condoms** for employees who travel. • **Place condoms in all hotels, entertainment centres, drinking establishments, etc.** • Provide health centre providers with friendly educational flipcharts to support facility based STI treatment, and HIV counselling. • Increase visibility of health centres

	exploring outreach service delivery to most at risk populations	of excellence to increase morale of providers. • **Explore provision of referral coupons through workplaces** to increase demand for STI treatment and HIV testing. • Conduct state led HIV testing week to promote testing of everyone. • Establish routine mobile testing services in hot spots.
Policy Maker Level Barriers Lack of supportive policy environment for condoms and services to be widely available.	**Advocate for enabling policy environment to increase men's access to condoms, HIV testing and STI treatment** through workplace policies and programmes, and outreach services.	• Advocacy for improved working conditions for health providers, highlight and reward best practices by facilities and states that are providing quality care to all populations in need. • Advocacy to policymakers to make condoms available at all hotels, and entertainment centers. • Advocate for workplace policies and programmes to be implemented among all key companies/networks for men who travel. • Work with finance institutions to support investments among USM and TW to reduce the influence of loose cash. • Advocate to institutional leaders to support these interventions at all levels. • Advocate to leaders of NURTW , other TW Unions and Uniformed Personnel authorities to implement the national HIV and AIDS workplace policy • Link services and ensure effective referral, partnerships, collaborations and linkages, and sharing of best practices.

Chapter 9:

Working with Women & Men of Childbearing Age

1 Working with Women & Men of Childbearing Age: Background

1. Key Issues:

Binta's story represents the needs of all women and men of childbearing age in the general population, though looks at the particular risks for women.

- High prevalence of HIV among women is due to a range of factors including biology, gender and socio-cultural norms that relegate women to lower status & decreased decision-making power and encourage men to have polygamous relationships.
- High birth rates in Nigeria, coupled by prolonged breastfeeding among women, also increase the risk for parent to child transmission of HIV.
- Women and girls face additional risks of violence for refusing sex, requesting condoms, accessing testing services, and for testing positive and often have little access to education, income generation opportunities, and services.
- Women and girls also bear the greatest burden of care for those living with HIV, and for orphans.

2. Problem Behaviours:

Unsafe SRH Behaviours

- Men and women have multiple concurrent sexual partners.
- Couples that don't know their HIV status, do not use condoms for dual protection to protect themselves from STIs, HIV and unwanted pregnancy.
- Discordant couples do not use condoms to prevent HIV transmission to their partners.

Inconsistent Health Seeking Behaviours

- Men and women do not seek early treatment for STIs that facilitate HIV transmission or notify their partners that they have an STI for early referral.
- *Women (and partners) do not use PPTCT related services.*
  - Women (and their partners) do not access HCT services before getting pregnant, during pregnancy, or when breastfeeding.
  - Women (and partners) do not disclose their HIV status to their partners.
  - Many women who have stated they would like to use FP methods, do not use modern contraceptives to space or limit the number of children (in light of HIV)
  - Women (and partners) do not attend ANC four times while pregnant or deliver with skilled attendant.
  - Pregnant women with complications often delay access to EOC and die
  - Women do not go for postnatal care during the first week
- *Women who are HIV+ do not seek advice/support to protect their newborn from HIV transmission (utilise proper infant feeding procedures)*
  - HIV + women mix feed during the first six months (no EBF or choose exclusive safe infant feeding option).
  - Women do not transition safely from exclusive breast feeding to safe replacement feed after six months (and safe weaning).

3. Behavioural Outcome Objectives:

- Reduce the number of multiple concurrent partners for both men and women.
- Increase correct and consistent condom-use among couples for dual protection
- Increase uptake of family planning methods.
- Increase uptake of HIV testing and PPTCT services by couples.
- Increase uptake and adherence to ART for men, women and children who are HIV positive.
- Reduce the number of PLWH reporting stigma and discrimination.
- Develop supportive legal environment to address gender inequalities and strengthen an accessible health delivery system for couples.

4. Key Strategic BC Communication Objectives for Interventions

Level of Intervention	Key BCC Objectives	Key Interventions.
Individual Level	• Increase personal risk perception • Develop culturally and gender responsive appropriate life skills • Reduce myths and misconceptions	• **Media communication** on key themes using all channels • **Peer/mentoring** with life skills
Community Level	• Increase community dialogue • Reduce reported stigma and discrimination • Reduce reported gender inequalities • Modify high risk cultural practices • Strengthen peer and community support groups	**Community transformation** (communities, workplaces, places where people meet) to address stigma, harmful cultural and gender norms, and strengthen community response for referral and service delivery.
System Level	• Strengthen positive provider-client interactions • Increase access to condoms and family planning • Increase number of HIV related service sites • Increase referral to HIV related services including ART.	**Increasing access to quality products and services** by strengthening provider –client interactions for education and adherence, positioning key products where clients can reach them easily, and increasing visibility of quality services through branding.
Policy Maker Level	• Increase friendly workplace policies • Increase supportive legislation	**Advocacy to address the wider policy environment** that determines access, protects fundamental rights, and fosters linkages between sectors.

2 Working with Women & Men of Child Bearing Age: Binta's Story

Binta is a woman 6 months pregnant with her third child.

Like all pregnant women in her community, she knows that childbirth is a risky time. Many women die in her village. Binta, herself, had a big scare during her last delivery when her baby was turned the wrong way and wouldn't come out. She was very thankful that her baby was delivered safely in the end and that she survived. Both Binta's children were delivered by the TBA in the community and she trusts that her spiritual prayers will once again protect her, and bring her third child into the world safely as well.

She has heard about ANC services for pregnant women but has never been. She would need permission to travel and her husband and mother-in-law don't really see the point in going. The distance is far, cost is high, and rarely do the health providers show any compassion towards poor women like her, or have the drugs, supplies to do anything of value. She is also a bit afraid to ask for the money to travel because resources in the family are limited. She and her husband have had many quarrels about money that have ended in her being beaten and threats of divorce. Anyway, she believes her husband secretly fears that if she were to go to the health centre, she would take medicines to stop having children, which he believes makes him more of a big man in the community.

She has also heard something about passing HIV to her unborn child from one of the other women in the community. While she is unsure about her own risk for HIV, she knows her husband has other girlfriends outside of the family, but there is nothing she can do about it. The community feeling is that all men are polygamous. Her husband and his family have also already warned her that if she does not behave well, they will bring in more wives. She tries to please them, even offering to contribute financially to the household to meet the costs of her increasing family, but this is not acceptable within her community. A woman can only accept.

She can't talk to anyone about her concerns. The health providers are not considered very friendly, and no one in the community seems to be very knowledgeable about these things. As a woman, she must rely solely on her husband for help.

What can we do as program planners?

Step 1

Know the problem behaviours that affect women and men of childbearing age in your area and the circumstances in which they take place.

Checklist to Consider

What are the key issues affecting women and men of childbearing age in your area?

Are there unsafe sexual reproductive health practices taking place?

- Do men have more than one sexual partner?
- Do women have more than one sexual partner?
- If so, do they know their HIV status?
- Do they use condoms consistently either with each other, or with all other partners, to protect each other from HIV?

Are there unreliable health seeking behaviours?

- Do they go for early STI treatment, and notify all their partners?
- Do they choose suitable contraceptives that prevent unwanted pregnancy or space their children?
- Do they use condoms for dual protection?
- Has either of them gone for HIV test but without their partner?
- Have they gone for HIV testing as a couple to know their HIV status to prevent parent to child transmission of HIV?
- Access health services to prevent passing HIV onto their children?
  - Go for ANC four times?
  - Deliver their baby with skilled attendants?
  - Go for postnatal care during the first week?
  - Choose an exclusive safe feeding option for their child?
- Seek help if the wife is physically beaten?

Binta's Problem Behaviours:

Binta and her husband do not access health services to prevent passing HIV on to their unborn child. (no ANC, skilled attendants, etc.)

Binta's husband has multiple sexual partners that could put Binta and her child in danger for HIV.

Bitna and her husband do not talk about SRH issues that could protect both of them, and their children from health risks.

Find out which barriers make it difficult for women and men of childbearing age to take more positive action to protect themselves.

Checklist to Consider

What are the most important barriers to consider in Binta's situation?

- Does Binta **feel personally at risk**?
- Does Binta have the **self confidence and skills** to negotiate her right to safe sex with her husband, or access to protective health services?
- **Does she have a supportive group of family and friends** to advocate for her right to make such decisions?
- What is the **role of Binta's mother-in-law and other family members**?
- **Does Binta's *husband* take responsibility** for the fact that having sex with other women increases his risk for HIV and for passing HIV to his wife and future babies? Risks about domestic violence?
- **Does the *community* talk** about the importance of protecting women, children and the community from early death, HIV, and domestic violence?
- Do the **community's cultural norms, beliefs and practices** about men and women's social roles put her and her husband at risk for HIV?
- Is there **stigma** within the community which would affect Binta's willingness to go for an HIV test and disclose a possible positive result to her husband? Her husband's willingness to go with her and get tested as well? Support for her to take care of her health and the health of her baby to prevent passing HIV to her baby?
- **Are culturally appropriate health services available** to her to prevent passing HIV on to her baby? What is the role of the TBA to protect Binta and her child from HIV? Would Binta's husband be welcomed at the facility if he went to the health centre with her?
- **Do policy makers ensure that health services are well-stocked, affordable, and have friendly skilled providers available** to meet Binta and other community member's needs in the community?
- If they work for a **large company**, does that company or **union** have supportive policies for HIV prevention, care and treatment?

Barriers Binta Faces

Individual level:

- *Binta does not feel very much at risk for HIV or maternal death, although her risk might be quite high.*
- *However, as a woman in her community, Binta has little control over her own body and ability to exercise her basic rights.*
  - *She has no right to go to health facility for maternal child health services, family planning, STI treatment, of HIV testing without her husband's permission.*
  - *She can not decide to use condoms by herself, and would only be able to use family planning in secret.*
  - *She has no access to any income, or trade, except her husband's support.*
  - *She has little ability to protect herself even from physical violence in her own home.*

Community level:

- *Binta has no control over her husband who has multiple partners and can put her and her unborn child at risk, and puts her physical and emotional health by beating her.*
- *All the men and women of the community believe that men are supposed to have multiple partners, and that women must do what the husband (and mother-in – law) says. This affects both Binta's lack of empowerment regarding decisions affecting her health and her baby's health, and her husband's risky behaviour.*
- *The TBA, even if trained, will not be able to save Binta from emergency complications related to home delivery, nor can she prevent HIV transmission through delivery.*
- *General stigma in the community around HIV makes it difficult for Binta and her husband to discuss the possibility of HIV in the family, access HCT and PPTCT services, disclose a HIV+ result to each other, to the family and the community and receive support to feed and care for her child.*

Health systems level:

- *The health facility is not seen as accessible to Binta's family – far away, and too expensive. Even if she could go to the facility, it is likely that there are no drugs, or equipment – she will need to have income of her own to buy the things she needs.*
- *The health providers are not seen as friendly to poor women, and do not have the basic drugs and supplies required to run quality services.*
- *Stigma around HIV by health providers might also affect Binta's access to friendly HIV related services.*

Policy maker level:

- *It may be that change will be necessary at policy maker level to address training for health providers, costs, drug issues, and location of health services.*
- *They may also need to look more closely at the relationship between the formal health sector and the informal health role that often untrained TBAs play in many communities.*

Identify existing assets and opportunities to help address Binta and other women & men's needs.

Checklist to Consider:

- Does the community have **key values that would be a benefit to address cultural beliefs and practices** that put men and women at risk?
- Does the community have **traditional structures that could be mobilised** to address community norms and practices that put Binta and her husband at risk?
- Are there **male and female role models** within communities that could be used to promote community awareness and dialogue around new ways that men and women could interact with each other, community groups and leaders that are addressing harmful community norms, or offer examples of positive community action?
- Are there **examples of good community materials** that could be used to facilitate community dialogue?

Examples of opportunities:

- Importance of the protecting the future of the community, reinforced by the fact that all Nigerians have a strong loyalty to their home of birth, and always go back to their home.
- Belief that during breastfeeding, a woman is to abstain completely from sexual intercourse" could be used to strengthen understanding of the importance to protect the baby – though need to explore safe alternatives to protect from risks of multiple partners.
- Belief that condoms should be used during breast-feeding to prevent spoiling the breast milk could possibly be used to promote condom use during pregnancy.
- Role models of assertive, self employed females/males to draw on for female empowerment and the "responsible" male.
- Faith and traditional leaders are very influential, willing to act as role models, and could be mobilised to raise awareness around socio-cultural norms that put men and women at risk, to delay first pregnancy and promote PPTCT services.
- Increasing readiness of faith-based and religious organisation (churches, mosques) to permit open discussion of SRH issues including talks on HIV & STIs.
- Religious sermons, media advocacy, community and town hall meetings to also be serve as tools for advocacy.
- Birth preparedness kits will be socially marketed to all women attending ANC and could include PPTCT related information.
- Pharmacies are widely available and the first place for contact by many community members.
- Markets where people meet can be a place for information and access to products.
- FBOs and CBOs could be mobilised to develop strong community based support networks for couples, and HIV+ mothers.
- SNR s community drivers of change program mobilised local leaders for stigma reduction in six states and has been locally sustained.
- Nonhuman condom dispensers could be made widely available through private-public sector partnership to increase access/reduce stigma.
- Some research showed high attendance for ANC, so this could be utilised for outreach, and possible integration of HIV related services.
- PPTCT services are being scaled out.
- Gov't receptivity to national policy direction – active national policy and response to HIV and integration of HIV with RH.

Step 4

Choose your doable actions at each level.

What can *Binta* do?

- Binta could organise with her friends to advocate for greater community responsibility in addressing the RH needs of women- including support for women who are HIV+.
- Binta could organise a peer education programme among the women the community to help others like herself.
- She could start a business to complement family income, (perhaps with her mother in law?)
- Binta could find a counsellor to help her and her husband learn to talk to each other.
- Binta could seek support from family members who want to protect her from physical and emotional violence.
- Binta could assert herself and demand to be treated better.

M2M is a peer mentor programme to provide psychosocial support to women who are HIV+ through other trained mentor mothers in the same situation. They help women to disclose their HIV status to one person they can trust, and help them to adhere to medical recommendations to prevent passing the virus to their babies.

What can the *community* do?

- Binta's husband could protect his family from HIV by reducing the number of sexual partners he has and by using condoms consistently to prevent HIV to himself and others.
- Binta's husband could find out his HIV status with Binta to prevent passing HIV on to his children.
- Binta's husband could learn to control his anger through counselling.
- Binta's mother-in-law could advocate for Binta's health and safety by supporting her access to key health services, attending services with her and ensuring that her baby does not get mix feeds during the first six months.
- The community faith and traditional leaders could use their influence to promote community dialogue and responsibility around social roles that encourage men, like Binta's husband, to have multiple partners and suppress women's rights to safety and health, address stigma as well as address the need to advocate for community health.
- The community could also ensure that TBA in their village always refer women for HIV tests to prevent passing HIV to their children and advocate as a community for better health care through the greater dialogue with the nearest health facility.
- The community could try to work together to start a dialogue about ensuring a safe or health community: what do they want the community to look like, and how do they achieve that—e.g. HIV free community?
- The community could take action against domestic violence by keeping records of how often it happens in the community, penalising men who beat their wives, and setting up a system of alerting community members when violence takes place.

African Transformation is a community mobilisation package that supports exploration of new roles for both men and women in relation to their community through sharing of real stories of men and women who are doing something differently in relation to their social roles. It explores men who take care of their wives and families for their reproductive health and children's well being, women who take on traditional male jobs, women who successfully address issues of inheritance/property rights, violence against women, intergenerational relationships, and community group action. Stories come from Nigeria, Malawi, Kenya, Uganda, and Zambia.

- Community leaders could set up community networks to support couples and individuals who may be experiencing abuse.
- Community groups could start mentoring programme in which older couples mentor younger ones on communication and conflict resolution skills.

What can the *health system* do?

- The health provider could provide friendly health care to Binta and her husband to ensure that they choose appropriate FP, are counselled and tested for HIV, understand the risks of PTC, make a birth plan, and if HIV positive, choose a safe feeding option with support. – invite the mother-in-law to attend sessions with mother in the future.
- The health provider could liaise with TBAs to ensure that women are referred to health facilities for HIV testing, and receive proper guidance regarding safe delivery, safe feeding, etc.
- The health provider could organise with the community parent support groups for safe feeding, support for families living with HIV, etc.
- Health providers could expand services to address needs of couples experiencing violence.

In Malawi, one district health office, mobilised traditional leaders to promote prevention of parent to child transmission through a district based competition between traditional authorities. Traditional authorities mobilised chiefs and men's only groups to educate men about RH issues and PTCT and encourage them to go for HIV testing with their partners. The health facilities ensured that men who came to the health clinics with their partners were given preference to be seen first by counsellors. TAs who were successful in mobilising the most couples for testing were rewarded by the district with bicycles.

What can *policy makers* do?

- Policy makers could reward health providers and facility sites that are providing quality services to communities.
- Policy makers could promote community health committees to increase dialogue with communities around quality of care issues that affect their communities.
- Policy makers could integrate HIV into existing RH services at primary care level.
- Policy makers could set up more shelters for women who are physically and sexually abused.
- Policy makers design a community education program in every LGA to educate men and women on gender, violence, literacy, SRH and other rights issues, eg; Stepping Stones, African Transformation, etc.

In many countries, health facilities and providers who provide quality care are rewarded by being branded a quality care site/person. Brands include the gold star, flower, any important locally recognised symbol of excellence. They could also be recognised through monthly newspaper articles highlighting best practices found within different states.

Choose your minimum package of strategic interventions based on your identified barriers at different levels.

Guiding Principles for a Minimum Package of Strategic Interventions for Women & Men of Childbearing Age

Effective strategic interventions for women & men of childbearing age should:

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- **Address Binta's needs at individual, community, system and policy maker levels.**
- **Be driven by couples who are affected by HIV** to identify needs, best approaches to reach them, and identify role models from within the group
- **Be targeted towards young vs. older women**'s reproductive health needs
- **Consider urban vs. rural differences** in terms of access to information, key services and literacy.
- **Emphasise male involvement** in women's risk.
- **Have a strong peer mentoring component** focusing on building 'culturally appropriate and feasible" life skills for women affected by HIV and strengthen support for couples.
- **Draw on the strengths of the "community" gatekeepers** (including mother in laws, traditional and faith leaders).
- **Critically analyse cultural and gender values and beliefs** that put both men and women at risk in their communities, and strengthen male responsibility in reproductive health.

Behavioural Objectives:

- Reduce the number of multiple concurrent partners for both men and women.
- Increase correct and consistent condom-use among couples for dual protection.
- Increase uptake of family planning methods
- Increase uptake of HIV testing and PPTCT services by couples.
- Increase uptake and adherence to ART for men, women and children who are HIV positive
- Reduce the number of PLWH reporting stigma and discrimination

- **Address the wider policy environment** including protection of fundamental rights, and access to couple friendly RH and HIV related products and services.
- **Address the special needs of mobile women** for reproductive health information and services.
- **Reinforce rights of PLWH** to have positive but safe sexual relationships.
- **Focus on doable actions at all levels.**

Minimum Package of Strategic Interventions:

Level of Intervention	Strategic Interventions	Ideas and Resources to Support Do-able Actions for Each Level
Individual Level Barriers • Low personal risk perception among men and women regarding maternal death, and prevention of parent to child transmission of HIV and benefits of accessing RH services. • Lack of uptake of family planning methods including condoms for dual protection for couples. • Low partner communicati on on SRH issues. • Low demand for couples HIV testing.	**Media communications** highlight the benefits of keeping our Nigerian community strong by preventing transmission of HIV from parents to children - utilising the stories of men and women who are role models of Nigerians who takes responsibility for the health and safety of their family, and future of their community, highlight women's risk for maternal death, PPTCT, benefits of accessing RH services, and condoms for dual protection. Increase **spousal communication** on SRH issues through skills development activities. **Create demand for HCT for couples** and all Nigerians once services are available.	**Incorporate HCT and PPTCT access information in media messages at state and LGA levels.** • Change the term "mother to child transmission" to "Parent to Child transmission" to increase male and community responsibility to address risks of HIV affecting the future of the community. Use local language in talking about this important, but new concept affecting communities' future strengh. • Male Involvement Campaign – perhaps utilising the Nigerians Together: Keeping our Community Strong concept - highlight benefits of couples counseling….Utilise real stories solutions to the problems faced. • Draw on couples living with HIV (if possible) to share stories, and empower others on how to reduce risks and live positively with HIV. • Images from media could be put into story flips for peer/community mobilisation (using story based approach) • Nigerian African Transformation DVD and radio stories could be aired as part of campaign – interactive radio programme that gets young people and community members actively engaged in deciding what next… • Link PPTCT messages with birth preparedness kit to be marketed (related education/mobilization activities through RH). • Produce a Treatment Literacy Radio Programme addressing all aspects of HIV prevention, treatment, care and support- using personal stories.

Level of Intervention	Strategic Interventions	Ideas and Resources to Support Do-able Actions for Each Level
		• Increase visibility of HCT sites: Consider revamping and promotion of the national HCT logo- brand all related HCT materials with the logo so that image is reinforced. Have clear signage at all HCT sites: Expand use of logo as more sites become available: promote to prepare communities on HIV testing week if identified. (Take Control! Or HIV testing, the beginning of life… Concept): Key message: Everyone is at risk, so everyone should know. I want to know! (I'm pregnant…., I'm sexually active…., I have had STIs…., I feel chronically unwell…, I want to take control over my life….) • Phase 2: HIV testing week? : Need to explore how best to do this in context of limited services available: - target key states where prevalence is high but services are also available: mobilize counselors across state borders, use mobile testing in high risk areas (but as part of state wide campaign). • Promote the male and female condom by focusing on dual protection for couples, spacing of children, safety, and acceptance (highlight couples who use it) Could also address issues of discordance ….
Community Level Barriers • Lack of community dialogue on gender norms and cultural risks. • Lack of support among community leaders,	**Community mobilisation** with traditional and religious leaders to break cultural silence, stigma around condom use for dual protection and modify high risk cultural beliefs and practices that put women and men at risk for HIV. **Community mobilisation** to reduce practices that delay RH access and facilitate immediate referral to SRH services	• Get religious and community leaders to talk about male involvement and reduction of mulitiple partners openly – mobilise community education and action through traditional courts, faith activities, and CBO groups. • Capitalise on what is on ground in terms of radio talks by BBC etc. This should be adapted to suit community education • Community outreach plan for treatment literacy with faith and community leaders, TBAs, ward

Level of Intervention	Strategic Interventions	Ideas and Resources to Support Do-able Actions for Each Level
LGAs, CBOs FBOs, TBAs to promote community PPTCT services and male involvement. • Lack of community action around safe motherhood and reduction of multiple partners. • Stigma and discrimination which affects everyone's willingness to go for an HIV test and disclose to their family members.	**Community mobilisation around stigma** and discrimination against PLWH which affect everyone's willingness to be test for HIV, disclose their status, and seek social support.	and village heads, (base on Peer Plus Model?) Feasible to adopt AT approach for community education as well (base on short profile stories/process) • Share JHCCP's Malawi Bridge Project's Male Involvement and PPTCT community kits as possible models to adapt for community mobilization on these issues. • Engage traditional leaders at state level through monthly meetings, traditional elders, traditional courts, etc. • Adapt existing models for community mobilisation such as African Transformation community tool, Stepping Stones, etc to address key community issues related to couples. • Establish safe motherhood taskforces through traditional leaders to monitor all pregnant women and TBAs. (Canadian Public Health Association's Family and Reproductive Health Project in Malawi was a very effective model to consider.) • Mobilise women through existing community based women's groups. • Address stigma and fear among population about an HIV+ result, highlight real individuals who live positively with the virus, emphasise different groups affected (ie. Women, Men: urban and rural), pregnancy, couples, children, : emphasise different modes of transmission, benefits of knowing your HIV status. (Draw on SNR's community drivers of change program which mobilised local leaders for stigma reduction in six states and has been locally sustained, AED Stigma Package could be adapted)

Level of Intervention	Strategic Interventions	Ideas and Resources to Support Do-able Actions for Each Level
		• Highlight national/community responsibility: Break the Silence Campaign (community and faith leaders working hand in hand with PLWH, young people….) • Faith-based sensitisation workshops and forums to give religious leaders the opportunity to learn about male/female condoms and ways to promote them within their religious rules. • Institutionalise FC/MC promotions (regular group information sessions, peer education campaigns, and religious group events)
Health Systems Level Barriers • Lack of HIV counselling and testing for couples • Lack of access to family friendly reproductive health services which integrate key HIV related services. • Lack of effective provider-couple dialogue on PPTCT services. • Lack of Identify/establish and strengthen support	**Strengthen capacity for quality couples HIV counseling and testing** in all settings. **Promote male involvement and access to friendly health services** and SRH products through advocacy for service delivery changes **Strengthen access to male and female condoms** through SDPs**.**	**HCT for Couples** Strengthen quality of pre and post test HCT counseling in all areas, and address the needs of couples. • Ensure that there is link to prevention services as well as referral to treatments available. • Develop standard pretest counseling flipchart for waiting rooms, ensure key materials are there to highlight benefits of testing, services for PLWHAs, ART, PPTCT, OI, Staying negative, etc. highlighting different groups affected (young people, pregnant women, couples, children, etc.) **Integrate promotion of PPTCT services and routine HCT with other health programmes and improve quality of IPPC.** Identify when related health talks occur at facility level and develop cue cards/mini flips to support counseling in facility setting. • Flow chart related to counseling info (visits) different entry points (HCT, FP, ANC, Labour, Under 5, nutrition) – process once HIV positive mother is identified. • Have health flip for PPTCT (Your first ANC visit), FP flip should have additional info for PPTCT

Level of Intervention	Strategic Interventions	Ideas and Resources to Support Do-able Actions for Each Level
groups of women living with HIV to facilitate demand and access to PPTCT services		benefits of testing to support couples pretest counseling. • Additional flipchart for Under 5 clinics, labour wards, materials to support infant feeding counseling, breast feeding materials for wider distribution. • Checklist of items mothers would need to buy for replacement feeds. • PPTCT Video: do health facilities have VCRs for health talks? - could also use for community story flip. • Ensure related materials are there (STIs and HIV, FP and HIV, Pregnancy and HIV, Breastfeeding and HIV, etc., TB and HIV)…. **Identify/establish and strengthen support groups of women living with HIV to facilitate demand and access to PPTCT services** • Look at mother2mother (m2m) model in South Africa: international NGO which provides education and support for pregnant women and new mothers living with HIV. Consider developing a manual for mothers groups ongoing support education for infant feeding based on existing support group experiences (ensure men are involved as well) : work with UNICEF to identify potential groups to work with. **Strengthen education and promotion of male and female condoms through SDPs.** • Distribute IEC materials to Service Delivery Points • Utilise trained service providers as trainers for peer educators, building a plan for them to use their skills to demonstrate and answer questions about FC/MC. • Introduce job aids for providers on male and female condoms; ensure that HCT sessions always include condom demonstrations. (public, private, CBDAs, pharmacies) Address misconceptions, key counselling point’s particularly for first time

Level of Intervention	Strategic Interventions	Ideas and Resources to Support Do-able Actions for Each Level
		users of female condoms. • Provide demo pens to demonstrate correct use of condoms to providers, peer educators, pharmacies, (and also workplace programmes)
Policy Maker Level Barriers	**Advocacy** among policy makers at state and local level **to promote integration of HIV in routine RH services,** and ensure access to quality RH services by all. **Strengthen community responsibility and action** to improve quality of health care services. **Define acceptable ways in which TBAs support** the national response for HIV and safe motherhood. **Advocacy** among policy makers **to increase access of male and female condoms** through public and private sector channels.	• Reward health providers and facility sites that are providing quality services to communities by certifying and widely promoting services that are centres of excellence to motivate health teams. • Promote community health committees to increase dialogue with communities around quality of care issues that affect their communities. • Integrate HIV into existing RH services at primary care level. • Define role of TBAs for PPTCT. • Find ways to make the male and female condom widely available, affordable and accessible. Identify and develop/empower additional organisations to undertake social marketing and other condom promotion activities • Explore public private partnership for the use of vending machines for male and female condoms (especially in hotels, hospitals and tertiary campuses),, determine if the private sector would sponsor the machines, include their related products in the same machines and take responsibility for them.

Chapter 10:

Working with Young People

1 Working with Young People: Background

1. **Key Issues:**

- High HIV prevalence among young men and women and high MMR among young women
- Early sexual debut due to different contexts (early marriage, pressure for sexual exchange for economic benefits, sexual assault, some youth/children are vulnerable due to disability, marginalised status/lack of protection).
- Early and unwanted sex increases risk of HIV particularly among young women due to biology – coupled with early pregnancy, also linked to higher risk for PTCT.
- General lack of access to SRH/HIV related information and services due to age and gender.

5. **Problem Behaviours**

Unsafe SRH Behaviours

- Girls and boys start having sex at a very early age.
- Young women do not delay first pregnancy until they are physically mature (age 18).
- Girls and boys have more than one sexual partner at the same time.
- Sexually active youth do not use condoms and/or contraceptives consistently and correctly to prevent STIs, HIV and unwanted pregnancy (incl. Misuse of ECP)
- Those who are sexually active do not use condoms with all their partners.
- Young women and men use alcohol and drugs which impair their decision-making regarding safe sex.
- Girls do not actively participate in community activities, thus can not contribute towards anything that affects their health.

Unreliable Health-seeking Behaviour

- Sexually active youth do not access SRH services for information or related services
- Young men and women do not get counseled and tested for HIV.
- Girls do not report sexual violence and rape

6. **Key Behavioral Outcome Objectives:**

Safe SRH Behaviours

- Delay first sex until 18.
- Reduce multiple, concurrent partners among sexually active youth
- Increase community rejection of older men having sex with young women
- Increase correct and consistent condom-use among sexually active youth with all partners (condom at first sex).
- Reduce reported alcohol and drug use among young women and men.

Reliable Health seeking Behaviours

- Increase uptake of family planning and PPTCT services among sexually active youth.
- Increase access to youth friendly health and related services (early STI treatment and partner notification, HIV testing and disclosure, social support for sexual assault)
- Improve quality of provider client interaction and adherence to treatment protocols

- Develop supportive legal environment for protection against unwanted sex and an accessible health delivery system.

7. Key Strategic BC Communication Objectives for Interventions

Level of Intervention	Key BCC Objectives	Key Interventions.
Individual Level	• Increase personal risk perception • Develop appropriate culturally and gender responsive life skills • Reduce myths and misconceptions	• **Media communication** on key themes using all channels • **Peer/mentoring** with life skills
Community Level	• Increase community dialogue • Reduce reported stigma and discrimination • Reduce reported gender inequalities • Modify high risk cultural practices • Strengthen peer and community support groups	**Community transformation** (communities, workplaces, places where people meet) to address stigma, harmful cultural and gender norms, and strengthen community response for referral and service delivery.
System Level	• Strengthen positive provider-client interactions • Increase access to condoms and family planning • Increase number of HIV related service sites • Increase referral to HIV related services including ART.	**Increasing access to quality products and services** by strengthening provider –client interactions for education and adherence, positioning key products where clients can reach them easily, and increasing visibility of quality services through branding.
Policy Maker Level	• Increase friendly workplace policies • Increase supportive legislation • Advocate for more realistic budget allocations for youth focused HIV prevention	**Advocacy to address the wider policy environment** that determines access, protects fundamental rights, and fosters linkages between sectors.

2 Working with Young People: Sara's Story

Sara is worried. She is fifteen years old and has a boyfriend whom she met on her way home from school who wants to have sex with her. She thinks she is in love with him but she is not sure.

Although he is much older, she isn't so worried about HIV, though she wonders if she will get pregnant, and how that will affect her education.

Her friends think she is really lucky because he has a lot of money, and gives her gifts. They don't think she should refuse sex. She likes her friends but she's not comfortable with what they're saying.

She can't talk to her parents about it -nobody talks about such things - but sometimes feels like her mother would be relieved if there was someone to take care of her.

She knows from watching her mother and other women in the community, that as a girl, you are supposed to get married, and anyways, women always do what the man says in the relationship.

She can't talk to her teacher or a health provider because they would say she is too young to know about such things, and certainly too young to use family planning methods.

What can we do as program planners to help her?

Step 1

Know the problem behaviours that affect young people in your area and the circumstances in which these behaviours take place.

Checklist to Consider

What are the key issues affecting young people in your area?

Are there unsafe sexual reproductive health practices taking place?

Are girls and boys having sex at a very early age, like Sara?

- Do girls tend to have sex with older men, rather than boys their own age (cross-generational sex)?
- Are girls getting pregnant when they are still physically immature?
- If boys and girls are sexually active, do they know their HIV status, and use condoms to protect each other from HIV? Use other contraceptives to prevent unwanted pregnancy?
- Do boys and girls have more than one sexual partner at the same time?

Are there unreliable health seeking behaviours?

- Do sexually active youth access sexual reproductive health services for information and related services?
- Do they get counselled and tested for HIV?
- Are girls who are sexually assaulted reporting rape/violence against them?

In Sara's case, you need to **consider why girls are having sex early in your area:**

Are there….

- Economic incentives to have sex?
- Cultural norms of early marriage?
- Social acceptance of men having sex with teenage girls?
- Pressure from family to "find a good man to marry?"
- Pressure from peers to have sex with older men?
- Boredom?
- Rape or violence against women?

Gathering information:
What evidence do you have that these conditions exist? Is there factual data, or is this information based on rumour? Be careful to separate gossip from accurate data. Who can provide you with good qualitative information?

- The young women themselves
- Providers?
- Teachers?
- Mothers?
- Sisters?

What do you think are **the differences between girls that are in school vs. those out of school? How do those differences** affect their ability and willingness to take positive action? How does it affect their access to information and support?

Step 2

Find out which barriers make it difficult for young people to take more positive action to protect themselves.

Checklist to Consider

What are the most important barriers to consider in Sara's situation?

- Does Sara feel **personally at risk** for HIV?
- Does Sara have the **confidence and skills** to avoid such situations or deal with pressure?
- **Are Sara's friends supportive** of her waiting to have sex or do they encourage her to have sex with her boyfriend?
- **Are there trustworthy people in her community** that she can talk to?
- Are there **cultural and gender norms, beliefs and practices** that put her at risk?
- **Is there friendly support from health providers or teachers** within the existing health or educational system?
- **Are the support services there** to help her and her friends?

Barriers Sara Faces

Individual level:

- *Sara does not feel very much at risk for HIV though she does worry about getting pregnant.*
- *It is unlikely that Sara has the skills and confidence to deal with pressure to have sex from her older boyfriend or from her friends.*

Community level:

- *Her friends encourage her to have sex with her boyfriend because of his wealth.*
- *Her parents do not encourage open discussion around her emerging sexual needs, and may even be inadvertently encouraging her to find someone to take care of her because of the benefits of financial security.*
- *Community norms can encourage girls to get into early marriage with older men. Traditional roles of women make it difficult for young women like Sara to take more control over her life and future, particularly with men.*

Health systems level:

- *The health facility is not friendly to young people like Sara. She would not be permitted to access information or family planning methods if she requested them.*

Policy maker level:

- *We don't know if youth friendly health services are available where Sara lives.*

Identify existing assets and opportunities to help address Sara's and other young people's needs.

Checklist to Consider

- Do young people have **key values that would be a benefit to address cultural beliefs and practices** that put young men and women at risk?
- Are there **youth friendly channels** that could support the ways in which young people get information and build skills?
- Are there **community gatekeepers** that could be mobilised to address cultural norms and practices that put young people at risk?
- Does the community have **traditional structures that could be mobilised** to address community norms and practices that put Sara and other young people at risk?
- Are there **male and female role models** within communities that could be used to address harmful community norms, or offer examples of positive community action?
- Are there **existing policies and programmes** to draw from?
- Are there **opportunities to link across sectors** to increase access to young people and address wider social, health and economic needs?
- Are there **examples of good community materials** that could be used to facilitate community dialogue?

Examples of opportunities:

- Young people are worried about their future security so could be motivated if there were opportunities to build skills for future employment.
- Young people are enthusiastic and willing to try new things.
- Young people are influenced by role models who they can relate to.
- Young people talk to their peers so could be reached more readily through peer education programmes, and through youth focused/led NGOs and CBOs.
- Youth based clubs exist and can be mobilised e.g. Anti AIDS clubs, Boy Scouts, Girls Guild, youth rescue club (ARFH) etc.
- Young people could be accessed through sporting events, festivals, use of music etc.
- High consumption of media products by youth makes mass media very cost- effective in reaching youth – the emergence of Nija Hip Hop and IT can also be used as an opportunity.
- Many young people are strongly influenced by religious organisations – in some areas female Mallamah teachers have been used as peer educators for female out of school youth. In other areas, the innovative use of sermons, peer led approaches, coordinated by Interfaith Coalition of HIV/AIDS, could be effective.
- Community traditional and faith leaders could be used to address cultural norms that put young women and men at risk, affect parents' ability to talk to their children, and determine whether or not youth friendly health services can be made locally available.
- Existing resources for young people include PEP for out of school female and male youth, PEP listener groups, and referral cards for health services, African Transformation community mobilisation manual on gender issues, and the success of youth oriented campaigns BBC World Trust Stop HIV, SFH Zip Up Campaign, I need to know, Ask Aunty…)

Choose your doable actions for each level.

What can *Sara* do?

- Sara could wait to have sex until she is older and more mature (18).
- If Sara decides to have sex, she could protect herself from unwanted pregnancy and HIV risk by using condoms and other family planning methods.
- Sara could try to avoid older men, and seek the agreement of her girlfriends to agree that they will support each other to stay away from the older men.

Young Empowered And Healthy (Y.E.A.H) campaign from Uganda is a national social and behavior change effort for Uganda's young people that uses mass media, person-to-person dialogue, and community media approaches to stimulate dialogue and action and model positive practices.

Phase I of the campaign, "Something for Something Love" focuses on sexual exploitation through transactional sex. Phase II, Be a Man, concentrates on masculinity and male gender norms.

www.hcpartnership.org/Programs/Africa/uganda/

What can the *community* do?

- Her friends could have a club that focuses on other activities that are fun, and help them to achieve their goals.
- Community leaders could discuss with youth and adults how to generate opportunities for youth skills training, or income generation (e.g. providing community buildings to youth to set up workshops or youth centres
- Her community leaders could open a dialogue with adults in the community around cultural beliefs and practices that are putting young boys and girls at risk for early sex.
- Her community leaders could also penalise older men who have sex with girls, and even traditional healers who help girls to unsafely abort.
- The community could have local events in which parents and their children compete with each other in a friendly fashion—e.g. a sports day in which girls compete against their mothers and the boys compete against their fathers. This could start more open and accepting discussion and trust in families.

What can the *health system* do?

- Government ministries of health could institutionalize "youth friendly" approaches in their services at all levels, and work with communities to design, monitor and maintain such services
- Her health provider could provide friendly reproductive health information and products if required.
- Other places where young people access health care, like chemists, could refer young people to appropriate services.

What can *policy makers* do?

- Policy makers at local level could locate youth friendly health services near vocational centres and/or youth centres where young people can meet and have access to general information/services.
- Policy makers at state level could link establishment of vocational centres with private companies that could support youth development of related skills and opportunities.
- Policy makers at national level could establish private-public sector partnerships through NiBUCCA to address youth needs.
- Government and private sector could work together to create micro-credit and loan schemes for youth groups interested in trying to generate income or build skills which can generate jobs and income.

Choose your minimum package of strategic interventions based on the identified barriers at different levels.

Guiding Principles for a Minimum Package of Strategic Interventions for Young People

Effective strategic interventions for young people should:
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- **Address Sara's needs at individual, community, system and policy maker levels.**
- **Be driven by young people** to identify needs, best approaches to reach them, and identify role models from within the group.
- **Start before first sex** in primary level education to prevent risky behaviour.
- **Have strong peer mentoring component** focusing on building 'culturally appropriate and feasible" life skills for young people within the circumstances they find themselves in (ie. in school vs. out of school, rural vs. urban settings.) and include related issues of substance abuse, violence, trans-generational and transactional sex.
- **Draw on the strengths of the "community" gatekeepers** depending where they are.
- **Focus on community cultural and gender norms** to address gender and cultural norms that put young women and men at risk for early and unwanted sex and **Tackle the issue of community acceptance of older men having sex with unmarried young women**
- **Recognise and address young people's need for other services that support their goals for future security.**
- **Address wider policy environment** including protection of fundamental rights, and access to youth friendly RH and HIV related products and services.
- **Have strategies to address the needs of vulnerable groups.**

Behavioural Objectives

- Delay first sex until age 18.
- Reduce multiple, concurrent partners among sexually active youth
- Increase community rejection of older men having sex with young women
- Increase correct and consistent condom-use among sexually active youth.
- Reduce reported alcohol and drug use among young women and men.
- Increase uptake of family planning and PPTCT services among sexually active youth.
- Increase access to youth friendly health and related services including early STI treatment, HIV testing, ART and support services.
- Improve quality of

Minimum Package of Strategic Interventions:

Level of Intervention	Strategic Interventions	Ideas and Resources to Support Do-able Actions for Each Level
Individual Level Barriers • Low risk perception among young men and women • Lack of gender responsive life skills	Media communications **highlight youth risk for HIV and unwanted pregnancy**, the different circumstances in which unwanted sex occurs, consequences…and address misconceptions/questions that young people have through enter educational channels. Interpersonal education **develops gender responsive life skills** through schools, youth clubs, peer education, footballers	• Utilise real stories based on different circumstances that young people find themselves in. Highlight positive solutions found, and/or provide opportunities to engage young people to find their own solutions to the problems faced. • Draw on youth PLWH to share stories, and empower others on how to reduce risks. • Consider utilising Real Man and Real Woman Campaign Materials developed by PSI International with Society for Family Health for immediate campaign. • Consider the Young Empowered And Healthy (Y.E.A.H) campaign from Uganda as a vehicle for youth empowerment • Images from media could be put into story flips for peer/community mobilisation (using story based approach) • Nigerian African Transformation DVD and radio stories could be aired as part of campaign – interactive radio programme that gets young people and community members actively engaged in deciding what next… • BBC West youth programme materials could be more widely disseminated. • Use listener clubs
Community Level Barriers • Lack of community dialogue on gender norms, culture risks.	Interpersonal education **develops parent-child communication** **Community mobilisation** with traditional and religious leaders **to break cultural silence around sex and sexuality, gender norms that put young men and young women at risk** including intergenerational sex, sexual assault , **and modify high risk cultural beliefs and practices**	• Engage traditional leaders at state level through monthly meetings, traditional elders, traditional courts, etc. • Utilise existing opportunities including Islamic teachers, circumcision rituals in the North, etc. • Use existing models for community mobilisation such as African Transformation community tool, Stepping Stones, Hope Kit, HIV Peer education Picture codes (PACT Botswana), Dramaide's interactive package on young men and gender (RSA), • Create mechanisms at community level to protect young people and children from sexual assault

Level of Intervention	Strategic Interventions	Ideas and Resources to Support Do-able Actions for Each Level
		through punitive measures. • Address through community mobilisation related issues of substance abuse as risk for young people. • Initiate community dialogue around the concept of "healthy" or "safe" communities, related to youth
Health Systems Level Barriers • Lack of access to youth friendly health and vocational services	**Promote youth access to friendly health services** and SRH products and try linking to vocational needs of young people :	• Ensure that health providers have youth friendly toolkit for counselling, addressing youth needs (incorporate content into existing channels for family planning, PPTCT, STIs, condoms, etc.) • Toll free national hotlines, (RSA< Ethiopia, DRC) • Utilise youth community based distribution agents. • Highlight role of chemists, traditional healers, where young people are likely to go for informal health care services including unsafe abortion • Mobilise peer networks to offer referral cards (PEP model) • Increase youth friendly health sites based on models that work – ensure community buy in to the establishment of youth services.
Policy Maker Level Barriers • Lack of supportive enabling environment to support youth access to products and services.	**Promote vocational training and internship** opportunities to young people **Promote wider access to PEP and EC** for women who have been sexually assaulted.	• Work with NiBUCCA to see how the private sector could be mobilise to set up vocational schools/internship links near youth friendly health facilities. • Advocate for PEP and EC to be available to women who have been sexually assaulted through victim support centers (if they exist), women's organisations (if not), health facilities, etc. • Create a youth Ombudsman who can be an advocate for youth issues within government