



**National
HIV & AIDS
Behaviour
Change
Communication
5-year Strategy**

2004 - 2008



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**National HIV and AIDS
Behaviour Change Communication Strategy
2004–2008**

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Contents

Foreword	v
Acknowledgements	vi
List of Tables	vii
List of Figures	vii
List of Acronyms	vii
Executive Summary	ix
Vision	x
Modes of transmission	x
Priority audiences	x
Priority strategies	x
The ABCs of Prevention	x
Prevention of Mother to Child Transmission	x
Stigma Reduction	x
Advocacy	x
Care, Support and Compassion	x
Access to Treatment	x
Capacity Building	x
Gender Issues	xi
Monitoring and Evaluation	xi
Operational framework	xi
1. Introduction	1
Goal	2
2. Situation Analysis	3
2.1. Nigeria: Demographic Situation	3
2.2. HIV/AIDS Situation in Nigeria	3
2.3. Key modes of transmission	5
2.4. Responses to the HIV/AIDS Situation in Nigeria: Efforts so Far	6
3. National HIV/AIDS Policy Summary	7
3.1. Key Strategies of the National Policy	7
4. Conceptual Framework	9
4.1. Information-Motivation-Behavioural Skills (IMB) Model	9
4.2. Risk Diagnosis: The Extended Parallel Process Model (EPPM)	12
4.3. Applying the Behaviour Change Theories to development of effective programme .	13
5. Vision, Goals, Targets	15
5.1. Vision	15
5.2. Targets for impact	15
6. Priority Strategies	19
6.1. The National BCC Strategic Framework	19
6.2. Prioritising interventions	20
6.3. BCC Interventions	22

7. Priority Audiences	28
Segmentation	28
7.1. Youth.....	29
7.2. High Risk Behaviour Groups or Most at Risk Persons (MARPs).....	31
7.3. People living with HIV or AIDS (PLWHAs).....	32
7.4. Health Care Providers	33
7.5. Men and Women of Reproductive Age.....	34
8. Desired Behaviour and Key Messages for Priority Audiences	35
9. Monitoring and Evaluation Framework	42
9.1. National research data for baseline and programme evaluation	43
10. Operational Framework	44
10.1. Coordination and avoidance of unnecessary duplication	44
10.2. Steps to Implementation	44
10.3. Quality Control for Promotional Materials.....	45
10.4. Role of NACA BCC Committee	45
Appendix 1: Gap Analysis for Priority Audiences	47
10.1 Health Care Providers	47
10.2 High Risk Behaviour Groups – Female sex workers	49
10.3 High Risk Behaviour Groups – Clients: Transport Workers, Uniformed Services ...	50
10.4. People Living with HIV or AIDS (PLWHA)	51
10.5 Youth (15 – 24 yrs old)	52
10.6 Men and Women of Reproductive Age (25 – 49 yrs old)	53
Appendix 2: Audience Strategic Communication Matrix	56
Communication Strategic Plans for Strategic Groups.....	56
Audience 1: Nigerian youth.....	56
Audience 2: High risk behaviour groups (most at risk persons)	63
Audience 3: People living with HIV/AIDS and people affected by AIDS	71
Audience 4: Health care providers	75
Audience 5: Men and women of reproductive age.....	79
Appendix 3: Five Year Timeline (2004-2008)	84
Appendix 4: Worksheet (Step-by-Step Guide) For Audience Selection	96
Appendix 5: Chart	97

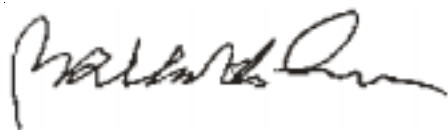
Foreword

Nigeria reported its first case of HIV and AIDS in 1986. Since then the phenomenon has reached pandemic proportions. Nigeria now has more reported cases of HIV infection than any other country in Africa outside South Africa. AIDS prevalence stands at 5.0% of reported attendees antenatal clinic in 2003. The Federal Government of Nigeria in cooperation with development partner organisations, NGOs and civil society organisations has responded in several ways to stem the spread of the epidemic. Major elements of the governments initiative include: the re-constitution of the National Response Team in 1999, from a health focused team into a multisectoral coordinating body, National Action Committee on AIDS (NACA); the development of a National Response strategy, (the HIV and AIDS Emergency Action Plan (HEAP)2001-2004; and the review of the first National Policy on HIV and AIDS and STI, adopted in 1997. The new policy was launched in August 2003 by the President of the Federal Republic of Nigeria, Chief Olusegun Obasanjo, to reflect current realities and best practices from other parts of the world in response to the AIDS scourge.

All the arms of government, professional bodies, private sector, trade unions, traditional and cultural associations, and civil society organisations have been involved in one form of intervention or the other. The Prevention of new infections, while halting the spread of existing infection remains a major element of interventions undertaken to date. The creation of awareness through the mass media (electronic, print and the non traditional channels) has been ongoing at all levels in the country. Research reports have indicated high level of awareness and low level of knowledge among the population, this has not been matched by corresponding change in behaviour for prevention nor has it translated into a slowing down of the epidemic. Thus, Nigeria is at a critical point in the management of the epidemic. This is critical because, for the epidemic to be stemmed, interventions must advance beyond awareness creation and address the issues underpinning behaviour change through strategic, evidence-based, theory-driven and result-oriented interventions. It is very important that these programmes are community-driven and well-coordinated.

This Behaviour Change Communication (BCC) strategy provides a response to some of these concerns and indeed is one of the several implementation components outlined in the National Policy on HIV and AIDS. This document provides a strategic framework for combating HIV and AIDS that is realistic, practical and responsive to local realities. It builds on internationally documented and scalable best practices. It will serve as guide for Government and all its partners (NACA, NGOs, CBOs, FBOs, the public and private sector, national, international agencies and donors) to help Nigerians adopt healthy behaviour and sustainable lifestyle changes to slow the HIV and AIDS epidemic.

It is hoped that this document will be useful to stakeholders in planning, designing, implementing, and evaluating behaviour change interventions. The plan provides the much needed framework to assure all of a systematic and strategically coordinated approach to eliminate waste of resources and encourage complementarity and synergy among all stakeholders in the struggle to mitigate the HIV and AIDS pandemic among Nigerians.



Prof. Babatunde Osotimehin,
Chairman,
National Action Committee on AIDS (NACA),
Abuja, 2004.

Acknowledgement

This document is the product of an extensive and detailed participatory process involving key stakeholders from the Behaviour Change Communication field within Nigeria and abroad. The process involved federal government line ministries and Parastatals, developmental partners, behaviour change experts, donor agencies, civil society organisations, non-governmental organisations and networks of people living with HIV or AIDS. Many groups and individuals have contributed to this process, particularly during the three key workshops and meetings at which the strategy was developed, reviewed and finalised. Those workshops took place in February, May, and November of 2003. On behalf of the National Action Committee on AIDS (NACA), I wish to express my appreciation to the following individuals and institutions that contributed in no small measure to the success of this very important strategy document:

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Alex Ogundipe
Director,
Policy, Strategy & Communications
National Action Committee on AIDS (NACA)
Abuja, 2004

LIST OF ACRONYMS

AFPAC	Armed Forces Project Advisory Committee
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-Natal Care
ANCOPSS	Association of Nigerian Conference of Principals of Secondary Schools
ART	Anti-retroviral treatment
ARVs	Anti-retroviral Drugs
ATF	AIDS Trust Fund
BC	Behaviour Change
BCC	Behaviour Change Communication
CBOs	Community Based Organisations
DFID	Department for International Development
EPPM	Extended Parallel Process Model
EU	European Union
FBOs	Faith Based Organisations
FCT	Federal Capital Territory
FGD	Focus Group Discussions
FHI	Family Health International
FLE	Family life Education
FMOH	Federal Ministry of Health
FSWs	Female Sex Workers
HCP	Health Care Providers
HEAP	HIV and AIDS Emergency Action Plan
HIV	Human Immunodeficiency Virus
IDIs	Individual In-Depth Interview
IGA	Income Generating Activities
IHAA	International HIV and AIDS Alliance
IMB	Information, Motivation, Behaviour
INGOs	International Non Governmental Organisations
IPC/C	Interpersonal Communication and Counseling
IPs	Implementing Partners
JAAIDS	Journalists Against AIDS
JHU/HCP	Johns Hopkins University/ Health Communication Partnership
KAPB	Knowledge, Attitude, Practice and Behaviour
LATH	Liverpool Associates on Tropical Health
M&E	Monitoring and Evaluation
MAN	Manufacturers Association of Nigeria
MARPS	Most At Risk Persons
MOE	Ministry of Education
MOH	Ministry of Health
MOS	Ministry of Sports
MSM	Men having Sex with Men
MWAYD	Ministry of Women Affairs and Youth Development
NACA	National Action Committee on AIDS
NAOWA	Nigerian Army Officers Wives Association

NARHS	National AIDS and Reproductive Health Survey
NASCP	National AIDS and Sexually Transmitted Infections Control Programme
NCH	National Council on Health
NDHS	Nigerian Demographic and Health Survey
NEACA	National Expert Advisory Committee on AIDS
NGOs	Non Governmental Organisations
NNELA	Nigerian Network on Ethics, Human Rights, HIV and AIDS Prevention, Care and Support
NURTW	National Union of Road Transport Workers
OVC	Orphan and Vulnerable Children
PABA	People Affected by HIV and AIDS
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
POWA	Police Officers Wives Association
PPST	Pre-Packaged STI Therapy
PRAs	Participatory Rural Appraisals
PTA	Parents Teachers Association
RH	Reproductive Health
SDPs	Service Delivery Points
SFH	Society for Family Health
STIs	Sexually Transmitted Infections
TV	Television
UNAIDS	The Joint United Nations Programme on HIV and AIDS
UNDP	United Nation Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
USG	United States Government
VCCT	Voluntary Counseling and Confidential Testing
VOA	Voice of America
VVF	Vesico Vaginal Fistula
YEF	Youth Empowerment Foundation
Youth BSS	Youth Behavioural Surveillance Survey

Executive Summary

Nigeria is at a crossroad with a reported 3.5 million Nigerians between ages 15 and 49 years infected with the HIV virus. HIV prevalence has already reached pandemic proportions. With the first AIDS case in Nigeria reported in 1986; the epidemic has since grown rapidly. The adult HIV prevalence has increased from 1.8% in 1991 to 4.5% in 1996 and 5.8% in 2001 before dipping to 5.0% in 2003. The Nigerian epidemic has different faces with some states in the federation recording prevalence rates well over the national average; there is no state with a prevalence rate below 1%.

Vision

In line with the National Policy on AIDS, NACA hopes that, if the strategies in this document are pursued effectively, the rate of HIV transmission in Nigeria will be reduced by 25 percent by 2008.

Modes of transmission

The major modes of HIV transmission in Nigeria are: sexual transmission (categorized into heterosexual sex and men having sex with men -MSM), and parent/mother-to-child transmission. Heterosexual transmission, at approximately 80% of total infection, is the main mode of transmission. Mother to Child Transmission (MTCT) is however, growing in importance as it is thought to account for up to 15% of transmission in recent times. It has the additional complication of affecting both the infant and the mother. MTCT can take place in three ways: in-utero (during pregnancy); during childbirth, and through breastfeeding during the baby's first 6 months. Other modes of transmission exist but have less impact. These include contamination of blood through transfusion of infected blood, or through cutting or piercing by a contaminated instrument such as razor, needle, and scissors. **The National HIV and AIDS Behaviour Change Communication Strategy puts the highest priority on halting heterosexual sexual transmission of HIV and AIDS and MTCT, but also deals with other modes of transmission.**

The 2003 National HIV and AIDS Reproductive Health Survey (NARHS) conducted in Nigeria revealed that 8 of 10 adults have heard of HIV and AIDS but fewer are knowledgeable about it. Only 6 out of 10 know that an HIV infected person may appear healthy; 5 out of 10 know two methods of preventing sexual transmission of HIV, and only 2 of 10 adults have complete knowledge of HIV transmission as measured on four internationally accepted criteria. The survey also showed that at least 7 out of 10 (72 percent) men and women in both rural and urban areas believe they are at no risk for HIV, and only 2 out of 5 (41 percent) want to be tested for the virus.

Priority audiences

Research has shown that the most effective and cost-efficient strategies focus first on reducing exposure to HIV among the people at highest risk, while addressing the potentially most vulnerable. Based on that premise and the results of a comprehensive research, this strategy identifies five priority audiences:

- Youth;
- High risk behaviour or most at risk people (MARPs);
- People Living with HIV or AIDS (PLWHAs);
- Health care providers; and
- Men and women of reproductive age (24 – 49 years old).

Priority strategies

In addition to identifying priority audiences, the plan also identifies priority strategies and interventions. The most effective strategies focus on:

The ABCs of Prevention

In Nigeria, real knowledge about HIV and AIDS (as opposed to awareness or pre-knowledge) is still low among most of the priority audiences. Thus, a major requirement is the need to get accurate information about causes, modes of transmission and prevention across to people. This information should be delivered within the context of daily life activities and not outside it. Recent evidence from a number of sub-Saharan countries confirm that *abstinence and reduction of partners* were as important in reducing the overall HIV prevalence rates in Uganda (particularly among adults) and in Zambia (particularly among young people) as were the promotion of consistent and correct condom use.

Prevention of Mother to Child Transmission

An estimated 30 to 40 percent of children born to HIV positive mothers risk becoming infected during pregnancy, at birth or soon after delivery through breastfeeding, in the absence of appropriate anti-retroviral drugs. This situation is preventable but requires dealing with complex social issues if a successful strategy were to be implemented.

Stigma Reduction

Stigma surrounds the HIV and AIDS epidemic, and as such it needs to be addressed from the outset as an underlying and consistent BCC theme until surveys show it is no longer a major factor. Stigma makes HIV and AIDS a taboo, keeps people in denial and prevents affected & infected people from coming to terms with their status.

Advocacy

Advocacy among political and community leaders needs to be an integral part of the BCC strategy because active political support is critical to establishing an enabling environment.

Care, Support and Compassion

Care, support and compassion are essential elements of the continuum of interventions addressing HIV and AIDS. Both are at the centre of a community's ability to respond effectively to the epidemic.

Access to Treatment

The ethics, politics, and logistics of providing full treatment for those in Africa who are living with HIV or AIDS (PLWHAs) over the last few years have changed and continue to change rapidly. Over the next five years, issues about equitable access to anti-retroviral (ARVs) drugs will be a high priority in the overall response to the epidemic.

Capacity Building

Capacity building is required across a broad spectrum of audiences: BCC practitioners need to know how to design and implement effective interventions; health providers need to know how to deal with the epidemic and relate to those directly affected by it; political and community leaders and gatekeepers need to understand the nature of the epidemic and how to address it; and PLWHA groups need to learn advocacy skills to bring the impact of the epidemic to the full attention of their communities and country.

Gender Issues

Gender issues are critical to HIV prevention and control: Sex and gender affect HIV and AIDS at nearly every level including vulnerability to infection, stigma, prevention behaviour and access to treatment. Innovative steps should be taken urgently to enhance the access to economic and social services for women and girls and to strengthen their protection in the following areas: expanding economic empowerment including job and skills training and property and inheritance rights; improving access to education and HIV and AIDS information for girls, and ensuring that school environments are safe; strengthening access to legal assistance and justice mechanisms, especially in cases of sexual violence; instituting training programmes to increase awareness about gender-based violence and child abuse for law enforcement, education, health, and community workers; and, increasing treatment and prevention options for women and girls, including care, treatment, and support for infected mothers as well as their babies (PMTCT-Plus), with appropriate counseling and testing services and the development of female-controlled prevention technologies.

Monitoring and Evaluation

Monitoring and Evaluation are critical to understanding if and how the strategies are impacting on the epidemic. Without accurate measurement of results we cannot learn anything about what worked and what did not. This strategy builds on the National Response's National Monitoring and Evaluation Framework (NNRIMS) and on a number of survey instruments, one of which is the National AIDS and Reproductive Health Survey (NARHS) conducted every two years beginning from 2003 among male (15-64 years) and female (15-49 years) in all states of the federation with over 10,000 respondents.

Specific impact evaluations will also be carried on all of the larger individual interventions.

Operational framework

NACA has the responsibility for coordinating the National Response to the HIV and AIDS epidemic in Nigeria. In this capacity, it acts as a liaison between government, the private and the non-profit sectors, coordinating initiatives, steering policy, framing the important issues and assisting organisations to develop capacity. NACA also serves as the clearing house for HIV and AIDS related information, materials, and relevant databases. Implementation of these strategies, however, rests with the many organisations, both local and international, whose mandate it is to address the HIV and AIDS crisis.

1. Introduction

This document seeks to provide a practical, concise and useful strategic instrument for addressing HIV and AIDS Behaviour Change Communication (BCC) issues in Nigeria. It also seeks to empower all stakeholders to coordinate a comprehensive, audience responsive, culturally appropriate Behaviour Change Communication programme for the control and mitigation of HIV and AIDS in Nigeria. It is not a manual on BCC processes and implementation.

This document is intended to address key issues relating to HIV and AIDS BCC over the next five years (2004 – 2008). It is theory-based, builds on the most recent accepted research and surveillance within the country and the world. It is community driven and grounded in the enormous range of experience in the field of the participants and their organisations. The theories outlined have been tested in many international contexts and have proven effective as a means of developing an approach that would address many audiences.

The strategy also responds to the guidelines in the National Policy on AIDS and the National HIV/AIDS & Reproductive Health Survey (NARHS), completed in mid-year 2003. The NARHS is the most recent large-scale survey on HIV and AIDS and reproductive health issues in Nigeria. The data from this research provides a baseline for the development of the framework.

The document therefore identifies:

- The key issues related to behaviour change communication (BCC) for HIV and AIDS in Nigeria over the next five years;
- The conceptual framework and analysis of most effective strategies to help ensure verifiable impact;
- The five-year vision, goal, and the target indicators that need to be met to achieve the vision in all priority areas;
- The priority audiences, relevant strategies and priority interventions that should be addressed; and
- Practical timelines for rolling out the overall strategy to maximize impact.

The strategy identifies five priority audiences based on their overall role in HIV transmission in Nigeria and in line with research findings and the provisions of the National AIDS Policy:

- Youth;
- High risk behaviour or most at risk people (MARPs);
- People Living with HIV and AIDS (PLWHAs);
- Health care providers;
- Men and women of reproductive age (15 – 49 years old).

Each of the priority audience is further segmented to identify sub-groups with clearly different desired behavioural outcomes or situations (for example, young people who are not yet sexually active as different from those who are sexually active with multiple partners). At the heart of the strategy are the audience analyses. A narrative section covers the background for each priority audience while a full matrix (see Annex II) lays out the various objectives, strategic approaches, activities, related research needs, and potential partners, implementing agencies and gatekeepers for each of those audiences.

The strategy focuses principally around prevention, but also addresses care and support, treatment and capacity building. The strategy's conceptual model begins with the individual and community and examines their requirements for change including the need for knowledge, motivation, the skills and ability to act and the establishment of an enabling environment. (See Section 5: Conceptual Framework).

This BCC Strategy is developed as a guide for all those who are or wish to get engaged in the challenging, complex but increasingly important area of behaviour change communication for HIV and AIDS in Nigeria. Nevertheless, the document is not meant to promote a top-down approach, but to guide critical BCC efforts at all levels, and promote genuine community-driven initiatives, among others. The document will only be valuable if it is seen and used as a working/planning tool. The HIV and AIDS epidemic could grow exponentially over the coming five years and it is important to respond appropriately. The strategies and activities need to be flexible enough to respond to the changing situation, resource allocations and new learning about response to the epidemic.

NACA therefore encourages active participation in responding to this strategic document, providing comments and suggestions for changes, or seeking technical support for implementation. NACA also requests that all stakeholders who develop BCC interventions provide copies of their materials to NACA for record keeping and archiving. NACA will also be promoting the principle of peer review of messages and materials on a regular basis.

Goal

The goal of this five year strategy is to attain a coordinated national response for BCC programming addressing HIV and AIDS issues that ensures coherent, uniform, evidence-based, community-oriented and theory-driven interventions from all stakeholders, which will produce measurable impact within the shortest possible time.

2. Situation Analysis

2.1. Nigeria: Demographic Situation

Nigeria is the largest country in sub-Saharan Africa, and the tenth most populous in the world. It has a land mass of 923, 768 square kilometers, a population density of about 96.3 persons per square kilometer, and is predominantly rural. The 1991 population census puts the total population at 88.9 million people (National Population Commission, 1998), and recent projections put the year 2003 population at 126 million. The current growth rate is estimated at 2.8% per annum.

Life expectancy increased from 45 years in 1963 to 51 years in 1991. Partly due to the effects of HIV and AIDS epidemic, life expectancy in Nigeria was estimated at 47 years in year 2001.

2.2. HIV and AIDS Situation in Nigeria

Since the first case of AIDS in Nigeria was reported in 1986, the epidemic has expanded rapidly. The adult HIV prevalence rate has increased from 1.8% in 1991 to 4.5% in 1996 and 5.0% in 2003. Estimates using the 2003 HIV/Syphilis sero-prevalence sentinel survey among women attending antenatal clinics indicate that between 3.2 and 3.8 million Nigerians aged 15-49 years may be infected with the virus. The epidemic in Nigeria has extended beyond the commonly classified high-risk groups and is now common in the general population. With the adult prevalence rate at 5.0% in 2003, the nation is at the threshold of an exponential explosive growth of the epidemic.

While some parts of the country are worse affected, no state is unaffected. In some sites of the survey, the prevalence rate was higher than 10%. All the states of the country have general population epidemics of over 1%. There was marked difference in HIV prevalence between major urban areas and sites outside urban areas. The infection cuts across both sexes and all age groups. However, youths between the ages 20 and 29 years are more infected.

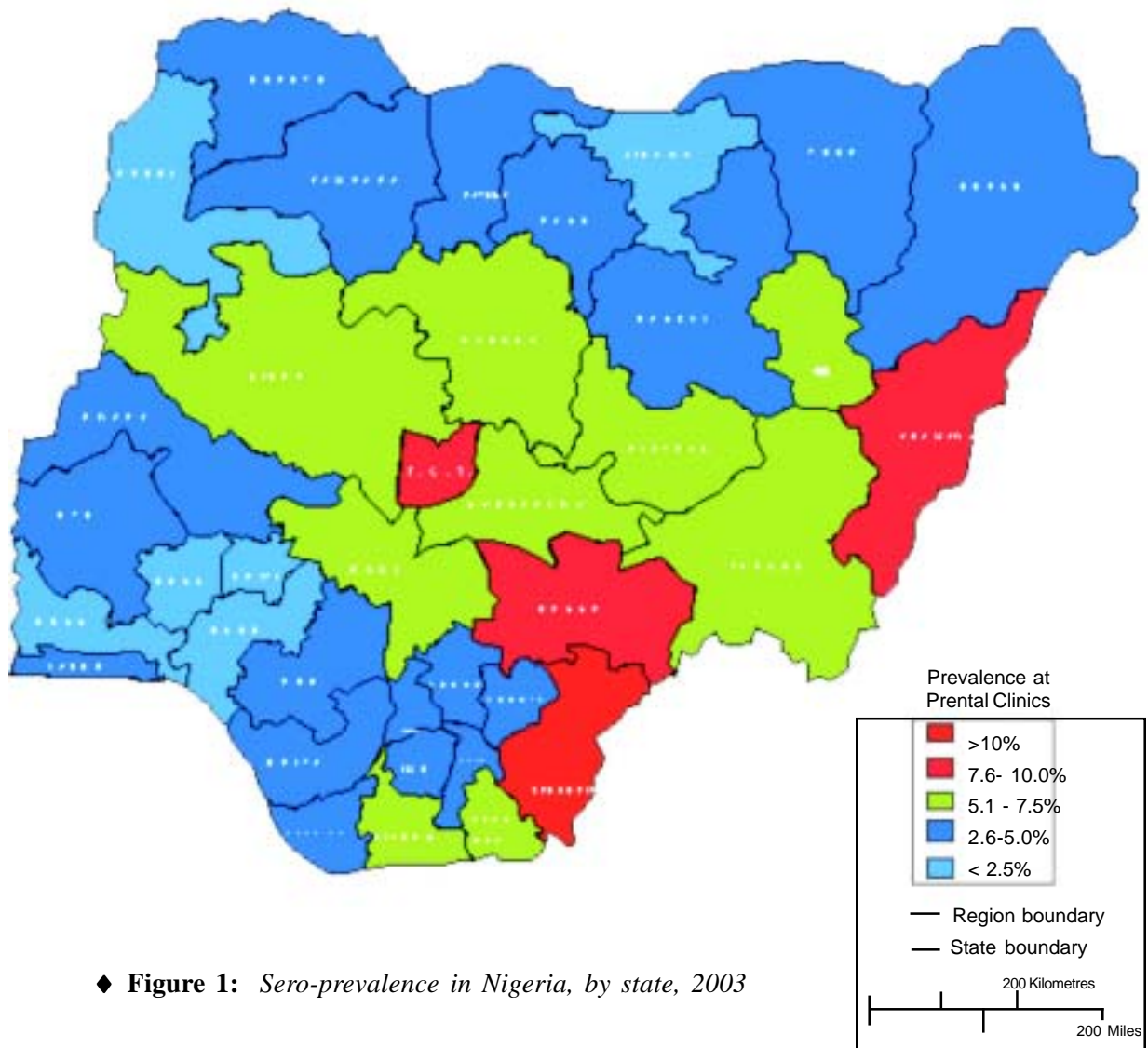
An increasing number of children are now being either infected with the virus, through mother to child transmission, or are losing one or both parents to the disease. By all indications the HIV and AIDS epidemic has continued to grow largely through heterosexual unprotected sexual relationships, mother to child transmission and contaminated blood and blood products.

The HIV and AIDS crisis has worsened the subordinate status of women and girls. In sub-Saharan Africa, women and girls account for more than half (58 percent) of those living with HIV and AIDS, and infection rates are rising rapidly among young women in many parts of the world including Nigeria. In the worst-affected countries in southern Africa, HIV prevalence among girls aged 15 to 19 is four to seven times higher than among boys their age, a disparity linked to widespread sexual abuse, coercion, early marriage, discrimination, and impoverishment.

In Nigeria, the epidemic's disproportionate impact on women and girls has given rise to a startling new reality: the feminisation of the epidemic, rooted in their economic dependency, stigmatisation and the denial of their rights. As HIV and AIDS spreads in Nigeria and in other parts of Africa and Asia, the situation is likely to worsen.

The complex gender dimensions of the HIV and AIDS crisis require an integrated, multisectoral response. Targeted services for women and girls need to be integrated into existing HIV and AIDS programmes and expanded over the next five years (2004-2008). Effective strategies will need to address the violence and inequalities that women and girls suffer in Nigeria.

Poverty is another issue that affects the HIV and AIDS situation. Available evidence from various parts of the world including sub-Saharan African countries, and Nigeria has prompted the conclusion that AIDS is already a disease of poverty: while all socio-economic classes are vulnerable, the disease affects *more* poor people than non-poor¹. Within the context of this BCC strategy therefore, it is important that poor people are strategically targeted with the provision of HIV prevention information, education and communication using appropriate channels.



◆ **Figure 1:** *Sero-prevalence in Nigeria, by state, 2003*

World Bank, *Confronting AIDS: Public Priorities in a Global Epidemic* (World Bank, Washington, DC, 1998)

As Figure 1 (Sero-prevalence in Nigeria by State, 2003) illustrates, there are already four sites with sero-prevalence over 7.5% (Federal Capital Territory, Benue, Cross River and Adamawa). Nine other states, six of which border on the first four, have rates of 5.1 – 7.5% (Gombe, Plateau, Nasarawa, Kaduna, Niger, Taraba, Kogi, Akwa- Ibom and Rivers). A further nineteen states have rates of between 2.5% and 5.0% (Abia, Anambra, Borno, Bauchi, Bayelsa, Ebonyi, Edo, Enugu, Delta, Imo, Kano, Katsina, Kebbi, Kwara, Lagos, Oyo, Sokoto, Yobe and Zamfara. Many of the states with the highest prevalence rates have high levels of mobile and transient populations or people living away from their families, both of which are core risk factors for the spread of the epidemic

Data from the 2003 National HIV/Syphilis Sentinel Survey (conducted among antenatal clinic attendees) show a variable urban-rural situation nationally. Generally, HIV prevalence was higher in the urban locations than rural locations except in the South East zone. These differences were more pronounced in the North East and South West zones. Awareness of HIV and AIDS and knowledge of its prevention is, on the whole, lower among rural compared to urban population. Pattern of access to mass media channels and the acceptability of various channels as sources of information on HIV and AIDS have also been shown to be lower for rural than urban population in Nigeria. The urban population has a better access to media, and a higher proportion of people to whom various mass media channels were acceptable as sources of information.

2.3. Key modes of transmission

To our knowledge no study has yet been carried out to determine the exact pattern of HIV and AIDS transmission in Nigeria. However, in line with the predominant epidemiological pattern in most sub-Saharan states, it is expedient to suggest that the following pattern of transmission obtains:

2.3.1. Sexual Transmission

Heterosexual transmission plays a dominant role in the transmission of HIV in Nigeria, but there is also a growing incidence of men having sex with men (MSM) and a formal network of Gays and Lesbians (GLAS: Gay and Lesbian Association) now exists.

a). *Heterosexual Transmission*

Heterosexual transmission is the major mode of transmission in Nigeria (possibly about 80% or more). Unprotected commercial, cross-generational or transactional² sex remains a major contributor to heterosexual transmission³. Unprotected casual sex, and transmission between spouses/partners who are already HIV positive or may have previously been exposed to HIV through the buying or selling of sex represent types of exposure that are already relatively frequent and that may increase in the near future. Sexual activity, in this category, includes oral, anal, and vaginal sex.

b). *Men Having Sex with Men (MSM)*

MSM is another mode of transmission. There is very little data about MSM in Nigeria. However, the experience of other countries suggests that regardless of its legal status in any country, MSM exists either through sexual experimentation between boys, as an alternative to heterosexual sex in societies where male and female relations are taboo before marriage, through sex workers, or between consenting adults. The risks of HIV transmission through anal sex are substantially higher than through vaginal intercourse.

² Transactional sex is defined as “engaging in sex out of economic need or want in exchange for money or material goods”.

³ Luke, N.; Kurz, K. Cross-generational and transactional sexual relations in Sub-Saharan Africa: prevalence of behavior and implications for negotiating safer sexual practices. International Center for Research on Women (ICRW), USA, 2002

2.3.2. Mother-To-Child Transmission (MTCT)

MTCT is the likely second major mode of transmission. It has been estimated that approximately 75,000 to 100,000 women who are HIV-positive give birth each year. There are three possible routes of transmission from an HIV-positive mother to her baby: (i) during pregnancy (i.e. in utero), (ii) during birth, and (iii) through breastfeeding of the baby by the HIV-positive mother, particularly during the first six months after birth.

2.3.3. Other modes of transmission

Other modes of transmission including unsafe blood transfusion, re-use of needles, sharp-piercing objects, and use of injecting drug, represent important but relatively less frequent modes of transmission.

For maximum impact, BCC interventions should concentrate on the high-risk behaviours and mother to child transmission (MTCT) but should also address all the other areas.

2.4. Responses to the HIV and AIDS Situation in Nigeria: Efforts so Far

Nigeria has passed through several phases in her response to the HIV and AIDS epidemic. The stages include an initial period of denial; followed by a largely health sector response; and now, a multi-sectoral response that focuses on prevention, treatment and mitigation of impact of the disease as distinct response components. A central body, NACA, is dedicated to leading and coordinating the National response, while various sectors that includes civil society organisations, the private sector, faith-based Organisations and people living with HIV and AIDS support groups focuses on packaging and implementing interventions based on the National Strategic Plan otherwise known as the HIV/AIDS Emergency Action Plan (HEAP) 2001-2004.

The health sector response, which started soon after the first case of AIDS was reported in 1986, was initially mounted in 1987 by an adhoc National Expert Advisory Committee on AIDS (NEACA) and supported by some state chapters that were set up soon after. By 1988, the National AIDS and STDs Control Programme (NASCP) was formally established, with state counterparts soon following, to organise as well as coordinate all HIV and AIDS activities at national and state levels respectively. NASCP has played a key role in developing guidelines on key interventions and monitoring of the epidemic.

In 1997, the National Council on Health (NCH) formally endorsed the multi-sectoral approach, while the Federal Government of Nigeria commenced the implementation of the Multisectoral approach with the establishments of a Presidential Committee on AIDS (PCA) and a National Action Committee on AIDS (NACA) in 2000. A four-year HIV and AIDS *Emergency Action Plan (HEAP)* was initiated in 2001 and is currently being reviewed. The partners implementing the plan include government institutions, non-governmental organisations, community-based organisations, faith-based organisations and networks of persons living with or affected by HIV and AIDS. Articulation and development of a national health sector response to the AIDS epidemic is underway.

In 2002, NACA commenced the development of a National HIV and AIDS monitoring and evaluation (M&E) framework to guide the National response and provide key indicators for the evaluation of the impact of the various interventions. The National HIV and AIDS and Reproductive Health Survey (NARHS) was conducted in 2003 to provide baseline information for most of the indicators. The study is to be repeated every two years to track progress made on the indicators. These studies will help to inform planning and implementation of BCC activities and to monitor its impact in the future.

Nigeria currently benefits from a high level of political commitment and international support. There is increasing activity in all sectors: advocacy, prevention, care and support, and the mitigation of the impact of the epidemic. However, there is a need to scale up activities, improve coverage, effectively coordinate, monitor and evaluate progress and impact of the interventions to ensure that the desired goals and objectives are achieved.

3. National HIV and AIDS Policy Summary

The revised National HIV and AIDS Policy, which was launched in August 2003 by President Olusegun Obasanjo, aims to improve the country's response to the HIV and AIDS crisis by adequately addressing the ignored components and improving upon the previously used strategies by promoting the use of cost-effective, practical, socially acceptable, and scientifically sound solutions to ensure that the HIV and AIDS epidemic is brought under control and the country resumes its social and economic development unhindered by the contagion.

The overall goal of the National HIV and AIDS policy is to control the spread of HIV in Nigeria, provide equitable care and support for those infected by HIV and mitigate its impact such that it is no longer of public health, social and economic concern, and that all Nigerians will be able to achieve socially and economically productive lives free of the infection and its effects.

The National HIV and AIDS Policy states that in order to achieve the overall goal, the Federal Government of Nigeria will:

- Promote a national multisectoral and multi-disciplinary response to the epidemic;
- Identify sectoral roles and assign responsibilities for the implementation of programmes based on sectors' comparative advantages;
- Increase awareness and sensitisation and foster behaviour change among the general population about HIV and AIDS;
- Improve national understanding and acceptance of the principle that all persons must accept responsibility for the prevention of HIV transmission and the provision of care and support for those infected and affected;
- Provide cost-effective care and support for those infected;
- Protect the rights of those infected and affected by HIV and AIDS as guaranteed under the constitution and laws of the Federal Republic of Nigeria;
- Remove all possible barriers to HIV and AIDS prevention and control;
- Empower people infected and affected by HIV and AIDS through training, counseling, and education to cope with their circumstances;
- Develop standards and guidelines that lead to the institutionalization of best practices to mitigate the impact of AIDS;
- Stimulate research, monitoring and evaluation of programmes;
- Ensure that prevention programmes are developed and targeted at vulnerable groups

3.1. Key Strategies of the National Policy

The main strategies specified in the policy for the achievement of its overall goal include:

3.1.1. The Prevention of HIV and AIDS transmission

Prevention through the promotion of safe sexual behaviour, appropriate use of condoms, safe supply of blood and blood products, implementation of voluntary counseling and testing, prevention of mother-to-child transmission, early treatment of sexually transmitted infections (STI), and youth focused interventions.

3.1.2. Law and Ethics

Policies and laws must ensure respect for and protection of the rights of all Nigerians including persons living with and affected by HIV and AIDS;

3.1.3. Care and Support

Care, support, and compassion are vital for those infected or affected by HIV and AIDS. These include the provision of clinical management of diseases and access to care for all PLWHAs; provision of home-based-care; treatment of opportunistic Infections (OIs); provision of access to anti-retroviral therapy; care of orphan and vulnerable children; support for the infected; support for the people affected by HIV and AIDS; and the certification of traditional healers and other alternative health practitioners

3.1.4. Effective communication

Effective communication includes greater public enlightenment, focusing on the removal of socio-cultural barriers; informational barriers; systemic barriers; the improvement in the general public's base knowledge regarding the HIV and AIDS epidemic; and catalyzing community-based responses to HIV and AIDS.

3.1.5. Effective Programme Development and Management

Good management includes the constitution of a permanent statutory body or agency which shall assume principal responsibility for the definition of the HIV and AIDS policy; guide the multisectoral response to the HIV and AIDS epidemic; build up the in-country capacity to plan, implement and monitor HIV and AIDS programmes; and monitor and evaluate the progress and impact of the country's response to the epidemic.

4. Conceptual Framework

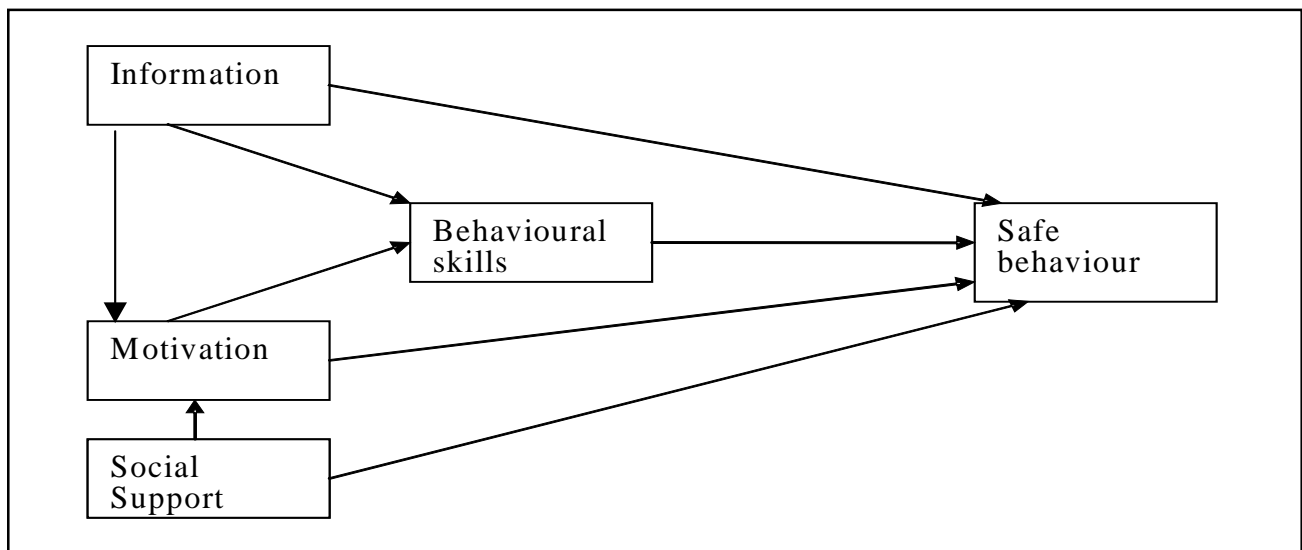
Experiences in various parts of the world have shown that behaviour change communication activities are more successful when they have strong conceptual basis. The use of appropriate conceptual framework has the potential of adding significant technical and practical value to the planning and implementation of health promotion and/or communication programmes as they allow the programme personnel to, among others, view the bigger picture and context of health problems and associated behaviours. Thus, conceptual frameworks can be and are useful for health promotion and BCC practice.

While a wide variety of health behaviour change models have been developed to explain why people do or do not protect their health, two theories that are germane to the development of strategies highlighted in this document are included here. Both have been used in the development of successful interventions around HIV and AIDS in sub-Saharan Africa. The first is the Information-Motivation-Behavioural Skills (IMB) Model, and the second is the Extended Parallel Process Model (EPPM) for Risk Diagnosis.

4.1. Information-Motivation-Behavioural Skills (IMB) Model

The IMB model is based on an analysis and integration of theory and research in the HIV prevention and social psychological literature, and focuses on the set of informational, motivational, and behavioural skill factors that are empirically associated with HIV prevention, but which are often dealt with in isolation.

◆ *Figure 2: An Adapted IMB Model (from Fisher and Fisher)*



The IMB model specifies that information and motivation work primarily through behavioural skills to influence HIV preventive behaviour. The IMB model also specifies that prevention information and prevention motivation may have direct effects on preventive behaviour separately, where complicated or novel behavioural skills are not necessary to effect prevention. For example, HIV prevention information may have a direct effect on preventive behaviour when a pregnant woman learns of the benefits of prenatal HIV antibody testing and agrees with her doctor's suggestion that she undergo such testing. Motivation may have a direct effect on behaviour when a motivated adolescent maintains a sexually abstinent pattern of behaviour as opposed to consistently using condoms. The latter requires relatively complicated and/or novel behavioural skills including those involved in condom

discussion, acquisition, negotiation, and consistent use. Finally, IMB model holds that information and motivation are regarded as generally independent constructs, in that well-informed individuals are not necessarily well motivated to practice prevention and well-motivated individuals are not always well informed about prevention.

This slightly modified IMB model proposes four broad determinants of behaviour: information, motivation, behavioural skills and social/community support (or an enabling environment) (See Figure 2)

In an HIV prevention programme, key activities that could be defined based on the model and which are also in line with Nigeria's national policy are briefly described below.

4.1.1. Prevention Information

According to the IMB model, HIV prevention information that is directly relevant to preventive behaviour and can be enacted easily by the individual is a prerequisite of HIV preventive behaviour and includes specific facts about HIV transmission (e.g. "Presence of an STI significantly increase the chances of HIV transmission during sexual intercourse"); about HIV prevention that serve as guides for personal preventive actions (e.g. "consistent condom use can prevent HIV"), and about risk perception information (e.g. "you cannot tell by looking, if a person is HIV positive").

4.1.2. Prevention Motivation

Motivation to engage in HIV preventive acts is an additional determinant of preventive behaviour and influences whether even well-informed individuals will be inclined to act on what they know about prevention or not. According to the IMB model, HIV prevention motivation includes personal motivation to practice preventive behaviours (e.g. attitudes toward practicing specific preventive acts), social motivation to engage in prevention (e.g. perceptions of social support for performing such acts), and perceptions of personal vulnerability (risk perceptions) to HIV infection.

4.1.3. Social/Community Support (Enabling environment)

In addition to personal motivation for prevention, social or community norms are important factors in motivating and sustaining behaviour change. Hence, social support is given specific attention for the purpose of the community-level strategy to show the essential role of advocacy to improve the enabling environment for social motivation to occur. An example is to advocate for the rights of sex workers so that they are better empowered to practice safer sex.

4.1.4. Behavioural Skills

Preventive behaviour skills are an additional prerequisite of HIV preventive behaviour and determine whether even well-informed and well-motivated individuals will be capable of practicing prevention effectively. The behavioural skills comprise, among others, an individual's objective ability and his or her perceived self-efficacy to perform HIV preventive behaviours (such as delaying sexual debut until marriage, purchasing and using condoms effectively, negotiating consistent condom use before or during sexual contact, negotiating HIV testing and mutual fidelity, and maintaining patterns of preventive behaviours singly or with a partner across time).



(McKee et al. 2000) Model from *Involving People, Evolving Behaviour*, Southbound, Penang and UNICEF, New York.

■ **Figure 3:** *Alternative view of IMB type model.*

Figure 3 visually depicts the relationship among the key elements identified in the IMB model. Behaviour change is often difficult and sexual behaviour change related to HIV infections is even more complex. People need accurate and timely **information** about HIV and AIDS, but information is seldom enough. **Motivation** must be provided through good communication, such as effective counseling or entertaining radio programmes. Such programming helps to bring about attitudinal and social norm change. However, even this is often not enough. For example, many African women have little power in negotiating the use of condoms. They need psychosocial life skills or the **ability to act** appropriately in particular circumstances that pose a threat to their health and survival. Such skills are sometimes called life skills or emotional and social skills such as problem solving (in social relationships), decision making, critical and creative thinking, assertiveness, communication skills, interpersonal relationships, and coping with stress and emotions.

Finally, progressive action must be taken on an overall **enabling environment** that is needed to sustain primary behavioural change. An enabling environment consists of organisational structures that facilitate needed change, access to services, supportive policies and other factors such as supportive educational, cultural/media, religious and socio-economic systems that allow change and the growth of human potential. Communication methods can be employed to help make changes in this greater, enabling environment. The model below demonstrates how all of these elements described above fit together in a synergistic way.

4.2. Risk Diagnosis: The Extended Parallel Process Model (EPPM) ⁴

The Risk Diagnosis EPPM model looks principally at a critical factor in the behaviour response to HIV and AIDS: the emotion of fear. Fear appears to have a critical influence on whether or not one engages in health-related behaviours. For example, for many people, especially for those living in high prevalence areas like motor parks and border crossings, discussions about HIV and AIDS infection are intensely fear arousing. The Extended Parallel Process Model (EPPM) is a health behaviour change theory that focuses on how to channel fear in a positive protective direction instead of a negative maladaptive direction. This theory appears especially appropriate for fear arousing health topics like HIV and AIDS.

The EPPM proposes that campaign messages should contain a threat component and an efficacy component. The threat portion of the message tries to make the audience feel susceptible to a severe threat (e.g. Truckers are susceptible to HIV). The efficacy portion of the message tries to convince individuals they are able to perform the recommended response (i.e., self-efficacy—"I can use condoms"), and that the recommended response effectively averts the threat (i.e., response efficacy—"condoms are good protection").

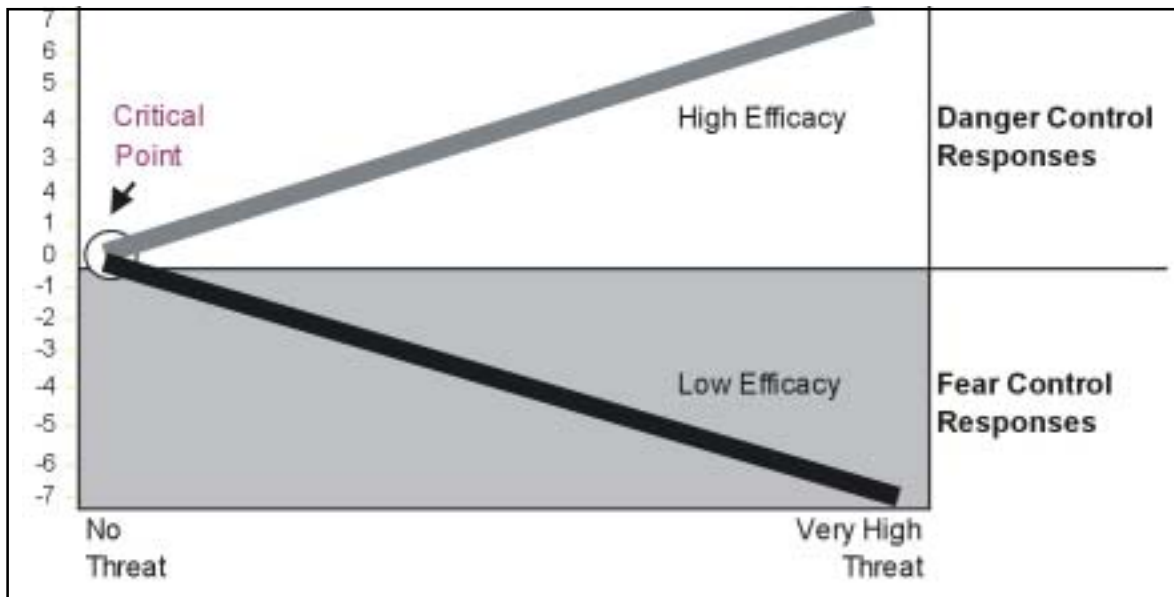


Figure 4: Risk Diagnosis, Threat and Responses

⁴ Adapted from *Preventing AIDS in Kenya: A Theoretically-Based Evaluation of HIV/AIDS Prevention Campaigns Along the Trans-Africa Highway in Kenya, 2000*, by Kim Witte, Kenzie A. Cameron, Maria Knight Lapinski and Solomon Nzyuko

According to this theory, a campaign message may promote two appraisal processes. First, is the threat appraisal where individuals evaluate whether or not they are susceptible to the threat and/or whether or not the threat is serious. If a threat is seen as either trivial or irrelevant, then the campaign message is not processed any further. There is no response to the campaign. If a threat is seen as serious and relevant, however, people become frightened and motivated to act. Then, efficacy appraisal occurs, where people evaluate the recommended response in terms of self-efficacy (e.g., “Am I able to protect myself against HIV infection?”) and response efficacy (e.g., “Does the recommended response work?”).

If people believe themselves able to perform an action that effectively averts a serious and relevant threat, then they are motivated to control the danger by engaging in self-protective actions like monogamy or condom use. In contrast, when people either feel unable to perform a recommended response (e.g., “I’m not able to bring up the issue of condoms with my partner”) or they believe the response to be ineffective (e.g., “condoms don’t work, they have holes in them”), then they give up on trying to control the danger and instead control their fear by denying their risk of HIV infection, defensively avoiding the HIV and AIDS issue, or perceiving manipulation (e.g., “AIDS is a hoax; it’s really a government plot”).

According to the EPPM, the most effective campaign message would be one that promotes high levels of susceptibility, severity, self-efficacy, and response efficacy. If a person perceives the threat as severe and also feels they are susceptible to that threat, they are motivated to act. If then they believe the recommended response will work and also believe they can do something (self-efficacy), they will take positive action. However, if campaign materials simply scare people without promoting strong self-efficacy and/or response efficacy perceptions, then they are likely to backfire and cause denial, defensive avoidance, or reactance responses.

Campaign messages can fail for two very different reasons (Witte, 1992b, 1994). First, a campaign message can fail because an audience perceives the threat to be trivial and/or not pertinent to them. In this case, there is simply no reaction to the campaign message as people fail to process it. Second, a campaign message can fail because it initiates fear control processes, where people control their fear and not the threat.

While the EPPM model can be used to measure an individual’s response to an issue (such as HIV and AIDS), it can also be used very effectively as a tool to ask prospective audiences to review planned campaign messages and materials (e.g. posters, radio ads) to evaluate the level of perceived susceptibility, severity, response efficacy, and self-efficacy they produced. This latter application is critical in evaluating the relative efficacy of materials before they are produced. Thus, the application of the EPPM will enable workers in the area of HIV and AIDS BCC in Nigeria to produce more effective materials and achieve better impacts.

4.3. Applying the Behaviour Change Theories to development of effective programme

The Behaviour Change (BC) theory for understanding and promoting HIV preventive behaviour specifies a set of universally applicable operations for constructing, implementing, and evaluating HIV prevention interventions for particular target populations and behaviours. On the basis of the BC theory, there are three steps involved in the process of changing HIV preventive behaviour that the national BCC strategy follows:

1. Investigative research conducted with a sub-sample of a population of interest, to empirically identify population-specific deficits and assets in HIV prevention information, motivation, behavioural skills, and HIV risk and preventive behaviour.
2. Design and implementation of conceptually based, empirically targeted, population-specific interventions, constructed on the basis of elicitation of research findings. These targeted interventions address identi-

fied deficits in HIV prevention information, motivation, behavioural skills and behaviour, and capitalise on assets in these factors that may be identified within a population.

3. Rigorous evaluation research conducted to determine whether or not an intervention has had significant and sustained effects on the information, motivation, and behavioural skills, which are determinants of HIV preventive behaviour.

The BC theory provides the basic framework used to develop the national behaviour change strategy; it can also be readily applied to create a conceptually based and empirically identified roster of targets for focused interventions.

The National BCC strategy will use an integrated multi-channel approach as derived from best practices elsewhere to provide information, motivation and behavioural skills building for the various target groups defined in the strategy. The following describes how the national BC strategy employs each type of medium to enhance the overall impact on behaviour change:

1. **Mass Media** (TV, radio, billboards, print) – to build awareness, increase knowledge, promote role models and influence societal norms.
2. **Enter-educate events** such as road shows, street drama, rallies targeting groups of more than 20 people up to hundreds – to reinforce awareness and knowledge, clarify misconceptions, desensitise behaviours and shape societal norms.
3. **Interpersonal communications** – to personalise information, model and practice behavioural skills and build self-efficacy through skills and confidence building strategies. Activities involving significant time, multiple methods & recurrent sessions with small groups are more effective.
4. **Community Mobilisation and Advocacy** – to sensitise and advocate for societal response to the HIV and AIDS pandemic, and to influence policy change to create an enabling environment for sustained behaviour change.

5. Vision, Goals, Targets

5.1. Vision

Taking into consideration, the National HIV and AIDS Policy, this strategic document has the following vision for the next five years:

(To reduce the rate of spread of HIV infection in Nigeria by 25% by Year 2008)

Indicators for the vision are divided into four themes (see below), which parallel the social mobilisation model described in the previous chapter.

5.2. Targets for impact

The following objectives have been identified in each of the four areas identified in the theoretical model (see Section 9: Monitoring and Evaluation Framework) to achieve the vision. These areas are: Enabling Environment (Advocacy), Social and Community Support, Access to Quality Services (Ability to act), and Knowledge and Behaviour (Motivation).

Table 1 below outlines the targets under each of the four categories and the related indicator in the National HIV and AIDS M & E framework (NNRIMS).

KEY TARGETS BY THEM	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,
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,
3. Reduction in the rate of spread of HIV among the Most At Risk Persons (MARPs) 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.
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.

KEY TARGETS BY THEM	PERFORMANCE INDICATORS*
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 .
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 IDU sharing 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.
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 .
9. Increase in pregnant women counseled and tested for HIV.	Percentage of pregnant women at public antenatal clinics offered counseling and voluntary testing for HIV by trained staff or referring to VCCT services by all pregnant women attending antenatal clinics. UNAIDS.
10. A reduction in percentage of people who stigmatize HIV/AIDS and PLWHAs	Percentage of respondents agreeing to the statement that PLWHAs should be discriminated against. NARHS.
11. Increase in HIV positive women provided with anti retroviral therapy in pregnancy	Percentage of women testing positive at 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. UNAIDS .
12. Increase in HIV positive people receiving ART.	Percentage of people with advanced HIV infection receiving anti-retroviral combination therapy. UNAIDS .

KEY TARGETS BY THEM	PERFORMANCE INDICATORS*
Enabling environment (Advocacy)	
1. Work place policies	Percentage of large enterprises/companies that have HIV and AIDS work place policies and programmes. UNAIDS .
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 nosocomial transmission of HIV adequate sterilization procedures and surgical gloves in stock of all facilities surveyed. UNAIDS .
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 .
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)	
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 .
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 all respondents aged 15 to 49 in the survey. UNAIDS .
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.
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.
Social and Community Support	
1. Improved parent-child communication around life skills, values and RH 2. Reduction in stigma expressed towards	Percentage of respondents reporting discussion on HIV / AIDS and reproductive health with children / parents in the last three months preceding the survey divided by all respondents. NARHS.

KEY TARGETS BY THEM	PERFORMANCE INDICATORS*
PLWHAs by families, peers and faith based organisations	Percentage of respondents disagreeing to the statement that PLWHA should be discriminated against divided by all respondents. NARHS.
3. Greater family care and support for PLWHAs	Percentage of PLWHA reporting that they enjoy care and support from their family divided by all PLWHA surveyed.
4. Active involvement by majority of FBOs in advocacy and community action to support for greater compassions and care around HIV/AIDS	Number of FBOs involved in HIV and AIDS education, advocacy, and care and support activities.
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/AIDS Related Services (Ability to act)	
1. Condom access	Easy, affordable condom access in every community in Nigeria especially at high risk communities
2. Work place policies and programmes	Effective HIV and AIDS workplace policies and programmes in every major corporation in Nigeria
3. Access to ARV by PLWHAs	Increased access to inexpensive or free ARVs and drugs for opportunistic infections and palliative care for those who meet international criteria

■ **Table 1:** *Key Targets and Performance Indicators for BCC Activities*

6. Priority Strategies

In developing the strategies outlined in this document, we have drawn from the experiences and best practices in selected sub-Saharan African countries that have implemented successful HIV and AIDS infection control. The three countries most often cited as success stories are Senegal, Uganda and Zambia. In the three countries, the key factors have been early and open admission of the severity of the problem by their governments and political leaders; early demand by the leaders for the engagement of all sectors in an aggressive policy towards mitigation of the disease early in the course of the epidemic; reduction of stigma through promotion of open dialogue and promotion of care and support within communities; the implementation of a multi-sectoral response which demands a coherent, comprehensive response from every sector of the society, both public and private – for example, workplace policies; strong emphasis on the use of personal networks; and strong focus on abstinence, faithfulness, and reduction of partners and condom use.⁵

It is very easy to identify a long list of issues, interventions and appropriate audiences to address when dealing with HIV and AIDS because of the rapid spread of the epidemic and the severe implications for individuals, communities, governments and society. This makes it important to establish a well thought-out strategy that focuses on addressing the most critical and cost-effective issues first and then broadening the response in a calculated and achievable fashion.

An understanding of the dynamics of a country's HIV epidemic, how it changes over time, and identification of those currently at greatest risk is essential to guiding decisions about effective prevention. *“In the short term, people planning HIV prevention programmes will make most difference by focusing where most new infections are occurring, while other partners such as religious and political leaders take the lead in changing the social and cultural factors that influence people's sexual and drug taking habits”*⁶

6.1. The National BCC Strategic Framework

The following strategic framework is the conceptual summary of the strategic plan. The framework shows the components of the strategy such as, the broad strategy, the key audiences and priority communication strategy themes for reaching these audiences. It further summarises the sub-strategies that might be deployed to reach each audience as well as the indicators that will be measured to capture the impact of the strategies used.

An illustrative view of the BCC strategic plan is to address the basic fact that 90 to 95% of Nigerians are presently uninfected (though could be potentially at risk of exposure to the virus), while only 5% are infected. The objective of the strategy is to largely prevent the occurrence of new infections among the uninfected population and prevent re-infections among People living with HIV and AIDS. The second objective of this strategy is to promote attitudinal and behaviour change among relevant segments of the population that encompasses abstinence, condom use, treatment of sexually transmitted infections, partner reduction, care, support and compassion for all PLWHA and PABAs among others.

⁵ Daniel Low-Beer and Rand L Stoneburner. *Behaviour and Communication Change In Reducing HIV: Is Uganda Unique? African Journal of AIDS Research*; 2003, 2(1): 9–21

⁶ Elizabeth Pisani, Geoff P Garnett, Tim Brown, John Stover, Nicholas C Grassly, Catherine Hankins, Neff Walker, Peter D Ghys. *Back to basics in HIV prevention: Focus on exposure BMJ* 2003; 326; 1384-1387

In order to achieve the two stated objectives above, the BCC strategic plan has identified two broad strategies for national focus. The plan recommends that a substantial part of National and stakeholder efforts and resources – eighty percent (80%), be directed on Prevention strategies and sub-strategies. The remaining twenty percent (20%) of resources and efforts is targeted at care, support and compassion, for all affected and infected by the virus. The delineation between the two broad strategies is limited to the conceptualisation phase and not to audience segmentation. This is to ensure that all segments of the population will eventually be exposed to both strategies.

Studies and researches on the Nigerian HIV epidemic has identified and classified various components of the population according to levels of exposure to the risk of contracting the virus. The population therefore needs to be segmented and specially targeted with behaviour change communication strategies in order to maximize impact and be cost-effective. The Nigerian audience segmentation in this Behaviour Change Communication strategy is based on the high prevalence rates of infection among the different audiences. The segments of the population prioritised for intervention are, the youth, the Most at risk persons (MARPs), men and women of reproductive age (M&WRA), People living with HIV and AIDS (PLWHA) and health care service providers (HCP).

Young Nigerians were further segmented on the basis of education (in-school and out of school status), and age (10-14, 15-19 and 20-24). The most at risk persons (MARPs) is further classified according to level of exposure to the virus and risk associated with their profession. The groups identified here are the residential sex workers, long distance drivers and the uniformed service personnel.

The effectiveness of any campaign is dependent on the specificity of the strategy to the targeted audience. In designing BCC campaigns, due consideration must be given to the socio-cultural, religious and ethnic context particularly for Nigeria. In order to derive maximum impact and guarantee the harmonious implementation and ownership of this strategic plan, the key themes for each audience to be reached has been enumerated depending on the characteristics of the audience. (See audience matrix in appendix 2). This is illustrated in the following example where messages for in-school youths will revolve around key themes of abstinence and delay of sexual debut, while prevention messages targeted at married men and women, will mainly promote mutual fidelity and partner reduction.

Specific sub-strategies are identified and enumerated for reaching each of the prioritised audience. Key indicators to measure the impact of interventions in the plan are listed in the plan. These indicators are synchronised with the national level indicators in the NNRIMS.

The sub-strategies, interventions and indicators recommended in this plan are designed, refined and fine-tuned based on evidence from continuous operational research, monitoring & evaluation reports as well as other studies.

6.2. Prioritising interventions

Three criteria are critical in prioritising interventions⁷: importance of the intervention to the spread of HIV; amenability to change; and cost-effectiveness of the intervention.

⁷ Jha P, Nagelkerke NJD, Ngugi EN, Prasada Rao JVR, Willbond B, Moses S, et al. Reducing HIV Transmission in Developing Countries. *Science* 2001; 292:224-5.

6.2.1. Importance in spread of HIV

First, one must consider **how important the intervention is to HIV spread**. HIV transmission in developing countries is largely driven by heterosexual intercourse, yet how sexual behaviour drives transmission is often misunderstood.

Studies on the transmission dynamics of HIV⁸ have shown that the risk of HIV transmission is very high in populations with a high prevalence of sexual risk behaviours, and there will also be a relatively high prevalence of STIs that can facilitate HIV transmission in such population.

This has prompted the concept of focusing on high-frequency transmitter core groups of individuals who have multiple partners, because they are important in driving or maintaining HIV epidemics.

6.2.2. Amenability to change

The second criterion is amenability to change, that is, the extent to which the strategy is responsive to variable circumstances, as this would impact upon **the feasibility of success** of the intervention in accessible populations. For example, it is usually more feasible to make sexual contacts safer than it is to avert such contacts. Similarly, it is more feasible to ensure condom use during casual sex than with steady partners. In many countries, the dependence of a given intervention on a well-functioning health care system may limit the ability to implement it.

6.2.3. Cost-Effectiveness

Cost-effectiveness is the third criterion. As the many effects of intervention accrue over time, mathematical models are important for assessing and comparing the **long-term cost-effectiveness** of particular measures. The intervention ratio, effect size, and cost-effectiveness of various interventions are summarized in the Table 2.

INTERVENTION ANALYSIS					
	Efficiency ratio	Effect size (% reduction in HIV incidence)	Cost per HIV infection prevented (\$)	Cost per disability-adjusted life-year (DALY) saved (\$)	Dependence on health delivery system
Female sex workers	0.6-1	80	8-12	0.35-0.52	Low
STI management	48	44	218	9.45	Medium
High-risk heterosexual male intervention	116	25-33			Low
Voluntary counselling and testing	9.1-11.2	50	249-346	12.77-17.78	High
Anti-retroviral in pregnancy	44	37-50	276	10.51	High
Formula feeding	51	44			Medium

■ **Table 2:** Evidence-based interventions for HIV prevention in developing countries. Comparison of efficiency, effect size, and cost-effectiveness⁷

⁸ May RM and Anderson RM. Transmission dynamics of HIV infection. Nature 326: 137-142, 198

6.3. BCC Interventions

Some of the interventions mentioned in Table 2 above are not specifically BCC interventions – for example, blood supply safety, and management of sexually transmitted infections (STI), though both of them have BCC implications and need effective BCC strategies to be successful.

For BCC, there are effective priority interventions, recorded internationally and nationally.

6.3.1. The ABCs of Prevention

Real knowledge about HIV and AIDS (as different from awareness or pre-knowledge) is still quite low among most of the priority audiences. Thus, one of the first approaches needed is to get accurate information about causes, modes of transmission and prevention to people. The process should be integrated into the broader context of daily life. Recent evidence from a number of sub-Saharan African countries points out that **abstinence**⁹ and **reduction of partners** were as important in reducing the overall HIV prevalence rates in Uganda (particularly among adults) and in Zambia (particularly among young people) as were the promotion of consistent and careful condom use.^{10,11}

ISSUE	AUDIENCE	DESIRED BEHAVIOUR
ABCs of prevention	Persons most at risk	Understanding causes, transmission and all means of prevention
Parent/Mother to Child Transmission (PMTCT)	Young women; pregnant women; married couples	Go for HIV testing; take preventive treatment
Stigma	General population, all the priority and their secondary audiences	Cessation of stigmatisation of HIV/AIDS infected and/or affected persons
Advocacy	Relevant gatekeepers and leaders for all priority audiences	Create an enabling environment: Provide active support for increased response to HIV/AIDS epidemic; making increased resources, available
Care, Support and Compassion	Religious and community leaders	Advocate for and actively engage in care and support without stigma
Treatment	Government, health ministries	More positive treatment policies, increased allocation of resources for provision of ARVs, testing sites
Capacity Building	Health providers, community leaders, NGOs, CBOs	Ability to confront HIV/AIDS knowledgeably, openly, sympathetically without stigma

■ **Table 3:** *Issues, Audiences, and Desired Behaviours*

⁹ Abstinence is sometimes expressed in youth campaigns as waiting or delaying sex, which seems more palatable to some than abstaining—i.e. completely rejecting sex; it is the psychological equivalent of the difference between cancellation of an event and postponement. Abstinence also is understood very differently in different places: some youth consider it relating only to some sorts of sex (e.g. vaginal sex) and not others (e.g. anal sex).

¹⁰ Bessinger R, Akwara P, Halperin D. *Sexual Behavior, HIV and Fertility Trends: A Comparative Analysis of Six Countries. Phase I of the ABC Study.* Washington, D.C.: Measure Evaluation/USAID, 2003

¹¹ Daniel Low-Beer and Rand L Stoneburner. *Behaviour And Communication Change In Reducing HIV: Is Uganda Unique?* African Journal of AIDS Research; 2003, 2(1): 9–21

It is important to note that abstinence and faithfulness, are not as concerned with behaviour *change* as with behaviour *maintenance*, and *maintaining* a behaviour is often easier than changing it.

These factors have important implications for designing the BCC response in Nigeria. Abstinence should be promoted among young people, as much as consistent condom use. Reduction of partners is less successful with young people, but should be promoted among adults. Reduction to one partner is the equivalent of 100% condom use with that one partner, which is known to be very difficult to achieve or maintain.

Condom use among those already sexually active with multiple partners or with non-spousal partners is now more clearly defined as *'correct condom use every time you have sex'*. This is a subtle but important change, because previous statements about condom use did not emphasize the need for consistent regular use. And without correct use every time, condoms are not a very reliable means of prevention.¹²

6.3.2. Prevention of Mother to Child Transmission (PMTCT)

Aside from sexual transmission, mother to child transmission (MTCT) is an increasingly important cause of infection, accounting for possibly up to 20 percent of infections in the country. An estimated 30 to 40 percent of children born to HIV positive mothers thus risk a chance of becoming infected during pregnancy, at birth or soon after delivery through breastfeeding in the absence of appropriate anti-retroviral drugs. This dire but preventable situation is complicated by the fact that infected mothers are often unaware of their HIV status, and neither attend ante-natal clinics during pregnancy nor deliver in health facilities with skilled birth attendants.

The recorded proportion of pregnant women who are willing to be tested for HIV is very low. Thus, there is an urgent need for a campaign to change the attitude of mothers towards testing for HIV as well as to enlighten those already infected on the possibility of preventing the vertical transmission of the virus to their babies.

6.3.3. Stigma Reduction

Stigma compounds the HIV and AIDS epidemic, and it should be addressed from the outset as an underlying and consistent BCC theme, until surveys show it is no longer a major factor. Stigma makes HIV and AIDS a taboo, keeps people in denial and prevents people from confronting the issue directly and openly. Research carried out in Ethiopia, Tanzania and Zambia found six consistent themes around the issue of stigma:¹³

1. People are largely unaware that their attitudes and actions are stigmatising
2. Language is central to how stigma is expressed
3. Knowledge and fear interact in unexpected ways that allow stigma and discrimination to persist
4. Sex, morality, shame, and blame are closely related to HIV-related stigma
5. Disclosure of positive HIV status is advocated, but acknowledged as difficult and unusual
6. Widespread care and support for people living with HIV and AIDS (PLWHA) co-exists with stigma and discrimination.

¹² Some research shows that in actual general use, condoms are about 80% effective. Ted Green, *AIDS Prevention and Paradigms: An Electronic Discussion*.
<http://puffin.creighton.edu/aarg/prevention.html>

¹³ *Understanding HIV-Related Stigma and Resulting Discrimination in Sub-Saharan Africa*. Research paper, International Center for Research on Women (ICRW), Washington D.C., 2003.

6.3.4. Advocacy

Advocacy among political and community leaders should be an integral element of the BCC strategy for every priority audience because active political support is critical in establishing an enabling environment. We have incorporated advocacy into each of the audience strategies so that it can be carefully tailored to the particular needs of each audience. No strategy can be successful without a strong coalition of supporters and key stakeholders who are willing and able to approach all the relevant leaders and gatekeepers and to hold those leaders accountable for specific deliverables. Until there exists open, gender-equitable policies and increased allocation of resources and funds to address HIV and AIDS for all the priority audiences, nothing substantive will happen.

6.3.5. Care, Support and Compassion

Care, support and compassion are essential elements of the continuum of interventions addressing HIV and AIDS. As research about stigma has shown, stigma, care and support go hand in hand. Families and communities typically may look after their own who are HIV-positive or who have full-blown AIDS while simultaneously stigmatising PLWHAs, for example, by separating their utensils, bedding and clothes from the rest of the family. But care, support, and compassion are at the centre of a community's ability to respond effectively to the epidemic. Faith-based leaders are influential allies in this area and should be actively solicited for full involvement and to mobilise their followers to support the struggle and to eliminate stigma. On the other hand, faith-based organisations can be sources of stigma and need to be assisted to see beyond stigma through discussion of their own principles of faith and caring.

6.3.6. Access to Treatment

The ethics, politics, and logistics of providing full treatment to those in Africa who are living with HIV or AIDS (PLWHAs) over the last few years have changed, and seem set to continue to change probably even rapidly. With the increasing funds available from many sources for addressing the problem, the precipitous drop in pricing, and increased access to anti-retroviral (ARVs) drugs, it is important that policies and processes be put in place to permit widespread access to ARVs. The implementers and designers of BCC interventions need to remain vigilant in responding to the issue in all its aspects—through advocacy for supportive policies, creation of demand for quality services, and increase in capacity of health providers in private and public sectors to provide proper, continuing access, and clear information for the public on all the issues of treatment.

6.3.7. Capacity Building

Capacity building is required by a broad spectrum of audiences, and again is tailored in the matrices to each audience. **BCC practitioners** (including government, national and local HIV and AIDS NGOs and CBOs) need to build their knowledge and expertise to understand how to conduct effective BCC interventions and campaigns. **Health providers** need to know how to deal with the epidemic and those directly affected by it, without stigma or prejudice, but with concern, professional skill, and sympathy. They need to improve their knowledge base and their skills in dealing with the difficult issues of counseling, testing and referral. **Political leaders, community leaders and gatekeepers** need to understand the nature of the epidemic and what specific agendas they can address to alleviate the impact of the disease. **PLWHA groups** need to learn advocacy skills to bring the impact of the epidemic on a human scale to the full attention of the country.

6.3.8. Gender-Focused Programmes

Gender issues are very critical to HIV and AIDS transmission, prevention and control. Females are at greater risk of HIV infection for biological and social factors. There are also differences in the implication of HIV

and AIDS for males and females. While gender issues are often addressed specifically to women's issues, gender by definition also involves men. It is men's behaviour that most often puts women at risk; so men need to be engaged in discussions about their roles, responsibilities, assumptions and actions in their relationship with women. Behaviour change cannot be the sole responsibility of women when confronted by this reality. Without the engagement of men in re-focusing their attitudes and behaviours, no real societal and individual behaviour change can happen.

Nigeria faces a practical and moral challenge to reduce the acute vulnerability of women and girls to HIV and AIDS. To be effective, interventions have to address the root causes behind these vulnerabilities. In a huge culturally, socially, and economically diverse country like Nigeria this will be an enormous challenge as the root causes are embedded in social practices, traditions, and attitudes. However, there are examples of programmes that work and Nigeria could learn from them.

Gender-focused programmes will require strong, focused leadership in the executive and the legislative arms of Government. Such initiatives should not overburden existing programmes and would constitute only a small part of the cost of a comprehensive National AIDS plan. Ultimately, considerable new resources will be required to expand treatment and prevention options for women and girls, including MTCT - Plus and the development of female-controlled prevention technologies. The longer women can stay healthy, the better they will be able to care for themselves and their children and contribute to the development of their communities.

To fully address gender issues around HIV and AIDS, there is need for:

- **A systematic effort to expand access to information and counseling about innovative and meaningful HIV and AIDS prevention approaches through sexual and sexuality behaviour change and reproductive health.** Programmes that are strictly abstinence-oriented are inherently incompatible with the realities of abuse and subordination that women and girls face around the world. The time has come to strengthen, not limit, the tools essential for women and girls to protect themselves and their families from this virus;
- **A reduction in the vulnerability of women and girls to HIV and AIDS and developing expanded treatment, care, and prevention programmes for women and girls.** This requires:
 - Rapid scaling up of programmes through immediate and intensive support for non-governmental organisations and government mechanisms that work to reduce women's and girl's vulnerability to HIV and AIDS;
 - Targeting assistance to groups providing social and economic services to women and girls and protecting their rights. Where possible, these services should be linked to MTCT sites or other reproductive health clinics. These services should focus on:
 - Improving access to justice, especially in cases of sexual violence as well as succession planning, widowhood, property and inheritance rights;
 - Expanding economic empowerment through access to micro-credit programmes, job and skills training;
 - Facilitating access to education for primary and secondary school girls and improving HIV and

AIDS information and curricula that target girls;

- Increasing support services for victims of rape and sexual assault, including counseling, testing, and legal and financial services;
- **Expanding support for training of law enforcement and judicial personnel, as well as educators and health care providers, on the link between gender-based violence and HIV and AIDS.** In particular, provide training in the enforcement of women and children's rights and in investigating and prosecuting sexual violence, child abuse, and domestic violence, as well as in forensic skills. This should include ensuring legal protection for people living with HIV and AIDS, or those orphaned or widowed because of HIV and AIDS;
- **Engaging in high-level public advocacy campaigns focused on the gender dimension as a central part of the HIV and AIDS crisis;**
 - High-ranking government officials, parliamentarians and community leaders should speak directly and frequently to the centrality of this issue in ensuring effective prevention, care, and treatment;
 - Mobilise the opinion leaders, donors and United Nations, the World Bank, and other international institutions to address the gender issues by supporting expanded treatment, care, and prevention programmes for women and girls;
 - Support leadership at the national, local, and community levels that highlights and integrates gender analysis into HIV and AIDS programmes. Underscore the importance of empowering women as decision makers within their societies;
- Supporting expanded treatment for women and their families, including PMTCT-Plus with increased counseling and testing, and the short course of antiretroviral drugs (post-exposure prophylaxis) for rape victims; and
- Expanding prevention options for women and girls, especially accelerated support for the development of microbicides and other female controlled prevention technologies.

7. Priority Audiences

Each component of the BCC strategy is important but probably more important than others is having a thorough knowledge and segmentation of the intended audience(s). The audience could be individuals or groups of people who are more exposed to or most affected by the problem or those who serve as gatekeepers in attempts to reach the audience. The strategy in this document focuses on five primary audiences with sub-groups within each of them. The audiences have been chosen because they and their secondary (associated) audiences comprise those people identified by various studies as most at risk or most immediately affected by the HIV and AIDS epidemic in Nigeria. The National Policy on AIDS emphasizes the importance of addressing the needs of these audiences to mitigate the impact and abate the spread of the epidemic. Not only is it necessary to target the priority audiences, PLWHAs for instance, with key BCC interventions, but also it is important to be prepared to work with them as agents of change. This section of the strategy document focuses on the characteristics, behaviours and segmentation of the five priority audiences.

The five priority audiences are:

- Youth
- Most at risk persons (MARPs)
- People Living with HIV or AIDS (PLWHAs)
- Health Care Providers (HCP)
- Men and women of Reproductive Age (25-49 years)

Segmentation

Segmentation identifies traits within audience sub-groups that make them significantly different from others in the larger audience category. These traits require that the BCC approach to them should differ in some ways.

Each of the aforementioned key audiences has been further segmented to provide more specific guidance in addressing the sub-groups with clear, focused objectives and appropriate indicators against which impact can be measured.

An audience can be segmented, for example, by:

- Demographic information (age, gender, marital status, education, etc)
- Geography (urban/rural, region, city)
- Socio-cultural issues (language, culture, religion, and lifestyle)
- Actual behaviour (sexually active, multiple partners, monogamous, abstinent, high risk, etc)
- Stages of understanding of the issues (pre-knowledge, knowledge, approval, intention, practice, advocacy)

Segmentation, if properly done, will lead to a more carefully focused BCC approach, with clearer, more relevant themes and messages. However, it should be done carefully and cautiously, with a focus on what the difference is between the groups principally from the point of view of their actual behaviour (for example, young girls 15 – 19, not yet sexually active, versus those who are sexually active, unmarried and have multiple partners).

The worksheet in Appendix 4 is one simple way of identifying those groups by characteristics.

Characteristics, behaviours and desired behaviours, and segmentation of priority audiences:

7.1. Youth

Nigerian youth are not a coherently defined, homogenous group. Within the internationally accepted category of youth as being from 15-24 years old, there are many issues and behaviours that require that this broad category be further subdivided to ensure greater BCC impact.

Youth are a priority audience not only because they are the largest audience but also because they are the audience in which prevalence rates are growing the fastest in Nigeria (and in most African countries). Female youth in particular are at risk: in countries with the highest rates of HIV prevalence, girls 15-19 years old are between four and nine times as likely to be HIV-positive as are boys their same age.

Youth have many different behaviours depending upon many variables. Younger girls (below 15 years old), for example, are less likely to be sexually active than older girls. It is therefore appropriate to address the younger age group of females as a distinct audience with the message to maintain their current behaviour of remaining sexually abstinent in order to avoid HIV infection. Females above 15 years old are more likely to be sexually active and therefore need different desired behaviours to remain safe – for example, consistent condom use with all partners and staying with one uninfected partner.

This Strategy segments youth into the following categories, each having its own distinct behavioural characteristics:

- Education (in-school and out-of-school)
- Age (up to 14, 15-19, 20-24) (national statistics show sexual activity begins after 14 years. Interventions targeted towards the under-14 age groups should focus on non-sexual activity, while those targeted at age 15 and above will address sexually activity)
- Geographic Region (urban and rural)
- Gender (male and female)

Education and Age

7.1.1. Ages 14 and below

The younger pre-teens are a critical audience to address around HIV and AIDS, life skills and adolescent health. Their attitudes about sex are often already established by what they see and hear and learn in place before they become sexually active:

- In-school youth age 14 and below – usually not sexually active, impressionable, lack access to correct HIV information, captive audience;
- Out of school age 14 and below – non-sexually active, vulnerable to contracting HIV and AIDS, lack access to information and services, highly impressionable, difficult to access by intervention channels.

RATIONALE:

- Influenced by tradition, religion and cultural values and practices.
- Expectation of sexual prowess for boys, and virginity for girls
- Northern female: early marriage with implications for vesico-vaginal fistula (VVF).

DESIRED BEHAVIOUR:

- Delay Sexual Debut/Primary Abstinence
- Increased knowledge about HIV and AIDS and life skills

7.1.2. Ages 15–19 years old

- In-school youth 15-19yrs – at higher risk of sexual activity, under peer pressure, limited access to correct information and services, low sense of personal risk of HIV infection;
- Out-of-school youth 15-19yrs – often in vocational work, more independent, limited information and services, vulnerable, somewhat difficult to access, high risk, sexually active.

RATIONALE:

- Northern female may be married and out of school.
- Southern female – single and in school.
- Northern and Southern male – single, may be in school

DESIRED BEHAVIOUR:

- Delay in sexual debut for the single male and female who not sexually active.
- Renew abstinence for singles that are sexually active.
- Condom use and partner reduction.
- Mutual fidelity for married male and female; use condom for non-spousal partners.

7.1.3. Ages 20-24 years old

- 20-24yrs (in-school): majority are sexually active, more knowledgeable than those out of school, higher perception of risk, easier to access;
- 20-24yrs (out of school): often in vocational work, more independent, limited information and services, vulnerable, somewhat difficult to access, high risk, sexually active. Females in this age group have highest percentage of HIV-positive of any age group;
- 20-24 in between school: independent, bored, vulnerable, some in-between schools may be difficult to access. Multiple partners, low safer sex practices; females in this age group highest risk of HIV infection.

RATIONALE:

- Most are sexually active
- Mostly married in the north, not likely to be married in the south

DESIRED BEHAVIOUR:

- North – Mutual fidelity for females/males;
- Northern Male/Female – Use condom with non-spousal partners;
- Southern Female/Male – Condom, mutual fidelity, partner reduction.

7.1.4. Geographic Region

In general, the location where young people live has some influence on behaviour, but the key difference is in access to information, support and services. Generally, the differences are:

- **Urban – greater access to information and services**
- **Rural – limited access to information and services**

7.1.5. Gender

A complex set of factors create the difference in levels of risk between female and male youth in Nigeria. There are different cultural expectations for sexual behaviour, for roles within the family and society at large, for educational achievement, for working life, and for many other factors. Collectively, they typically put the male in the role of decision-maker and the female in a more supplicant role: the man's will is expected to be obeyed; the women are at risk if they question or refuse to obey. While things are changing, the gender balance is far from equitable and therefore leaves females of all ages more vulnerable than men.

RATIONALE

Young men and women have been assigned different social roles that make it difficult for women to assert themselves or to have a real choice in sexual decisions. This puts female youth at greater danger. They need skills and self-esteem to be able to avoid risky behaviours. Young males need to better understand that they have a responsibility to respect their partners and to be more equitable in their relationships.

DESIRED BEHAVIOR

- Males – need to understand gender imbalance, gender rights, need to be more respectful of their partners in life decisions
- Female – need to build skills and self esteem, to be able to influence decisions to reduce their risk of infection.

Section 12.1 presents the communication strategic plans for youth as a priority audience.

7.2. High Risk Behaviour Groups or Most At Risk Persons (MARPs)

High Risk Groups are defined as those with a higher chance of contracting or transmitting HIV either because of their HIV status or their sexual or other high-risk behaviour. This audience has been segmented into four groups:

7.2.1. Female Sex Workers (FSWs)

Those who are brothel based are easily accessed by location. They are generally women aged 18 – 40, and economically poor. General awareness about HIV and AIDS is high but motivation to practice safer sex is low due to fatalism and faith-based sense of invulnerability to infection, as most believe that contracting HIV is a matter of destiny.

They are often driven to sex work by economic necessity and socio cultural inequalities. Many see this as a temporary occupation and hope to earn enough money to move on to other work. Younger FSWs are keen to have families. Many have regular boyfriends in addition to their clients. The typical day of a sex worker is a routine. While some engage in other income generating activities (for example, hair-plaiting) during the day and retire to their brothels at night to entertain their “customers”, the majority entertain “clients” all day. Outside of

this routine, the life of a sex worker is much the same as that of other women in other vocations. They watch television, listen to the radio, and read soft sell magazines.

DESIRED BEHAVIOUR: Embrace the consistent and correct use of condom for every sexual act. The early detection and proper treatment of STIs.

7.2.2. Male High Risk Groups

Segmentation is based on sexual behaviour, specifically multiple partnering and high rate of partner change. For convenience the professions with the highest prevalence of this behaviour were identified and prioritised:

7.2.3. Transport Workers

High mobility, long periods of separation from family, high levels of disposable income, opportunity for anonymity, low level of knowledge, high use of alcohol, and common attitude of fatalism are some of the key factors that define this group and make them to be at high risk of HIV infection. Males between 25 and 50 years old transport workers especially the long distance ones break their long distance travels by spending the nights at different junction spots along their routes. With nothing much to do these nights often starts with alcohol and end with a girlfriend from that spot. They listen to the radios/recorded cassettes on their vehicles while driving.

DESIRED BEHAVIOUR

Embrace the consistent and correct use of condom and reduction in non-spousal partner.

7.2.4. Uniformed Services

This group is characterized by the following socio-demographic and behavioural characteristics: highly mobile, long separation from family, disposable income, non-marital sex is common, anonymity and a common attitude of fatalism.

DESIRED BEHAVIOUR:

The consistent and correct use of condom for every sexual act and the reduction in non-spousal partner. Section 12.2 presents the communication strategic plans for most at risk persons as a priority audience.

7.3. People living with HIV or AIDS (PLWHAs)

All those who are HIV positive are potential transmitters of the disease. Experience elsewhere has shown that unless this group can be offered help and support they are unlikely to disclose or acknowledge their status. This greatly increases the chances that they may pass on the virus to others or acquire a more virulent strain. Segmentation of this group is largely based on access to care and services:

- All PLWHAs – require a range of care and services
- Female PLWHAs – require specific information and care with regard to mother to child transmission and its prevention.
- People Affected by AIDS (PABA) – many in this group may not be HIV positive but have been affected by losing parents or other family members to the disease. Their specific requirements include access to support groups.

DESIRED BEHAVIOUR:

- Know their status and embrace safer sex practices
- PLWHAs become more proactive in living positively

Section 12.3 presents the communication strategic plans for PLWHAs as a priority audience.

7.4. Health Care Providers (HCP)

The long-term vision for the health service delivery sector is that by the year 2008, all health and ancillary workers are professionally trained, well informed and highly competent to provide quality, client-friendly, non-judgmental services to all clients especially young people, PLWHAs, and PABAs. This is an ambitious goal, but one which is relevant to the rapid control of HIV in Nigeria.

Health care providers are the backbone of the health delivery system in Nigeria. Even in the absence of well-functioning facilities, providers can still provide a basic level of care and support. However, in the current climate, their ability to respond appropriately to issues around HIV and AIDS are severely compromised. Public health services at PHC level are almost moribund in the majority of locations across Nigeria; working equipment and regular and reliable drug supplies are a fiction; training and performance improvement has not been done for many years and community outreach is hampered by lack of appropriate skills or resources.

The vacuum created by a virtually collapsed public system has been filled by a wide array of informal or private sector entrepreneurs and professionals with a very wide range of knowledge, skills, training and legitimate interest in public health.

There also exists within the health system, generally, a high level of stigma towards HIV and AIDS and people infected and affected. On the positive side, there is, within the public system, a huge pool of health care providers who desire to do a better job, who want to get better training and who will respond with commitment if the environment in which they work improves and real opportunity exists for providing valued services.

The rate of growth of the HIV and AIDS epidemic requires urgent and comprehensive response within the health services sector. To achieve that, specific approaches have been identified for different groups within the provider audience. Segmentation was therefore done on the basis of indicators which differentiated the approaches needed to achieve performance improvement within each group, as follows: present level of knowledge; entry qualifications into professional training institutions; length of professional training and assessed exposure to occupational hazards; and finally the perceived socio status and importance of the health care provider within the community.

The segmentation is as follows:

- Physicians/Nurses/Midwives/Pharmacists/ Laboratory Technologists
- Community Health Extension Workers (CHEW)/Ancillary Health Care Professionals (Medical records, ambulance drivers and officers)
- Health Care Administrators (Non-health professionals, Permanent Secretaries, Finance officials, Procurement officials, etc.)

The audience matrix for health care providers outlines the objectives and some suggested strategies for achieving those objectives over the next five years.

DESIRED BEHAVIOURS:

- Good understanding of causes, transmission, prevention, care, support and treatment for HIV and AIDS
- Improved interpersonal communication skills to address HIV and AIDS issues with all clients without prejudice
- Ability to provide basic counseling and refer clients to effective VCCT sites
- Positive, open attitudes towards PLWHA

Section 12.4 presents the communication strategic plans for health care providers as a priority audience.

7.5. Men and Women of Reproductive Age (M &WRA)

Men and women in the reproductive age group are the most likely to be infected by HIV. Within this age group, there is a wide variation between their knowledge of HIV and AIDS including modes of transmission and prevention and lifestyles around safe sexual behaviours that will reduce the likelihood of infection. This group needs to become better informed on modes of HIV transmission and prevention – for example, heterosexual and mother-to-child transmission.

Safer sexual practices among this group is influenced by socio-cultural constraints vis-à-vis ability of women to negotiate safer sex with men, polygamy and serial monogamy, resistance of condom use by men due to its effect on sexual satisfaction, religious and traditional beliefs and convictions that are hard to shake and a reluctance to test for HIV due to confidentiality concerns and fear. There are also many myths and misconceptions about HIV and lack of receptiveness to facts among this group.

Also, as the primary socialising agents of their children and/or wards, they are a great resource to target children and young people with correct information and skills for HIV and AIDS prevention.

DESIRED BEHAVIOURS:

- Practice mutual fidelity in marriages (monogamous and polygamous)
- Limit the number of sexual partners and insist on correct and consistent use of condoms where needed;
- Increase discussion and communication about issues of sexuality and openly discuss reproductive health issues including HIV and AIDS with children and wards;
- Become models of advocacy for HIV and AIDS information and the uptake of services including voluntary counseling and confidential testing (VCCT) and PMTCT services
- Reduce transmission of infection from infected mothers to unborn babies
- Willingness of religious and community leaders to act as positive role models

Section 12.5 presents the communication strategic plans for men and women of reproductive age group as a priority audience.

For each group of priority audience, there are key messages that need to be targeted at them based on the desired behaviour as shown in the table below (section 8). These messages are guidelines, and need not be repeated verbatim. Messages need to be presented in the appropriate socio-cultural context and language, and in creative ways that will be appealing to and meet the needs of specific targets or segmented audience.

8. Desired Behaviour and Key Messages for Priority Audiences

DESIRED BEHAVIOUR	KEY MESSAGE ¹
Men and Women of RH age (24 - 49 yrs old)	
<i>Increased support for PLWHA</i>	
<ul style="list-style-type: none"> Do not stigmatize people living with HIV and AIDS Provide care and support for PLWHAs and PABAs. Support other men and women to adopt healthy lifestyles 	<ul style="list-style-type: none"> PLWHAs are people just like everyone else in your community, despite their HIV positive status. Everyone benefits from helping PLWHA. PLWHAs have a lot to contribute to your community, but they need your care, support and compassion to do so. Talk about the issue of HIV/AIDS with friends, family and community members
<i>Increased safer sex, risk perception</i>	
Men and women are knowledgeable about HIV and AIDS issues	Getting the correct information about HIV/AIDS will help you and your family stay safe. Talk to people you trust- professional providers, doctors, religious leaders.
<ul style="list-style-type: none"> Limit the number of sexual partners and insist on correct and consistent use of condoms where needed Practice mutual fidelity and partner reduction in marriages (monogamous and polygamous) 	<ul style="list-style-type: none"> Reducing the number of your sexual partners reduces the risk of STIs and HIV infection. The safest way to avoid STIs and HIV is to remain faithful to one partner who is also HIV negative. Getting tested for HIV will help you and your partners understand the risks. Everyone who has multiple partners and does not use a condom is at risk of STIs and HIV
Openly discuss reproductive health issues including HIV and AIDS with children and wards	Get the facts and talk about HIV/AIDS with your children. You will all understand better how to avoid HIV and STIs.
<ul style="list-style-type: none"> Knowledge of HIV status Avail self and partner of ANC, PMTCT and FP services; Discuss HIV and FP issues with partner(s) and family members 	<ul style="list-style-type: none"> Knowing your status will help you and your partner stay safe from STIs and HIV. Most people are HIV negative. Find out now to be safe for ever. Pregnant women and young married women should visit the ANC clinic regularly to find out how to prevent HIV. If you are pregnant, visit a PMTCT clinic to keep your unborn baby safe from HIV.

■ **Table 4: Key Message – Man & Women of RH age.**

¹ These messages are only guidelines and should not necessarily be used verbatim (as is). They may need to be revised to be more locally appropriate. Creativity in messages is important. There are lots of ways to say “Use a condom every time”. For example, in Ghana the message is, “If it’s not on, it’s not in.” This slogan is very successful and is now in national use as a universally understood statement for safer sex.

Health Care Providers (HCPs)	
<i>Advocacy for enabling environment policy for HCPs</i>	
<ul style="list-style-type: none"> • Develop and operationalise policies and provide adequate resources to facilitate quality service provision by health care personnel; • Professional bodies should monitor and supervise to ensure HIV is addressed openly and accurately. • HIV/AIDS should be integrated into other health services, not treated separately or in isolation 	<ul style="list-style-type: none"> • Policymakers should enact fair and complete policies and regulations to address HIV/AIDS. • All staff within health sector (public and private) need training to address HIV/AIDS. • HIV/AIDS should be integrated as a normal part of mainstream of health services. • Providers should talk about HIV to all clients, especially to pregnant women, and young women.
Full knowledge of HIV/AIDS by administrators to fully support health care providers in quality service delivery	<ul style="list-style-type: none"> • HIV/AIDS is taking up a heavier burden of health resources. Administrators need to ensure their providers: <ul style="list-style-type: none"> - Provide good quality advice and services to clients; - Are fair, open and friendly to PLWHA; - Promote positive living and care and support by families and communities to lessen the burden on the health system.
<i>Improved performance of HCPs in dealing with HIV/AIDS</i>	
Full knowledge of HIV/AIDS and good inter-personal skills for healthcare providers to ensure accurate and quality information sharing in relationship with clients	<ul style="list-style-type: none"> • Universal safety precautions are critical to protecting all providers when dealing with HIV. • HIV/AIDS carries a lot of stigma. Providers need to deal with clients openly, honestly, and with care and compassion • Confidential counselling is an effective approach which gives the client more confidence to act positively to fight HIV • Providers need to know all the causes, means of prevention and potential treatment to help clients make good safer sex decisions.
<i>Improved attitude of health personnel towards their clients especially PLWHAs/PABAs</i>	
Increase positive attitudes care and support towards PLWHA/PABA & people with STIs.	<ul style="list-style-type: none"> • PLWHA are people just like everyone else in your community, except that they have a terminal disease. • PLWHA need to be dealt with openly and honestly. • PLWHA need accurate, useful information about positive living. They need your care, support and compassion.

■ **Table 5: Key Message – Health Care Providers**

PLWHA	
<i>Reduced self stigmatisation by PLWHA</i>	
PLWHA live positively	<ul style="list-style-type: none"> • Even if you are HIV+, there are ways to live positively that will improve the quality of your life, your family, and partner. • Good nutrition can help you stay strong and active. • PLWHA who get involved publicly in the fight against AIDS will help the public understand the disease better, will reduce stigma, and will make major contribution to successfully fighting the epidemic
Reduced stigmatisation of PLWHA nationally and among communities	
General population and communities to accept and care for PLWHA	The psychological, social, economic and health support of PLWHA will help them and your community live better lives
<i>Increased access by PLWHA, OVC and PABA to holistic services¹</i>	
<ul style="list-style-type: none"> • PLWHA & PABA to link up with support groups • PLWHA to visit ART centers as necessary and treat opportunistic infections. 	<ul style="list-style-type: none"> • Joining or establishing PLWHA support groups will help all PLWHA and will increase positive change in society • ARVs will greatly improve your quality of life, though they have side effects that you need to know about.
• Female PLWHAs to visit PMTCT sites	<ul style="list-style-type: none"> • If you are HIV+ you can pass HIV to your baby while you are pregnant, during childbirth or by breastfeeding. • You can prevent your unborn baby from being infected with HIV. Visit a PMTCT centre to find out how.
• Employees who are living with HIV to access workplace VCCT and other programmes	<ul style="list-style-type: none"> • Employers cannot discriminate against you because you HIV+ or have AIDS. Ask your employer what services they have to help you. • Visit a VCCT centre to get help on positive living and treatment.
<i>Increased access to income generation activities (IGA) and protection of livelihood</i>	
Employers to have positive and supportive attitude towards employees with HIV	<ul style="list-style-type: none"> • It is illegal for employers to discriminate against staff who are HIV+. • It will help your company and all your staff if you have a good employee programme to help prevent and treat HIV/AIDS

■ **Table 6: Key Message – PLWHA**

¹ Holistic services include workplace health education and treatment, VCCT, ARVs, PMTCT, opportunistic infections, diagnosis of STIs, home-based care, grief counseling, psychosocial counseling, community-based support for OVC and PABA

High risk uniformed services	
<ul style="list-style-type: none"> • Consistent condom use outside marriage • Complete appropriate treatment of STIs 	<ul style="list-style-type: none"> • If you have sex outside marriage, you should use a condom every time with every partner • STIs seriously increase your risk of HIV infection. Get treated for STIS regularly. • Knowing your status will help you make more positive decisions about your life.
<i>Increased personal risk perception of HIV among members of the uniformed services and their networks (including families and professional contacts such as prisoners)</i>	
<ul style="list-style-type: none"> ▪ Increased knowledge of HIV transmission • Accurate perception of personal HIV/AIDS risk 	<ul style="list-style-type: none"> • You have a duty to protect your country from danger, but you must first protect yourself from HIV. • If you ever have casual sex without a condom, or with multiple partners, you are at serious risk of getting HIV. • If you have sex with a sex worker without using a condom, you are at very high risk of getting HIV. • The only way to know if someone does not have HIV is through a proper test not by looking at the face.
<i>Reduced stigmatisation and discrimination against PLWHA in barracks and work settings of uniformed services workers</i>	
Acceptance and care for colleagues with HIV	Help your colleagues who are HIV+ by giving them support not rejecting them. You can help their wives and orphaned children by showing them support.
<i>Increased participation in VCCT</i>	
Service personnel of existing VCCT centers	Help your military colleagues who are HIV+ by giving them support not ostracising them. You can help their wives and orphaned children by showing them support.
<ul style="list-style-type: none"> • Consistent condom use outside marriage • Complete appropriate treatment of STIs 	<ul style="list-style-type: none"> • To protect yourself and your country, use a condom every time you have sex outside marriage; • A strong soldier is a safe soldier, who protects himself first; • STIs make it much easier to get infected with HIV. Treat all STIs immediately.
High risk transport workers	
<i>Increase personal risk perception of HIV among long distance drivers and their networks</i>	
<ul style="list-style-type: none"> • Increased knowledge of HIV transmission • Accurate perception of personal HIV AIDS risk 	<ul style="list-style-type: none"> • Unprotected sex with anyone puts you at a risk of HIV • If you have casual sex without a condom or regularly with multiple partners you are at serious risk of getting HIV

■ **Table 7: Key Message – High Risk Group**

	<ul style="list-style-type: none"> The only way to know if someone does not have HIV is through a proper test
<i>Reduced stigmatisation and discrimination against PLWHA</i>	
Acceptance and care for colleagues with HIV	Help your working colleagues who are HIV+ by giving them support not ostracising them. You can help their wives and orphaned children by showing them support.
<i>Increased use of VCCT services</i>	
Service personnel of existing VCCT centers	<ul style="list-style-type: none"> The only way to know for certain that you are HIV+ or negative is to take a test Knowing your HIV status will help you to make safer choices about sex and to make good decisions about living positively VCCT is confidential. The counsellor will help you make safer choices.
Consistent condom use with non spousal partners	<ul style="list-style-type: none"> If you have sex without a condom outside marriage you are at risk of getting HIV If you have sex without a condom with a sex worker you are at very high risk of getting HIV The only way to know if someone does not have HIV is through a proper test.
<i>Improved self-efficacy for condom use</i>	
Proper treatment of STIs by transport workers	STIs make it much easier to get infected with HIV. Treat all STIs immediately.
High Risk: Female sex workers	
<i>Increased positive perception of condom efficacy</i>	
Sex workers to use condoms for every sex act with clients & boyfriends	<ul style="list-style-type: none"> Any sex without a condom puts you at serious risk of HIV The more unprotected sex you have, the higher the risk of HIV infection Your regular partner (boyfriend) may have unprotected sex with others. Love and trust are not enough to protect you against HIV. You need to use a condom every time you have sex.
<i>Appropriate and complete treatment of STIs among sex workers</i>	
Increase proper treatment of STIs	STIs seriously increase your risk of HIV infection.
<i>Increased risk perception of HIV and AIDS</i>	
<ul style="list-style-type: none"> Increase knowledge about HIV transmission 	<ul style="list-style-type: none"> Any sex without a condom puts you at serious risk of HIV

<ul style="list-style-type: none"> • Increase correct personal risk assessment for HIV/AIDS 	<ul style="list-style-type: none"> • The more unprotected sex you have, the higher the risk of HIV infection • Your regular partner (boyfriend) may have unprotected sex with others. Love and trust are not enough to protect you against HIV. You need to use a condom every time you have sex.
<p><i>Advocacy: an enabling environment for safer sex practices</i></p>	
<ul style="list-style-type: none"> • Police to reduce harassment of sex workers • Health care workers to be more responsive to FSW health problems 	<ul style="list-style-type: none"> • Police should acknowledge the rights of all citizens. • Health workers need training to be able to help sex workers stay safer.
<p>Youth</p>	
<p><i>Increased knowledge and understanding of HIV/AIDS and Adolescent Reproductive Health (ARH)</i></p>	
<ul style="list-style-type: none"> • Improved knowledge of the health benefits of abstinence in relation to HIV and AIDS • Increase in knowledge of transmission and prevention of HIV and AIDS • Decrease in level of stigma and discrimination of PLWHA by the youth 	<ul style="list-style-type: none"> • Abstinence is the best protection against HIV and AIDS • If your partner respects you, he/she should also respect your desire to abstain or delay having sex. • You can protect yourself better if you find out all the facts about HIV/AIDS now • Talk to a trusted person about HIV and AIDS. They can help you make safer decisions to protect yourself from HIV. • A friend with HIV/AIDS is still your friend. They need your friendship and support even more when they are sick.
<p><i>Increased social, political and financial support for pro-youth interventions to reduce high risk behaviours</i></p>	
<ul style="list-style-type: none"> • Increased public statement for pro-youth interventions by gatekeepers (government officials, religious/ traditional leaders) • Increased funding by government and Organized Private Sector for pro-youth intervention • Successful operationalisation of policies for pro-youth intervention 	<ul style="list-style-type: none"> • Political leaders have a responsibility to guide youths and to help them to keep healthy and safe. By providing more youth-friendly information and services to young people you will help them and your society stay strong. • Policies need to be translated into real action in the community. Make sure resources are properly allocated to help young people live and learn positively.
<p><i>Increased life skills relevant to HIV/AIDS prevention amongst youth</i></p>	
<ul style="list-style-type: none"> • Improved personal skills to resist pressure to have early sex and practice abstinence • Improved personal skills to negotiate condom use, 	<ul style="list-style-type: none"> • Talk to your parents, to your friends and to trusted adults about HIV and AIDS. They can help you make safer choices. • If you respect others and respect yourself you can make safer choices about HIV/AIDS

■ **Table 8: Key Message – Youth**

<ul style="list-style-type: none"> Improved skills to practice single partner relationship 	<ul style="list-style-type: none"> If you stay with one uninfected partner, who remains faithful, you have a much lower risk of getting HIV and AIDS Talk to your friends and parents about life, and about the future.
<p><i>Increased safer sex practices amongst youth, including delay of sexual onset, decrease in number of sexual partners, consistent and correct condom use, and mutual fidelity</i></p>	
<p>Delay sexual debut, abstinence, mutual fidelity, consistent condom use with non-spousal partners, and partner reduction</p>	<ul style="list-style-type: none"> If you have sex without a condom you are at risk of getting HIV and AIDS. If you have sex with more than one partner, and without a condom, you increase your risk much higher. If you have sex with only one partner, and you are both tested as HIV negative, you have low risk of getting HIV. The safest way to prevent HIV is by not having sex
<p><i>Advocacy: improved access to services for youth on HIV/AIDS, STI, VCCT, and increase distribution of condoms</i></p>	
<ul style="list-style-type: none"> That well equipped, affordable, comprehensive and accessible youth service centers be provided Increased utilization of services (VCCT, STIs, Counseling) and condoms where applicable by youth 	<ul style="list-style-type: none"> By providing good quality, accessible services for youth, you will help them stay safe and productive. Research shows that young people who have better knowledge and have easy access to condoms act more safely and are less likely to get STIs or HIV.
<p>Advocacy: Creating an Enabling Environment</p>	
<ul style="list-style-type: none"> Community leaders act positively to protect their people against dangerous diseases like HIV/AIDS Leaders talk openly about HIV/AIDS and promote all preventive measures, care and support and compassion (and potential treatment) of all their community members Political leaders allocate more resources to fight against HIV/AIDS 	<ul style="list-style-type: none"> Leaders have a moral, social and practical obligation to protect their communities against HIV/AIDS and other deadly diseases. A leader well-informed about all the issues surrounding HIV/AIDS (socio- economic impact, causes, prevention, care and support) can help his community to be healthier, safer and happier. There are many groups available who have the capacity to help communities to help themselves. Political leaders are the guardians of well-being in their society. In the face of the HIV/AIDS epidemic they have a duty to address the issue in every way possible, not as a health issue but as a social issue that affects everyone.

9. 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 exists a collection of national HIV and AIDS indicators in the national HIV M&E framework. The success or otherwise of all implementers in HIV and AIDS prevention, support and care will be assessed based on these indicators.

The Nigerian National Response Information Management System (NNRIMS) for HIV/AIDS Guidelines and Indicators has been developed in response to the need for a well-coordinated Management Information System for HIV and AIDS activities. The overall objective of this system is to monitor the implementation of HIV and AIDS prevention and control activities in the country as well as assess the impact of the strategies. NNRIMS shall also be the repository for the core indicators to be reported on by all programme implementers. NNRIMS is thus defined as a tool to track the nation's response to the HIV and AIDS Epidemic.

The national HIV indicators derived from the NNRIMS and presented in the M&E framework can be classified into impact, outcome and output level indicators. Impact level indicators highlight long term results such as reducing the prevalence levels of HIV and its impact; outcome level indicators present the medium term result of expected behaviours that would lead to the achievement of the impact level indicators; while the output level indicators highlight the short term results of interventions such as increase in knowledge of HIV and AIDS, accurate assessment of personal risk to HIV, and access to products and services.

Implementers are encouraged to include participatory evaluation, where appropriate, to enhance the quality of the evaluation process.

Basic guideline for monitoring and evaluation 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.

9.1. National research data for baseline and programme evaluation

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. The listed data sources are currently on-going and will be available in country for a while. Also funds are presently available to conduct the surveys e.g. DHS, NARHS, Sentinel Survey and the BSS. Most of the surveys are nationally representative with ownership by government and other key stakeholders in the HIV and AIDS national response.

9.1.1. Sentinel Survey

The National HIV sero-prevalence sentinel survey is conducted biennially among women of reproductive age attending ante-natal clinic nation wide. It measures prevalence for both HIV and STI among the women. Findings are used to estimate prevalence of HIV among the general population. The last survey was conducted in 2003.

9.1.2. National AIDS and Reproductive Health Survey (NARHS)

The NARHS survey is conducted every two years beginning from 2003 among males (15-64 years) and females (15-49 years) in all states of the federation with over 10,000 respondents. The survey measures most of the HIV M&E indicators among others.

9.1.3. Youth Behavioural Surveillance Survey (Youth BSS)

This survey is also a biennial survey conducted among young people aged 15 to 24 years at sentinel sites across the nation. The first survey was conducted in 2002. The survey also measures most of the HIV indicators among the youth.

9.1.4. Nigeria Demographic and Health Survey

This survey is a quinquennial (five yearly) survey that measures mostly demographic and reproductive health indicators. The survey recently included a section on HIV that measures some of the national HIV indicators. It is conducted among women and men of reproductive age. The last survey was conducted in 2003.

9.1.5. FMOH (Service Statistics, Mapping of Service delivery points)

A mapping of junction towns/hot spots and service delivery points (ART, VCCT, and PMTCT centers) was conducted in 2003. Also periodic reports are collected from service centers through the NASCP HMIS system, which provides information on progress being made.

9.1.6. Behavioural Surveillance Survey among high-risk groups.

This is a two-yearly survey conducted among Most at Risk Persons (MARPs), including sex workers, transport workers, uniformed services, etc.

10. Operational Framework

Presently, BCC activities need to be better coordinated across the country. NGOs and other organisations are producing large quantities of BCC materials, particularly mass media, often with no reference to national themes or messages. In order for the BCC Strategy to be implemented effectively, the following concerns need to be addressed:

10.1. Coordination and avoidance of unnecessary duplication

Activities need to be coordinated in order to ensure a high level of dialogue between all the stakeholders and donors. This will help stem the unnecessary, wasteful, often ineffective and sometimes confusing duplications in various parts of the country.

Efficiency

Effective co-ordination will allow resources to be used to maximum effect. As resources continue to dwindle, it is important that available resources are judiciously utilized. Partners need to pool resources together for BCC campaigns and activities for more mileage and synergy. Responsibilities should be shared and synergies of effort should be encouraged. Implementers also need to be fully aware of the possibilities offered by various media and interpersonal communication strategies.

Impact and quality assessment

For every intervention, evaluation for impact should be built in during the design process. Impact indicators and the way in which they will be measured need to be agreed upon at that design stage by all parties involved. The M&E framework should be used as the reference point for appropriate indicators.

Focused Interventions

Interventions should be targeted, audience specific and community driven. It is important that the beneficiaries of the interventions are fully involved from the conceptual level.

Equitable Spread (achieve broad geographic coverage)

There is need for implementers to ensure the spread of intervention to all geographic areas as much as is achievable. Efforts should be made by all implementers to focus on the underserved areas of the country especially the “hard to reach” and “difficult to convince groups”.

10.2. Steps to Implementation

The BCC strategy is a large and technical document. There is likelihood that it may be ignored unless active steps are taken to promote it and review it periodically. NACA has constituted and chairs a coordinating body- the BCC committee that needs to actively pursue the following steps:

- Identify key implementers
- Dialogue with implementers from the planning stage of interventions
- Map the national BCC response; identify gaps in coverage and depth
- Develop protocol for M&E matching core indicators
- Develop a database of proposals and resources.
- Develop simple records of local activities with linkages to HMIS of the Federal Ministry of Health and the National Response Information Management System (NNRIMS) in NACA secretariat
- Facilitate the linkages between interventions and appropriate level of government (NACA, SACA & LACA).
- Encourage and facilitate networking with other BCC committees e.g. donors, line ministries etc.

10.3. Quality Control for Promotional Materials

To introduce a high level of quality control and ensure that organisations remain ‘on message,’ a system for vetting and assessing BCC materials produced by the various partner organisations should be in place.

The Advertising Practitioners Council of Nigeria (APCON) remains the final approving authority for all mass media materials. However, to ensure cultural acceptability and basic quality standards, an internal system will be developed that would ensure that messages from the various partners comply with the identified themes of the HIV and AIDS BCC national response. This internal system should be the responsibility of the NACA’s BCC committee.

10.4. Role of NACA BCC Committee

The main responsibilities of the NACA BCC Committee will be to coordinate BCC activities relating to HIV and AIDS, and ensure collaboration and information-sharing among partners as well as monitor the landscape of HIV and AIDS-related BCC and their impacts to achieve the highest quality and effectiveness of BCC materials and activities.

1. The committee will create guidelines for the development of BCC messages or interventions, which should be:
 - Community Driven
 - Evidence based
 - Impact oriented
 - Targeted and appropriate to particular groups or audiences
 - Address specific indicators
 - Peer reviewed
 - Pre-tested
 - Use high quality materials for production.
 - Builds on lessons learnt locally and internationally.
 - Incorporate effective monitoring and evaluation plans

2. Nationally targeted interventions should go through a peer review process. Materials should be submitted to the NACA BCC Committee prior to seeking approval from APCON.
3. The NACA BCC committee will make recommendations for corrections where necessary before submission of materials to APCON for final vetting and approval.
4. NACA BCC Committee should explore the possibility of setting up archival records of all related HIV and AIDS BCC materials within the NACA secretariat. Extra funding would be necessary to make this an effective resource.
5. NACA BCC Committee will facilitate the acquisition of relevant and up-to-date skills among BCC practitioners through the organisation of information-sharing and educational events such as state of the art training.
6. NACA BCC Committee should advocate with media regulators.
7. The NACA BCC Committee should ensure the submission of BCC work plan by major partners to NACA for record, co-ordination and facilitation purposes.
8. The BCC Committee will meet quarterly to review progress of the implementation of the National BCC response strategy.

The committee may also choose to recommend key national themes and messages for each key audience and group (based on research and existing campaigns) which stake holders should take into account in planning their campaigns and interventions periodically.

BCC committees should be encouraged to exist at SACA and LACA levels and play roles in peer review of messages and material developed at those levels.

Appendix 1: Gap Analysis for Priority Audiences

The Gap Analysis looks at the differences or gaps that exist between the current situation and the vision for 2008 for each audience with regards to halting the spread of the HIV and AIDS epidemic. In addition, the enabling and inhibiting factors towards the achievement of the vision are outlined for each audience. These factors will help programme managers determine how best to plan and implement effective BCC programme for each target audience and priority audience groups.

Information from these gap analyses helped to define, for each audience, the objectives or targets, the desired behaviours that need to be addressed, and the strategies and approaches that could help achieve those desired behaviours. These are laid out in tabular form under Appendix 2.

The order for the audiences is as follows:

1. Health Care Providers
2. High Risk Behaviour Groups (Most At Risk Persons - MARPs)
3. PLWHA
4. Youth
5. Men and Women of Reproductive Age

10.1 Health Care Providers

Long-term goal

That by the 2008, all health and ancillary workers are professionally trained, well informed and highly competent to provide quality, client-friendly, non-judgmental services to all clients' especially young people, PLWHA, and PABAs.

A. Enabling Environment (Policy/Governance/Funding)

Gaps and inhibiting factors

- Non inclusion of HIV and AIDS into HCP training curriculum
- Absence of appropriate legislation as it affects human rights, stigma etc
- Inadequate funding to match political commitment by leadership
- Absence of HIV and AIDS workplace policies and implementation strategies in many health care institutions
- Absence of appropriate M & E framework to guide private sector health operations

Enabling factors

- National HIV and AIDS Policy in place
- Development of HIV and AIDS workplace policy in progress
- HIV and AIDS curriculum mainstreaming into HCP training module in progress

- Strong political commitment by leadership and developmental partners
- Some form of legislation in development process

B. Access, services and support systems

Gaps and inhibiting factors

- Inadequacy of skilled manpower for efficient service delivery
- Inadequacy in infrastructure to deliver services
- Limitations in ART, VCCT and PMTCT access by all
- Dependence on quacks
- Inadequate funding to support delivery of quality services by professionals

Enabling factors

- Availability of skilled manpower within the health care sector
- Provision of limited ART and VCCT and PMTCT
- Provision of limited care and support services

C. Knowledge, Behaviour

Gaps and inhibiting factors

- Inadequate levels of knowledge and skills among majority of personnel
- Limited opportunities for continuing training and update information
- Inadequate provision of quality working tools, equipment and supplies

Enabling factors

- Availability of an enormous amount of skilled untapped human resources in country
- High literacy level among HCP
- Knowledge of HIV and AIDS among HCP

D. Community Support

Gaps and inhibiting factors

- Inadequate private sector involvement and participation in mitigating the HIV and AIDS pandemic
- Poor health seeking habits among the populace

Enabling factors

- The Nigerian community caring spirit
- Multisectoral participation of community in HIV and AIDS prevention and mitigation(the traditional African extended family coping mechanism)

10.2 High Risk Behaviour Groups – Female sex workers

A. Enabling Environment (Policy/Governance/Funding)

Gaps and inhibiting factors

- Illegality of sex work
- Constant police harassment of FSWs

Enabling factors

- Involvement of police in intervention among sex workers

B. Access, services and support systems

Gaps and inhibiting factors

- Inadequate service sites
- Stigmatisation of FSWs at health care centers especially for STI treatment
- Reluctance of FSWs to visit health care facilities

Enabling factors

- STI treatment and VCCT currently a strong component of many FSW targeted interventions.

C. Knowledge, Behaviour

Gaps and inhibiting factors

- Low risk perception
- Faith-based sense of invulnerability/fatalism
- Inconsistency in condom use
- Self medication e.g. antibiotics for prevention and treatment of STIs
- Unwillingness to know HIV status
- Poverty, cultural and religious beliefs
- Clients' attitude
- Competition for clients
- Stigma and discrimination at health care centers for treatment of STIs

Enabling factors

- Increased NGO activities in the field
- Brothel based captive audience
- Condoms are easily available, accessible and affordable.

D. Community Support

Gaps and inhibiting factors

- Lack/inadequate support for widows and divorcees promotes sex work
- Lack of support for the girl child e.g. no education and hawking
- Repressive widowhood rights

- Repressive inheritance laws
- Culturally FSWs are outcast

Enabling factors

- More girls now go to school

10.3 High Risk Behaviour Groups – Clients: Transport Workers, Uniformed Services

A. Enabling Environment (Policy/Governance/Funding)

Gaps and inhibiting factors

- Lack of programmes by NURTW
- Dismissal of PLWHA among uniformed (armed) services
- NURTW not seeing HIV as a priority for its members
- Uniformed services may not abide by work place policy legislation

Enabling factors

- NURTW has the potential to mobilise its members for HIV prevention and care and support if provided the capacity and resources

B. Access, services and support systems

Gaps and inhibiting factors

- Access gaps as with general population
- Stigmatisation of men presenting STIs at health care centers

Enabling factors

- STI treatment and VCCT currently a strong component of many HIV prevention programmes

C. Knowledge, Behaviour

Gaps and inhibiting factors

- Low risk perception
- Fatalism: It does not matter how death comes either through accident or AIDS (transport workers)
- “If bullet did not kill a man what is death by HIV” (Uniformed services)
- Inconsistency in condom use
- Self medication e.g. antibiotics for prevention and treatment of STIs
- Unwillingness to know status
- Cultural and religious beliefs
- Feeling of invulnerability by the uniformed services generally
- Belief that condoms reduce pleasure and sexual satisfaction
- Discrimination at healthcare centers for treatment of STIs, and the cost of treatment

Enabling factors

- Increased NGO activities in the field
- Uniformed services AIDS response initiatives
- Condoms easily available and affordable
- Promotion of VCCT and STI treatment to increase with increased donor funding

10.4 People Living with HIV or AIDS (PLWHA)

A. Enabling Environment (Policy/Governance/Funding)

Gaps and inhibiting factors

- Lack of legislation against discrimination
- Inadequate allocation of funds for anti-retroviral therapy (ART)

Enabling factors

- Possible mass supply of ART by donor programmes
- National Policy on AIDS enacted

B. Access, services and support systems

Gaps and inhibiting factors

- Providers; inadequate understanding of the needs of PLWHA
- Inadequate workplace intervention programmes
- ART services grossly inadequate
- Inadequate facilities for ART scale up and delay in allocating/release of funds for ART by the government

Enabling factors

- Pool of trained Health Workers and facilities available
- Emergence of several support groups and PLWHA networks

C. Knowledge, Behaviour

Gaps and inhibiting factors

- Poor knowledge of positive living e.g. nutrition
- Counseling gaps
- Poverty
- Self-stigmatisation (withdrawal)
- Non-disclosure of status
- Inadequate knowledge by the legislators
- Patronage of herbalists and spiritualists rather than orthodox health practitioners
- Stigma by the general population makes disclosure difficult
- Unaffordable and inaccessible ART

Enabling factors

- Legislation currently in process to protect rights of PLWHAs
- Support and network groups increasing

D. Community Support

Gaps and inhibiting factors

- Stigma
- Inadequate family/community support for PLWHA
- Inadequate knowledge by family and community members

Enabling factors

- Extended family system
- Traditional African family support system

10.5 Youth (15 – 24 yrs old)

Gaps.

A. Enabling Environment (Policy/governance/funding)

- Poor implementation of existing policies on HIV and AIDS, Family Life Education (FLE) and youth-focused issues
- Lack of a strong youth voice in the articulation of policies and implementation of activities targeting youths
- Poor system of response for youth in trouble
- Lack of strategic plan for policy implementation
- Inadequate financial resources to backup policy implementation

B. Access to services and support systems

- Lack of youth friendly reproductive health services
- Inaccessible and limited number of service delivery points
- Non-comprehensive package of service e.g. Career counseling, assurance of confidentiality, etc
- Limited youth involvement in programme design
- Inability to afford services
- Relatively high cost of services e.g. VCCT

C. Knowledge and behaviour

- Inadequate knowledge of HIV and AIDS transmission and prevention, including the ABC of safer sex.
- Weak implementation of structured FLE curriculum
- Prevention campaigns focus more on condom use than on abstinence, delay of sexual debut, faithfulness, or partner reduction
- Inadequate knowledge and skills in negotiating abstinence or condom use among the sexually active, especially females
- Distrust of the efficacy of condoms makes adoption of safer sex difficult

Inhibiting and Enabling Factors

Inhibiting Factors

- Weak Parent-child communication on sexuality and reproductive health
- Gap in knowledge and skills on HIV and AIDS issues leading to stigmatisation by youth
- Poverty and poor parental support/supervision often contribute to engagement in high-risk transactional sex for girls and street crimes for boys
- Low priority for youth issues in the community
- Youth themselves do not have the self-efficacy to respond positively to the epidemic
- Community depiction of girls undermines their self-esteem making them vulnerable
- Inadequate funding relative to the population of youth by Nigerian governments
- Low rehabilitation rate for youth in trouble
- Existence of family, community barriers to gaining access to relevant youth-oriented services
- Peer pressure and poor self-esteem make behaviour change and maintenance difficult
- Youth mistrust of leadership at every level
- Unregulated media exposure
- Low level of risk perception of STIs, including HIV infections

Enabling Factors

- More supportive policies towards youth focus are now in place
- Emergence of youth focused/led NGOs and CBOs
- Increasing youth involvement in programme design by donor agencies
- Youth enthusiasm and zeal to try new things
- High consumption of media products by youth makes mass media very cost-effective in reaching youth
- Increased funding to youth programmes by stakeholders

10.6 Men and Women of Reproductive Age (25–49 yrs old)

10.6.1 Knowledge and Information

Inhibiting factors

- Inadequate information about positive alternatives on mutual fidelity
- Incomplete information on HIV transmission and prevention (e.g. may not know that sharp objects constitute a mode of transmission)
- Inadequate information about PMTCT
- High levels of stigma towards PLWHA
- High labour mobility: they are often separated from spouses
- Economic constraints – if they want to be with spouses, finances might be prohibitive
- Permissive environment for extra-marital relationships
- Misconceptions about HIV and lack of receptiveness to facts

Enabling Factors

- Increasing attention to the groups by programmes
- Increasing understanding of issues by stakeholders

10.6.2 There's Need for Consistent Condom Use

Inhibiting Factors:

- Geographic and socio-cultural constraints vis-à-vis ability of women to negotiate safer sex
- Sexuality among mobile labour tends to be erratic
- Male resistance to condom use due to perceived effect on sexual satisfaction
- Inadequate access to condom in rural areas
- Unsupportive religious and traditional beliefs – conviction are hard to shake
- Polygamy is acceptable and extra-marital affairs are relatively permitted for men in many settings
- Reluctance to test for HIV due to confidentiality and fear

Enabling Factors

- Increasing access to affordable condoms
- Increasing acceptance of condom as alternative protection
- Increasing abstinence and partner reduction
- rise in awareness about HIV and AIDS

10.6.3 Access to Services

Inhibiting Factors

- Lack of directory of VCCT Centers
- Demand tends to exceed available services
- Need for cordial user-friendly service with respect and empathy
- Social stigma attached to using HIV and AIDS related facilities
- Inadequate health infrastructure

Enabling Factors

- Increasing attention to quality service provision
- Influx of funding to service delivery
- The existence of different cadres of service providers at all levels

10.6.4 Policy: Respect for the Human Rights of People Living with HIV and AIDS

Inhibiting Factors:

- Non-empowerment of Women
- Inadequacy of policies and programmes

Enabling Environment/ Community Support

Enabling factors

- Willingness of religious and community leaders to act as role models
- Increasing willingness and readiness of CBOs, FBOs and NGOs faith-based and religious organisations (churches, mosques) to permit open discussion and communication about issues of sexuality and reproductive health, including talks on HIV and AIDS and STIs
- Government receptivity to national policy direction – active national policy and response to HIV and AIDS
- Emerging models of advocacy for HIV and AIDS Information