

PEPFAR/NIGERIA ABSTINENCE & BEING FAITHFUL PROGRAM AREA SUMMARY, COP08

The available data for HIV prevalence in Nigeria to date remains the 2005 ANC survey. This survey showed a dip in National prevalence from the 2003 figures (4.4% as against 5.0% in 2005). Prevalence among young women aged 15-24 yrs, which serves as a proxy for new infections, has steadily been on the decline (6% in 2001, 5.3% in 2003 and 4.3% in 2005) though the 20 – 29 year age group had the highest prevalence rates. A high prevalence band was noted in the North-Central political zone, with spread to contiguous states of the North West, North East and South Eastern zones. Some outliers from this band were noted in the South-South zone. The rural vs. urban variation noted in several African countries was not markedly replicated here (3.9% vs. 4.6%) indicating some parity in transmission patterns within these groups. The 2005 National HIV/AIDS and Reproductive Health survey (NARHS) showed low risk perception (28%) amongst the general population and significant reports of transactional sex (11%) amongst young girls aged 15 – 29 yrs. Multiple partnerships are also noted in 26% of young males.

The AB prevention program has been redesigned based on suggestions from a recent prevention TA visit. The USG Nigeria's strategy for COP FY08 AB programming is: (1) to develop a comprehensive package of services to promote abstinence, fidelity and related community and social norms; (2) to implement the minimum prevention package of services within the populations and geographic areas that are driving the Nigerian epidemic; (3) to continue building the capacity of FBOs and CBOS to implement high-quality prevention programming; (4) to integrate comprehensive prevention programming in care and treatment services; (5) to support evidenced-based programming within the national and USG prevention portfolios.

In COP08, the USG/Nigeria AB program will follow a new direction. AB partners will be required to provide a minimum package of services from a pool of established best practices appropriate to the population being targeted. These best practices include the peer education model; PEP plus model; curriculum and non-curriculum based school programmes; community awareness campaigns; interventions that address income generation activities, and build essential life skills; and workplace programmes providing interventions targeting adult males and females and encouraging greater involvement of PLWA (GIPA). In COP08, partners will be expected to utilize a minimum of three of these interventions to count a target and these will be reinforced with mass media activities. The minimum package of services will increase the likelihood that the intended behaviour change outcomes are achieved and will provide a proxy tool for measuring targets reached with AB services. Although this redirection has resulted in an increase in cost per target (\$25), it will ensure a higher quality program package with emphasis on intensity and appropriate dosage of messages and services. It is envisioned that following implementation of the current minimum package, population specific (e.g. youths, adults in general population) packages will be recommended based on evidence from successful practices in the field.

In terms of programme expansion the USG AB program has shown significant progress. In COP06 activities were in 15 states, in COP07 21 states had AB activities and by end of COP08 the USG will be supporting activities in 29 of 37 states. The states have been selected in consideration of prevalence and GoN policy. The AB program will work to further expand services guided by available or soon to be available epidemiological data.

Key achievements to date include a very successful mass media campaign (Zip-up) targeting youths and males in the general population. There has been an increase in the age of sexual debut from 16.9 yrs in females and 19.8 in males (NARHS 2003) to 17.4 yrs in females and 20.1 in males (NARHS 2005). There has also been an improvement in delaying sexual debut amongst 15-19 yr age group. Within this age group, 40.5% of females and 19.9% of males had ever had sex (NARHS 2005) as opposed to 46.5% of females and 26.8% of males (NARHS 2003). The diversification of the AB portfolio has been another significant achievement and has resulted in the deployment of varied combinations of partners and strategies addressing specific high risk populations.

In COP 08, priority will be given to addressing adult behaviour and male norms as it relates to mutual fidelity and avoidance of multiple and concurrent partners through targeted mass media approaches. For the youth populations, there will be a reinforcement of the successful Zip-up campaign and the peer education plus models. These will be complemented with the “parents as counselors” model that encourages “A” messaging from an early age. COP07 plus-up funds were used to expand the scope of curriculum-based school HIV/AIDS programs. This entailed working with the Nigeria Union of Teachers to addresses HIV awareness and prevention by teachers for teachers; teachers’ ethics, including coercive sexual relationships with students; and teachers as role models to guide in-school youth peer prevention programs and in-school peer education program. In COP08 this expansion will continue with efforts to include more schools into the program.

To address programmatic gaps in previous years, new procurement mechanisms have been identified. AIDSTAR will be funded to address issues relating to adult male behaviour, risk perception and intergenerational and transactional sex. PHDC will address BCC interventions targeting youths transiting from abstinence to sexual activity and interventions to develop skills for personal risk assessment. PHDC will also address capacity building and training activities particularly for indigenous partners in the development of BCC strategies, design of IEC materials and in working with the media. Community Reach/PACT will support CBO’s and FBO’s formed during the exit phase of 07 behavior change interventions to continue with behavior maintenance activities at community levels. The exit phase refers to the period where SFH exits a community where it has built the capacity of local FBOs and CBOs to self-sufficiently implement programs. At the point of exit, SFH will move to a new community and these CBOs and FBOs will be supported in COP08 by Community Reach/PACT to further build their capacity and provide continued support in behavior maintenance interventions. This expands the USG prevention program to rural communities.

Project Search will address issues of data-guided programming by conducting analyses of clinical, community-level, and population-based epidemiologic, demographic, and surveillance data; test program implementation models including research on practical applications of new technologies and intervention models in resource-poor settings; and develop local capacity in applied research and ethical procedures by increasing technical skills of in-country investigators and providing technical assistance to local institutions. Project Search will be actively involved in analysis and information dissemination of data gathered from the IBBS, NARHS, and future ANC SURVEYS as well as gathering data on specific priority populations.

COP08 will also target efforts at special populations to address the 'bridge' phenomenon. Previous efforts towards transport workers, and adult males will be replicated in more states and sites across the country; while current services to the military will be expanded to reach other uniformed services.

In COP 07, a formal labor force program with AB and appropriate C messaging and services was developed to reach men and women in the workplace. This mechanism will be continued in COP 08. The Partnership Office at USAID will continue to support the USG team to establish public/private partnerships that will leverage private funds to institute well-integrated workplace programming that reinforces key prevention messages.

To ensure comprehensiveness of HIV/AIDS services, steps will be taken to integrate ABC with care and treatment services. Treatment partners will be supported to integrate prevention counseling and services for all clients in care and treatment settings and for others with emphasis on strong linkage to VCT services. Specifically, healthcare providers and lay counselors in care and treatment settings will be trained to deliver prevention messages during routine clinic visits using tools and job aids. These prevention messages will be delivered during risk-reduction counseling. Partner reduction messages will be given, emphasizing faithfulness to one partner, mutual fidelity while discouraging intergenerational and multiple sex partnerships.

The GON's 2003 National Policy and 2005-2009 Strategic Framework for Action provides a comprehensive framework for HIV/AIDS control efforts. The Expanded Theme Group inaugurated the national prevention technical working group which is mandated with providing technical leadership and direction for HIV prevention activities in Nigeria. The USG Prevention team supported the National prevention technical working group (NPTWG) to develop a two-year National Prevention Plan with a new strategic thrust and this will soon come into circulation. In COP08 the USG team will further support the NPTWG to develop National AB curriculum and guidelines in an effort to ensure harmonization of AB prevention efforts in Nigeria.

PEPFAR/NIGERIA CONDOMS & OTHER PREVENTION PROGRAM AREA SUMMARY COP08

Data from the 2005 ANC survey in Nigeria indicated a decrease in HIV prevalence when compared to data from the 2003 survey (4.4% versus 5.0% respectively). A high prevalence band was noted in the North central zone with spread to contiguous states of the North West, North East and South Eastern zones. However, review of data for specific populations, like sex workers shows an increasing trend for urban (from 1.71 to 30.50 from 1989 to 1996) and outside urban (from 0.37 to 54.7 from 1987 to 1996) areas (UNAIDS, 2004). HIV prevalence in clients with sexually transmitted infections rose from 0.67 to 8.35 between 1992 and 2000 in urban areas, and from 0.49 to 13.65 between 1987 and 2000 outside of urban areas (UNAIDS, 2004). Estimated HIV prevalence for males in the armed forces is between 5-10% (US DOD/Nigeria, 2006; military population 100,000).

The Condoms and Other prevention program has been redesigned based on recommendations from the COP07 prevention TA visit. The USG Nigeria's strategy for C&OP in COP08 are: (1) to develop a comprehensive prevention package of services for persons engaged in high-risk behaviors (PEHRBs); (2) to implement the minimum prevention package of services within the populations and geographic areas that are driving the Nigerian epidemic; (3) to integrate comprehensive prevention programming in care and treatment services; (4) to support evidenced-based programming within the National and USG prevention portfolios.

In COP 08, the USG C&OP program will follow a new direction. Partners receiving C&OP funding will be required to provide a minimum package of services from a pool of established best practices. These best practices include community outreach; structured peer education that includes systematic training curricula, supporting materials, refresher trainings and on-the-job support for peer educators; STI management; interventions addressing vulnerability issues like income generation activities, essential life skills, vocational training/alternative livelihood interventions, especially for young women engaging in informal transactional sex; condom services including education of sex workers on the use of water based lubricants, training in skills relating to condom negotiation and use. Inclusion of messages related to alcohol abuse and its attendant disinhibition effects will feature as a cross cutting message for target populations.

Partners are expected to utilize a minimum of three such interventions which are most appropriate to the specific population being targeted, with mass media efforts acting as reinforcement. The minimum package will increase the likelihood of the intended behavior change outcomes being achieved and serve as a proxy tool for measuring targets reached with OP services. This review has resulted in an increase in cost per target to \$35 for non treatment partners and \$45 for treatment partners (who will provide STI services), but will ensure a higher quality program that emphasizes intensity and appropriate dose of messages and services.

In terms of geographical expansion, services currently in 23 states of the federation will be expanded to cover 32 of the 37 states by end of COP08. This expansion will take cognizance of the USG/Nigeria 5 year country strategy which is responsive to state specific HIV epidemiology. Scale-up of the programming to reach high risk populations in areas with concentrated epidemics will take larger share of overall Other Prevention funding and program effort. Other Prevention

programs at the state and community levels will be targeted to “hot spots” within all states to reach sites where high risk behaviors are more likely to occur. The Priorities for Local AIDS Control Efforts (PLACE) method, a new assessment and monitoring tool to identify potentially high transmission areas will guide deployment of services.

In COP08, the OP program will be strengthened to provide priority population groups (female sex workers, Male and Female Out of school youths, Uniformed Service Men, long distance truck drivers, and taxi drivers) with direct access to quality CT services, STI treatment, condom services including messages on consistent and correct use. Also in COP08 OP programming will be expanded to other uniformed services, including the police and the prisons.

In COP08, implementing partners providing care and treatment services will be supported to provide a minimum package prevention services for people living with HIV. Several partners will provide appropriate information on the consistent and correct use and provision of condoms to PLWHA. The majority of costs associated with Prevention with Positives (PwP) will be offset under care and treatment. Details of PwP programs can be found in care and treatment narratives. In addition, prevention services will be integrated into other clinical services, including family planning and reproductive health. STI treatment rather than referrals will be provided in clinical settings for HIV positives and MARPS.

Current work with Female Sex Workers (FSW) will be expanded to non-brothel settings. FSW interventions will include STI management, C&T services, Provision of Condoms and training on condom negotiation skills with appropriate information on use of water-based lubricants. Training of FSW in vocational skills and savings will reduce dependence on commercial sex activity.

Interventions with transport workers will be continued through successful peer education models and condom services in motor parks, selected transport corridors and recreational spots of transport workers. Major transport corridors will be targeted with Mobile and “Moonlight” VCT services provided at truck stops and parks to encourage transport workers to know their status, and receive behavioral counseling on risk reduction. STI treatment services will be provided along these major corridors.

Work with high risk-youth will be refined to develop gender sensitive programming to meet the prevention needs of young, unmarried out-of-school females and males. The peer education model will be used as a channel to offer appropriate condom messages, provision of essential life skills training and addressing the risks of multiple partnerships, intergenerational and transactional sex. Messages promoting abstinence as the most effective form of prevention will also be given.

In COP07, formal labour force programs with “AB” and appropriate “C” messaging and services was developed to reach men and women in the workplace. This mechanism will be strengthened in COP 08 with emphasis on improving workers’ knowledge of safer sex and facilitating access to condoms. Public- private partnerships that provide appropriate prevention services to small and medium enterprise employees will be expanded. These efforts will complement workplace programs which promote fidelity, abstinence and stigma reduction.

The USG continues to collaborate with the UN and other organizations for the provision of condoms. Collaboration with DFID to leverage condoms from their social marketing programs will continue. UNFPA provides female and male condoms through federal and state government machinery; however proper forecasting and quantification for condom supplies nationwide had been a problem which is being addressed by the recently developed 5 year National condom strategy. These mechanisms will be further exploited in COP08 with partners assisted to provide quantifications disaggregated according to male and female condoms.

USG/Nigeria facilitated the development of a two-year National prevention work plan for Nigeria through the National Prevention Technical Working Group (PTWG); and supported the GoN in the development of a National 5 year Condom Strategy Document. In COP 08, USG/Nigeria will further address the need for improved coordination of these National prevention efforts and continue to provide the technical support required to strengthen these systems.