

Case Study: Nigeria's "Make We Talk" Program

In Nigeria, PSI works through its local counterpart Society for Family Health (SFH) which has been registered in Nigeria since 1985 and has conducted nationwide social marketing and behavior change communication activities since 1993. PSI and SFH have worked in partnership since 1985, and distribute over 80% of the contraceptives in Nigeria. SFH is headquartered in Abuja and has sixteen regional offices. SFH staff conducts communications activities among high-risk groups throughout Nigeria. Through the Make We Talk program, they reach the high-risk populations in brothels, markets, barracks, motor parks, work sites, schools and vocational institutions. SFH's current behavior change communication (BCC) program focuses on four ideas:

1. You can not tell by looking if someone has HIV: A healthy looking person can transmit the virus.
2. Sexually Transmitted Infections (STIs) enhance the risk of contracting HIV.
3. HIV can be prevented by abstaining from sex, faithfulness to an uninfected partner, consistent and correct condom use, and reducing the number of sexual partners.
4. Care and support are needed for people living with HIV/AIDS.

SFH integrates its mass media, mid-mass media, and interpersonal outreach with participatory, rights-based community work developed by a UK based NGO, ActionAID. In collaboration with ActionAID, the Make We Talk IPC program is being implemented in 112 intervention sites. Currently these activities make up the second phase of a pilot program, the first phase of which lasted 18 months and ended in July, 2004. This phase involved implementing IPC activities in 13 pilot sites, while an additional 13 sites served as control sites. The second phase which began in 2005, scaled-up the successful intervention into the 13 control communities and included the addition of drama activities to the core peer education activities. Phase two of the program also involves scaling-up the activities into an additional 86 sites.

IPC activities address four primary high risk groups. First, IPC outreach is conducted with both brothel and street-based sex workers. They also seek to target hawkers, other women who augment their income through transactional sex, but do not necessarily identify themselves as sex workers. Second, transport workers are targeted. This group includes long distance truck drivers, intra- and inter-city bus and car drivers, okada (motorcycle) riders, and transport assistants, such as mechanics. Third, out of school youth are targeted, with a special focus on those who engage in transactional sex such as waiters, food sellers, male youth who hang out in motor parks, and garage mechanics. Finally, males in the military and the police force are also targeted.

IPC activities are diverse and participatory in nature. Among all the target groups, peer education activities provide the core of IPC efforts. Interpersonal communicators (IPCs) are also used to lead individual or group activities with groups deemed to be "target group influencers." Target group influencers are people who are not members of a given high risk group, but may have close associations or regular contact with them in work or social settings. Brothel owners or managers, for example, may be target group influencers for commercial sex workers and union executives may be target group influencers for transport workers. IPC interactions are focused on a particular message or issue and are aimed at creating an enabling environment for behavior change. Currently, these activities are supplemented with dramas focused on the same messages. These dramas may occur in public streets and

parks, or at private locations, such as brothels, where target groups may be found.

Nigeria's Make We Talk activities were created through a partnership with ActionAID, a local NGO. In the past, ActionAID had developed a participatory, inter-personal communication methodology known as "Stepping Stones," which has been utilized in several African countries for community mobilization, empowering women, and developing consensus on rural development needs. ActionAID trained SFH field staff on participatory IPC, and utilized its network of field staff with extensive experience in community mobilization. All in all, SFH and ActionAID created 16 multidisciplinary field teams that operate out of 15 of the 37 states in Nigeria. By forging this interdisciplinary initiative, the participatory inter-personal communications skills and experience of ActionAID and SFH's expertise in service delivery, research-based decision-making, as well as its private sector efficiency have been combined to optimize HIV/AIDS prevention activities. For example, SFH leads, supports, and facilitates the activities of community based partners to achieve goals and outputs at the site level. Examining budgetary expenses also highlights the structure of the program.

How was it decided that IPC/PE was appropriate?

The literature on Nigeria as well as SFH's prior research and experience there demonstrated that those who were at the highest risk of contracting HIV were often part of relatively small groups that could not be successfully reached through the mass media. To target these groups whose behaviors put them at high risk, it was decided that interpersonal communications was likely to be the best alternative. To test their hypothesis, SFH planned the pilot study with 13 intervention and 13 control communities in geographic areas where sex workers, uniformed services personnel, mechanics, and truck drivers would congregate. The success of this initiative provided the rationale to scale-up the program.

Selection of Target Population

The selection strategy involved a focus on "hot spots" where target populations exhibiting high risk behaviors were likely to be found. Transport hubs including motor parks and bus depots as well as commercial markets were targeted. Within these settings, specific locations where the target population could be found were identified. Commercial Sex Workers (CSWs) were sought in brothels, military personnel at barracks, transport workers at truck stops and mechanics at garages.

Another strategy employed by SFH was using IPCs to engage "influencers," or opinion leaders who in turn have regular contact with the target population. For example, conducting IPC sessions with garage owners who would in turn influence the young mechanics working for them might be a beneficial way to inspire behavior change among the mechanics. Thirty different groups of "influencers" were identified and SFH spent much time developing and fostering trusting relationships them and the IPCs. By engaging these garage owners, program staff learned that they were as much at risk for HIV infection as the younger mechanics.

Formative Research

An initial community mapping exercise was carried out prior to the design of the pilot program. The mapping was used to identify different high risk groups and their locations. For commercial sex workers, for example, this included the identification of brothels, number of sex workers, the structure of brothel management, and the location of nearby transport and trucker stops.

The baseline assessment was carried out in December of 2002. This included quantitative surveys as well as qualitative research techniques including focus group discussions and in-depth interviews. The baseline research attempted to assess current behavioral trends among the high risk groups as well as obtain a better understanding of the populations themselves, while the objective of the qualitative research was to learn more about the intervention sites and better understand who goes to those sites and what kind of behaviors they exhibit.

A community needs assessment was also carried out by target group members as part of the formative research. The objective of the assessment was to identify needs that may have been overlooked by the qualitative and quantitative formative research efforts. The needs assessment also helped provide additional insight into the challenges faced by group members that potentially contribute to their high risk sexual behaviors. The community assessment helped program planners learn more about and better understand the target population because group members, themselves, were involved. For example, in one site, community members were found to have a high prevalence of eye infections and other eye problems due to the high prevalence of narcotic use in that area. In another site, a lack of good refuse disposal and toilet facilities for female sex workers was identified. In both circumstances, having knowledge of these problems allowed program planners to better meet target group needs.

Selection of Program Messages

The IPC message selection is an iterative process that was driven initially by quantitative and qualitative research findings and is continually altered based on monitoring research and general feedback from the field. The logframe indicators provide the backbone for these messages to ensure that all messages aim to make improvements in these indicators. All messages are pre-tested among the target groups to ensure that they are understandable and appropriate.

A focus on condom negotiation skills, for example, was decided upon due to findings from the monitoring research. The findings identified that CSWs were likely to defer condom decision making to the preference of their clients, most of whom did not want to use condoms. Behavior change strategies to improve their skills in negotiating condom use and promoting the benefits of using them were developed.

The Evolution of IPC Program Development

SFH made several attempts at developing their IPC program before finally settling on the activities in use today. Nonetheless, it was a valuable learning process, and much insight into IPC program development can be gained from understanding their lessons learned. The first approach used by SFH involved training SFH staff members as IPCs to give short talks on HIV issues, answer questions, and hand out pamphlets in the locations where target group members can be found. An evaluation conducted years later showed that this approach had little or no impact, and that there were no behavioral differences between those who had contact with the IPCs and those who did not. As SFH staff, the IPCs utilized were experts in HIV/AIDS. SFH identified this fact as a fundamental problem with their approach, and decided to no longer send in “experts,” but instead to focus on building the skills of the target population by focusing on peer education.

This more participatory approach was developed and implemented, but it also did not have the desired impact on behavior change. Further research indicated that most members of the

target population had only one contact with the PEs. The findings indicated that behavior change was difficult to inspire through only one person-to-person contact. The participatory approach was not repetitive enough to make a significant difference. Though they were successful at increasing HIV knowledge, this knowledge was not leading to risk reducing behavior change. They did, however, have some success with the CSW intervention component, in which condom use with clients rose significantly. This success was attributed to three primary factors. First, the sex workers were repeatedly contacted by peer educators at least once a week. Second, messages were targeted toward specific behavior change and the benefits of such behavior change, rather than focusing generically on HIV risk reduction. Third, the CSW program worked to create an environment of social support between the brothel management and the sex workers themselves. Nigeria applied these lessons learned to future campaign components.

Promoting Community Ownership

An open community meeting is a tactic often implemented to mobilize the community and enlist their support of a new program or service. Meetings serve to educate community members about program goals, and to promote community involvement in and ownership of the program. Participants in open community meetings might include community leaders, youth, members of a target population, and target group influencers.

For the “Make We Talk” program, open community meetings were conducted with each target group at each program site. For CSWs, for example, the open community meeting included sex workers themselves, and anyone who contributed to the structure and administration of the group, such as brothel owners and managers. Barmen, madams, and pimps were also invited. A community meeting among transport workers included all transport workers, their executives, vehicle assistants, and other vendors and touts. The process of these meetings helped increase participation and build ownership of the project among each target group. The agenda for an open community meeting with uniformed services personnel can be found here.

The challenge of NGO partnership

A significant challenge in the process of SFH/Nigeria’s IPC program development was developing and fostering its relationship with ActionAID. Although these challenges were resolved, it can be beneficial to learn from SFH’s experience. ActionAID was selected as a partner because it arguably has more peer education experience than any other NGO in Africa, and SFH hoped to benefit from that experience. As it turned out, their peer education experience was limited to community development, and they actually had little experience with high risk target populations like sex workers, truck drivers, and military personnel. Encouraging ActionAID to adapt its community mobilization methods to the needs of high risk groups was a long and arduous process. The “Stepping Stones” community approach did not work as well with high risk target populations, who are defined by their unique characteristics that distinguish them from a general, rural community.

This challenge is evidenced by the manual that ActionAID provided as a basis for SFH’s IPC activities. This manual, which draws on the “Stepping Stones” methodology, serves as a guide for IPCs and Peer Educators (PEs). The manual is too complex and was not appropriately adapted to the needs of the specific target populations in Nigeria. This posed a series of problems for the success of IPC program activities, as much of the content was found to be inappropriate by those using the manual. The following criticisms of the manual were made by IPCs attending a regional training workshop:

1. The content is not focused on high risk populations.

The manual was too focused on rural community mobilization and featured examples and role plays that were not relevant to SFH's target population. There were virtually no content or images that addressed the high risk populations including truck drivers, sex workers, uniformed services personnel, and mechanics who were selected to be specifically targeted by the IPC program.

2. The content was too complex for IPCs and PEs.

The language used and the complexity of the exercises and the instructions were not understood by the peer educators and the interpersonal communicators. The content of the manual was also too voluminous. A more practical and user-friendly version that takes into consideration the education and literacy levels of IPCs and PEs is needed.

3. Help needed with translation into local languages.

A translation to local languages of a simplified version of the manual would greatly facilitate its use. Producing a translated version can often be prohibitively expensive. Developing a local language lexicon of commonly used terms would be helpful and improve the applicability of the program to target populations.

4. More appropriate picture codes are needed.

The most commonly used behavioral materials were the picture codes, or illustrations that demonstrate a situation where participants can opt for either high or low risk behavior situations. These picture codes are designed to stimulate discussion among IPC program participants. Although the concept was appreciated by the IPCs and PEs, the situations they depicted need to be more appropriate for the target population. For example, picture codes of two teenage boys watching pornographic movies was the most relevant graphic to be used to stimulate discussion among mechanics, while an illustration of a pregnant teenager was used to facilitate discussions of safe sex among sex workers. IPCs and PEs also voiced a preference for photos rather than line drawings.

5. Need more of a focus on real sexual behavior choices and benefits.

Merely stating facts about HIV/AIDS does not have the same impact on inspiring behavior change as personal risk assessments that include an examination of personal behavior choices and consequences. A truck driver, for example, might be more motivated to use condoms with sex workers if he truly comes to understand that he might bring an STI home to his wife. Those in the high risk target populations need to identify their own obstacles and not simply be told what they are. The manual needs to be fine tuned to include more behavior choice and benefit scenarios.

6. The content of the manual is not explicit about behavioral options.

A key element for high risk groups comprised mostly of females, is to focus on enhancing their condom negotiation skills. Currently, the condom negotiation section of the manual is unclear and complicated to implement. The instructions for the IPCs and PEs were difficult to follow and the link to the adoption of positive behaviors is not always made.

With the absence of an appropriate manual which guides the preparation of individual IPC sessions, the jobs of the IPCs and PEs become quite difficult. To compensate for problems with the manual, the tendency is for IPCs/PEs to cover too much content in one session thereby overwhelming IPC participants. When utilizing IPC, it is more effective to cover one topic in detail rather than superficially covering many topics. Furthermore, a manual that is not designed specifically for the target population in question is much less likely to be successful in conveying the appropriate risk reduction messages.

Finally, the ActionAID approach considered the community mobilization process an end in and of itself. However, when focusing on mitigating HIV transmission, while community mobilization and empowerment are important components, there are other desired and necessary outcomes such as increased condom use or VCT uptake. Building the capacity of NGO partners for reaching high risk target populations was one of the major accomplishments to date according to SFH.

Links to Services

In order to promote STI treatment service usage, "Make We Talk" had to establish the necessary links to services in the community. To do so, SFH/Nigeria went through the following steps:

1. Made inquiries among target group communities to identify where they currently go to obtain services.
2. SFH/Nigeria staff visited those sites to ensure that they met a pre-established criteria (commonly used by community, offers necessary facilities, be youth and sex worker friendly, must maintain and track treatment records).
3. The owners and managers of those sites were interviewed to gain additional information about the site, and to help further determine quality standards.
4. A memorandum of understanding was developed with each site that met SFH's standards.
5. The specific sites are now promoted among the target groups.

This technique was beneficial because the sites targeted were those with which target population members were already familiar. SFH maintains a good relationship with its service sites, and provides training and quality improvement when necessary. For example, SFH found that sex worker use of STI services was low even though the services were accessible and affordable. Research revealed that they didn't access the services because they feared a negative reception from service providers and long delays in getting service. SFH then worked to help sensitize the STI service providers on the importance of not stigmatizing sex workers and worked with the sex workers so that they understood that the delays in service provision were encountered by all women and were not a result of sex worker discrimination.

Monitoring & Evaluation

There were three main time-related monitoring and evaluation (M&E) tasks. Baseline data was collected in 13 pilot communities and 13 control communities in December, 2002. A mid-term review was carried out in December of 2003, and a post intervention survey was conducted in August of 2004. Monitoring and evaluation activities were used to assess program impact, as well as whether the interventions were being implemented according to plan.

Data findings from each time period were used to improve upon the program design,

messages, and activities. During the mid-term evaluation, the study identified some major difficulties with the approaches which were gradually revised accordingly. In retrospect, a more effective monitoring system might have revealed the difficulties sooner, and there is some concern that the current approach to M&E is not producing the information needed to quickly identify problems and make the necessary adjustments to program activities. For example, programmers would like more insight into how to overcome the reluctance of sex workers to participate in interventions and how to reduce police harassment of IPCs. There are some additional complaints that the monitoring methods need to be more practical and less complex, especially if they are going to be replicated in other states in Nigeria. In general, there is a wide range of interventions conducted but little clarity on what each intends to accomplish which made it difficult to track progress with inspiring behavior change. A more flexible research approach that would allow for a series of small scale studies looking at emerging issues to guide the changes in approach might also have been useful to complement the larger 26 community studies.

Using Research to Inform Program Design

Findings from the baseline survey among sex workers in the six primary health care zones of Nigeria suggested that there were regional differences in condom self-efficacy (ability to negotiate condom use with clients and knowing how to use a condom correctly), and consistent condom use. The findings helped highlight the importance of focusing on condom self-efficacy to improve condom use among sex workers in IPC activities.

Research also identified high levels of stigma and discrimination as an obstacle to programming. Special IPC sessions were created to focus on stigma. Organizations of people living with HIV/AIDS (PLWHA) were recruited as partners in the IPC projects, and became heavily involved in some of the target group communities.

Research is also used to help design the dramatic IPC activities. Research is used to identify important barriers and misconceptions of the target populations. SFH staff use the research findings to prepare creative briefs which are shared with professional actors who create dramas with the appropriate messages. SFH's experience with dramas shows that because the dramas were based on behavioral research, the CSWs and other target populations saw themselves in the real-life situations presented. The drama group is also trained to lead a discussion following the presentation of the drama. Building condom negotiating skills among sex workers was a primary goal of one of the recent dramas in Nigeria.

IPC Trainings

The entire IPC/PE manual is divided into 12-14 modules. IPCs and PEs receive training on all modules over a period of 6-9 months, with 3 or 4 modules being covered at any given training. IPC/PE trainings are two-days in length and are approximately every six weeks. Trainings serve as both review of old material and to teach new materials, techniques, and messages. The trainings are designed to meet participant needs. For example, if a group is confused by a given module, it can be repeated to ensure better understanding.

Peer education candidates are identified and selected using a participatory process and following set criteria. Potential candidates are drawn from the target population and are brought together for a group meeting to demonstrate the responsibilities of the job, and to discuss performance expectations. Interested candidates are screened to ensure they fit into the following criteria:

1. Must be a member of the community with proper gender representation.
2. Must be available for the duration of the program.
3. Must be committed.
4. Must be of functional literary level.
5. Must be an accepted person among his/her peers.

Facilitators are also screened to ensure that they possess the following qualities:

1. Command respect in the community.
2. Act as a positive role model.
3. Possess interpersonal and good communications skills.
4. Possess good, innate facilitation skills.
5. Must be non-judgmental.
6. Must be confident and exhibit leadership potential.

Because IPC facilitator turnover rate is high, SFH/Nigeria typically trains more candidates than is needed at a given time so that they have back-up facilitators to rely on in case current facilitators quit earlier than expected.

SFH/Nigeria uses participatory training methods for their IPC trainings, as these have been shown to elicit more effective communicators. Each IPC and PE undergoing training has ample opportunity to develop their facilitation skills by practicing them during the training session. Role-plays, in which each IPC participant conducts activities and exercises while others in the training act as participants, are frequently used to build the skills of IPCs and PEs.

The low level of literacy among sex worker PEs has made training more of a challenge than training the largely literate IPCs. The training was adapted to include more illustrations and photos. With a manual that even the literate IPCs considered too complex, the trainers spent much time and energy simplifying the content to help the peer educators to better understand what was required of them.

Supervisors

The IPC/PE trainers also act as supervisors. They do team spot checks to determine whether the trained peer educators are doing what they have been trained to do in a participatory, interactive manner. If a problem is discovered, it will be addressed with the peer educator directly and may be shared during a review session or a future training session so that others may benefit from the learning experience.

Accomplishments:

1. Established a network of IPC activities which combined SFH and NGO staff. These programs were designed with built-in flexibility allowing for some experimentation to determine what is most successful.

2. Developed the skills to work and negotiate with NGO and community-based partners to successfully reach high risk target populations. Because of this collaboration, both ActionAID and SFH staff are better equipped to work with such populations in the

future, and are more likely to secure donor funding in order to do so.

3. Established a baseline and follow-up methodology for research based decision making.

4. Have demonstrated proven success in increasing condom use with brothel based sex workers, and in training community sex worker peer educators.

5. Established regular monthly trainings that have proven to be effective in maintaining facilitator and target group interest.

Recommendations:

1. Create a Peer Education manual focused on training trainers, supervisors, and the peer educators themselves, which is relevant to the target audience. This manual will help standardize both SFH/Nigeria's approach to peer education and its training techniques.

2. Create support materials that are better focused on the needs of specific target populations.

3. All training and support materials should incorporate more illustrations to cater to low-literate populations.

4. The trainings should include more activities that allow PEs and IPCs to practice facilitating participatory exercises with target group members. This can involve role-plays and/or actual practice in the field.

5. Program activities should focus more on risk reducing behavior change that is appropriate to the target population.