FEDERAL MINISTRY OF HEALTH

NATIONAL AGENCY FOR THE CONTROL OF AIDS
NACA

NATIONAL HIV SELF-TESTING (HIVST) AND PRE-EXPOSURE PROPHYLAXIS (PrEP)

COMMUNICATION STRATEGY

2022

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USAID
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CHOICE
Collaboration for HIV Prevention Options to Control the Epidemic

EpiC

RISE

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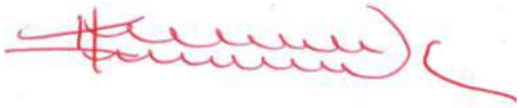
FOREWORD

Human Immunodeficiency Virus (HIV) Pre-exposure prophylaxis (PrEP) and HIV self-testing (HIVST) services are recognized as important sub-components of the minimum prevention package of interventions (MPPI) - a mix of biomedical, behavioural and structural interventions; to meet the HIV prevention needs of individuals and communities globally. The efficacy of HIVST and PrEP in preventing HIV infection has been demonstrated and affirmed globally.

Nigeria approved and recommended the use of PrEP in 2016 and HIVST in 2019; included PrEP in the national HIV prevention plan in 2017, and recommended that PrEP should be offered as an additional prevention choice for people at substantial risk of HIV infection as part of the combination HIV prevention approaches. The uptake of these commodities has been low, especially among the vulnerable and key population groups. Studies have shown that low awareness and knowledge of these HIV prevention methods may be responsible for the current low uptake of the commodities. Thus, the promotion of these commodities among persons at high risk, hard-to-reach and different sub-population groups in Nigeria became crucial upon the approval of these prevention methods.

Nationally, few programmes and interventions are already creating awareness about PrEP and HIVST services among the key populations, adolescent girls and young women (AGYW), and other groups with remarkable results. The priority prevention strategies contained in the HIV and AIDS strategic framework (HSF), as well as ongoing interventions all underscore the importance of HIVST and PrEP on the one hand, and the role and place of communication in HIV prevention on the other hand.

It is against this background and the need to harmonize all thoughts and actions that this strategy was developed as a communication action plan to address the challenge of low level of awareness of HIVST and PrEP services especially among the key populations and vulnerable groups. It will provide direction to initiating, maintaining, and strengthening positive behaviour among people at high risk of HIV infection. The strategy will also serve as a guide in engaging relevant stakeholders in creating an enabling environment for HIVST and PrEP interventions which will engender service uptake. The appreciation of strategic communication in creating awareness of the commodities for HIVST and PrEP, and retaining the interest of users will go a long way in increasing their uptake.



Dr. Gambo Aliyu
Director General,
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PREFACE

HIV case finding among various sub-populations is challenging and has worsened with the COVID-19 outbreak [1]. Nigeria, with the second-highest number of new HIV infections annually in Africa, needs to significantly slow the HIV epidemic to achieve the 95-95-95 UNAIDS goal of ending the AIDS epidemic as a public health threat by 2030. Low HIVST and PrEP service coverage among key and vulnerable populations pose a challenge in the achievement of the national targets of eliminating new infections. The key barriers to the uptake of these services include low awareness and knowledge, stigma and discrimination, negative attitude of the healthcare workers (HCWs), and low access [2]. To address these barriers, innovative strategies must be deployed to rapidly increase the uptake of HIVST and PrEP services, especially for populations with low access and those at higher risk of HIV infection.

Nigeria has adopted the MPPI strategies, including the complimentary implementation of biomedical, behavioural and structural interventions. These strategies include HIVST and the use of oral PrEP, which hold promise in protecting the vulnerable and at-risk populations from HIV infection. With the ongoing HIVST and PrEP interventions across programmes in Nigeria, this communication strategy document is a resource for revisiting existing communication-based strategies. The strategy document aligns with the national objectives and guidelines for HIV prevention. It sets the tone and direction so that all communication activities, products and materials work in harmony to achieve the desired change.

Many people will find this communication strategy useful in identifying the main barriers to the uptake of HIVST and PrEP services in Nigeria and how social and behaviour change communication can help to address these barriers. It will also help implementers leverage the motivators for HIVST and PrEP uptake among high-risk and vulnerable populations in designing communication interventions to foster increased uptake of the services in the country. The strategy will guide stakeholders, implementers and partners in providing input and agreeing upon appropriate communication plans and activities in the design and implementation of their projects for HIV prevention with respect to HIVST and PrEP.

While the strategy is designed for use by a range of individuals and organizations involved in HIV response in Nigeria, the primary users of this strategy are organizations or institutions implementing or coordinating HIV prevention programmes and interventions in the country. As a national document, the HIVST and PrEP Communication Strategy covers as much as possible a cross-section of the Nigerian populace in line with the national HIV prevention guidelines.

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ACKNOWLEDGEMENTS

This HIVST and PrEP Communication Strategy aims to communicate the national approach and guidelines for using the globally recommended combination approach of HIVST and PrEP for HIV prevention in Nigeria. It has received contributions from a wide spectrum of stakeholders working in HIV interventions in Nigeria through a series of carefully planned processes and activities led by NACA and the National AIDS and STIs Control Program (NASCP) of the Federal Ministry of Health (FMOH).

We acknowledge the contribution, enthusiasm and support of the National Prevention Technical Working Group (NPTWG), State Agencies for the Control of AIDS (SACAs), State AIDS Control Programs (SASCPs), United Nations and bilateral agencies as well as implementing partners and civil society organizations (CSOs) for their commitment and inputs that contributed to the success of the development of this document.

The hard work and commitment of the staff of the Community Prevention division of NACA (Dr. Funke Oki, Dr. Chinwendu Daniel Ndukwe, Mrs Ezinne Okey Uchendu, Mr Kingsley Essomeonu, Ms Tosin Ajiboye, and Ms Maryam Sani Haske) as well as the entire staff of NACA are appreciated. The efforts of the staff of NASCP (Mr David Oyeleke, Dr. Uba Sabo, Mr Audu Salif) in the development of this strategy document is acknowledged.

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ACRONYMS

AGYW	adolescent girls and young women
AHF	AIDS Healthcare Foundation
ANC	antenatal care
APIN	AIDS Prevention Initiative in Nigeria
ART	antiretroviral therapy
ARV	antiretroviral
AYP	adolescents and young people
CBO	community-based organization
CDC	United States Centers for Disease Control and Prevention
CHOICE	collaboration for HIV prevention options to control the epidemic
CITC	client-initiated HIV testing and counselling
COP	country operational plan
COVID-19	Corona Virus Disease 2019
CRS	Catholic Relief Services
CSO	civil society organization
ED-PrEP	event-driven pre-exposure prophylaxis
Epic	meeting targets and maintaining epidemic control
FBO	faith-based organization
FHI 360	Family Health International 360
FLHE	family life and HIV education
FMOH	Federal Ministry of Health
FP	family planning
FSW	female sex worker
GBV	gender-based violence
GBMSM	gay, bisexual and other men who have sex with men
HCD	human centered design
HCW	healthcare worker
HIV	Human Immunodeficiency Virus
HIVST	HIV self-testing
HTS	HIV testing services
IBBSS	Integrated Biological and Behavioural Survey
IEC	information education and communication
IP	implementing partner
IPC	interpersonal communication
IPV	intimate partner violence
JAMB	Joint Admissions and Matriculation Board
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
JSI	John Snow, Inc.
KOL	key opinion leader
KP	key population
M&E	monitoring and evaluation
MDAs	ministries departments and agencies
MPPI	minimum prevention package of interventions
MSM	men who have sex with men
NACA	National Agency for the Control of AIDS
NAIIS	National HIV/AIDS Indicator and Impact Survey
NASCP	National AIDS and STIs Control Programme
NCCH	National Call Centre on HIV/AIDS and Related Diseases

ACRONYMS

NGO	non-governmental organizations
NPTWG	National Prevention Technical Working Group
OSS	One Stop Shop
PEP	post-exposure prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PHC	primary health care
PITC	provider-initiated HIV testing and counselling
PLACE	priority for local AIDS control efforts
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child Transmission of HIV
PrEP	pre-exposure prophylaxis
PWID	people who inject drugs
SACA	State Agency for the Control of AIDS
SASCP	State AIDS Control Program
SDC	sero-discordant couple
SFH	Society for Family Health
SGD	small group discussion
SMART	specific, measurable, achievable, realistic and timely
SMS	short message service
SOP	standard operating procedure
SRH	sexual and reproductive health
STIs	sexually transmitted infections
TG	transgender
TV	television
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
VOFs	venue outreach facilitators
WHO	World Health Organization

CHAPTER 1: INTRODUCTION

1.1 BACKGROUND

The National HIVST and PrEP Communication Strategy is designed to support ongoing plans and efforts to increase HIV testing and prevent new cases of HIV infections in the country [3]. The deployment of HIVST and PrEP services in preventing HIV is well covered in global guidelines and recommendations by WHO and UNAIDS [4-6]. The use of HIV self-test kits and the drugs for PrEP has also been acknowledged and approved by the Government of Nigeria as contained in the National HIV Prevention Treatment and Care Guidelines [7].

Despite the effectiveness of HIVST and PrEP services in HIV prevention and Nigeria's approval to use these commodities (especially for people at high risk of HIV infection), the level of awareness and their use across the country is still low [2,8]. This communication strategy thus sets out a plan of action for creating awareness about HIVST and PrEP services in Nigeria. It also focuses on creating demand for the commodities and retaining their use, especially among the key and vulnerable population groups that are at high risk of contracting HIV.

The strategy harmonizes thoughts, ideas, knowledge and experiences that are needed to change the knowledge, attitude and behaviour of target population groups concerning the use of HIVST and PrEP services. It is the outcome of the desires and efforts of key stakeholders and partners in HIV prevention in Nigeria at ensuring that the country utilizes all viable means to achieve the goal of ending HIV/AIDS epidemic in the country. In this instance, the use of strategic communication to initiate or sustain behaviours that will lead to increased demand for and use of HIVST and PrEP services becomes pertinent.

The strategy proffers communication solutions to the issues and barriers around the low awareness and uptake of HIVST and PrEP services among the key populations such as female sex workers (FSWs), men who have sex with men (MSM), people who inject drugs (PWID), and transgenders (TGs) and persons in closed settings. It also covers vulnerable populations like adolescent girls and young women (AGYW) and sero-discordant couples (SDCs). Ultimately, the national HIVST and PrEP communication strategy supports the Government of Nigeria's commitment to the global HIV epidemic control mandate of ending the AIDS epidemic by 2030.

1.2 RATIONALE FOR NATIONAL HIVST AND PrEP COMMUNICATION STRATEGY

HIV self-testing and pre-exposure Prophylaxis (PrEP) services are recognized as important sub-components of the recommended combination prevention (a mix of behavioural, biomedical and structural interventions) for meeting the HIV prevention needs of individuals and communities across the globe.

WHO recommends PrEP, especially for vulnerable groups such as SDCs, AGYW and key population groups – FSWs, MSM, PWID, TGs and people in closed settings. Its efficacy as an HIV prevention method has been demonstrated and affirmed globally. The Government of Nigeria, also having included PrEP in its national HIV prevention guidelines in 2016, recommends that oral ARVs for PrEP should be offered as an additional prevention choice for people at substantial risk of HIV infection as part of combination HIV prevention approaches [3].

Similarly, the National Council on AIDS adopted a memo on the need to promote HIV self-testing among high-risk and hard-to-reach populations in Nigeria. This led to the launching of national operational guidelines for HIV self-testing, which recommends HIVST for different sub-population groups in the country. Like PrEP, there is increasing evidence that the use of HIVST can enhance HIV prevention. However, since Nigeria approved and recommended the use of PrEP in 2016 and HIVST in 2019, uptake of these commodities have been low, especially among the vulnerable and key population groups that need them most [2,8].

The revised National HIV and AIDS Strategic Framework (2019-2021) outlines the priority prevention strategies for general and key populations in Nigeria to include continuous messaging for HIV testing for persons at risk. It underscores community-level mobilization for HIV testing services, including self-testing, for the key populations.

Furthermore, as the HIV prevalence among FSWs and PWID continued to decline over the years, that of MSM kept rising. Thus, the framework recommends increasing access to PrEP, especially for MSM, male sex workers and their clients; including the use of social media platforms to communicate a health promotion agenda, and disseminate HIV information and strategic behaviour change messages. It is important to note that there are already interventions creating awareness about HIVST and PrEP services among KPs, adolescent girls and young women (AGYW), and other groups with considerable results.

These priority prevention strategies contained in the HIV and AIDS strategic framework as well as other ongoing interventions underscore the importance of HIVST and PrEP on one hand, and the role and place of communication in HIV prevention on the other hand. It is against this background and the need to harmonize all thoughts and actions that the Government of Nigeria through NACA and NASCP, in partnership with major stakeholders in HIV prevention in the country developed this communication strategy.

1.3 PURPOSE OF THE COMMUNICATION STRATEGY

The purpose of the HIVST and PrEP communication strategy is to serve all key stakeholders in HIV prevention in Nigeria with a communication action plan to contribute to the prevention of new infections in the country. The strategy is particularly intended to address the challenge of low level of awareness, demand, and uptake of HIVST and PrEP services, especially among the key population and vulnerable groups.

The sub-strategies of this document are aligned with the national objectives and guidelines for HIV prevention. Many people will find this document useful in identifying the main barriers to the uptake of HIVST and PrEP services in Nigeria, and how communication can help to address these barriers and motivators among the high-risk and general population in the country. The strategy will help organizations to design appropriate HIVST and PrEP communication plans and activities as they implement HIV prevention services. This will also help organizations to deploy appropriate demand creation support that will increase the knowledge of the commodities among the target audience and stimulate their interest for continuous use.

1.4 WHO WILL USE THIS DOCUMENT?

The national HIVST and PrEP communication strategy is designed for use by a range of individuals and organizations involved in HIV prevention in Nigeria. The primary users of this strategy are organizations or institutions implementing or coordinating HIV prevention programmes and interventions in the country. Such institutions include government ministries, departments and agencies (MDAs), development partners and donors, civil society organizations, community-based organizations, private sector and faith-based organizations.

This strategy will also serve frontline service providers and notably healthcare workers, who have a critical role and responsibility of providing HIVST and PrEP services in their respective communities.

1.5 TARGET AUDIENCE

The HIVST and PrEP communication strategy covers, as much as possible, a cross-section of the Nigerian populace. However, in line with the national HIV prevention guidelines, the focus of the strategy is on the KPs and other vulnerable populations. In addition, there are influencers and gatekeepers that facilitate uptake of HIVST and PrEP.

1.5.1 Primary Audience (Directly Affected)

The primary audience consists of the people who would directly receive the messaging and interventions contained in this strategy directly. They are persons whose behaviours are to be changed towards the uptake of HIVST and PrEP services. They include:

- Female sex workers (FSWs)
- Men who have sex with men (MSM)
- People who inject drugs (PWID)
- Transgender (TG)
- Persons in closed settings (prisons, correctional centre, and remands)
- Sero-discordant couples (HIV-negative partners)
- Adolescent girls and young women (AGYW), who are at substantial risk of HIV infection

1.5.2 Secondary Audience (Directly Influencing)

The secondary audience have a direct influence on the primary targets in the uptake of HIVST and PrEP services. They are intermediaries in getting the message across to the primary audience. They include:

- Champions/role models/ support group of AGYW
- Parent/guardians of AGYW
- Health care providers
- Correctional centre officers
- Community gate keepers (e.g. brothel chairladies, bar managers, drug bunk owners, etc.) for KPs, and people living with HIV/AIDS (PLHIV)
- Clients/partners of FSWs
- Partners of MSM
- Peers and partners of adolescents

1.5.3 Tertiary Audience (Indirectly Influencing)

This target audience comprises people who can facilitate social and behavior change communication of the primary and secondary audience. They also provide enabling environment for these activities. They include:

- Media (traditional and social)
- Policy makers
- Community and religious leaders
- Program managers

1.6 STRATEGY DEVELOPMENT PROCESS

This strategy is a product of extensive collaborative efforts of the government and other key stakeholders through a series of carefully planned processes and activities led by NACA and FMOH-NASCP. The development of the strategy involved a formative study, desk review and collation of information from various relevant studies, program documents, implementation data/feedback, national and international documents on HIV and other related areas, as well as human-centered design (HCD).

1.7 GUIDING PRINCIPLES

This communication strategy is guided by the following principles:

- **Evidence-based HIVST and PrEP messaging:** continuous use of evidence from HIVST and PrEP interventions, research and user-experience as a basis for informing timely communication interventions and messaging.
- **Consistency of messaging:** consistency in HIVST and PrEP messaging across various and appropriate channels of communication as the basis for frequency of exposure.
- **Rights and gender-responsiveness:** respect for gender equality and fundamental human rights through adoption of rights-based and gender-responsive approaches and messaging in HIVST and PrEP communication interventions by all stakeholders and at all levels.

- **Community involvement, engagement and participation:** involvement of community structures including peer educators, community-based organizations, influencers, and related elements as fundamental to achieving the goal and objectives of the communication strategy.
- **Partnerships and multi-sectoral collaborations:** synergy between all multi-sectoral partners for stronger collaboration and partnerships between all stakeholders, including government, civil society organizations, networks of people living with HIV, and international development partners.
- **Optimization of the point of service delivery:** inclusion of HIVST and PrEP services in existing health facilities as a basis for effective linkage and uptake of these services.

1.8 GOAL AND OBJECTIVES OF THE HIVST AND PrEP COMMUNICATION STRATEGY

Goal

The strategy aims to communicate the national approach and guidelines for using the globally recommended combination approach of HIVST and PrEP for HIV prevention in Nigeria. The effective use of this document will contribute to the reduction of the burden of HIV infection among individuals and groups exposed to a high risk of acquiring the virus in Nigeria.

Objectives

This document will guide implementers to design programmes and interventions using a wide range of social and behaviour change communication interventions, which will contribute to achieving the objectives listed below by 2030. These objectives are the broad objectives of the communication strategy. However, there are specific SMART objectives for each target audience in the social and behaviour change communication matrix (tables 2 and 3).

1. Increased awareness and knowledge of HIVST and PrEP services among individuals and groups exposed to the risk of contracting HIV, and the general population in Nigeria.

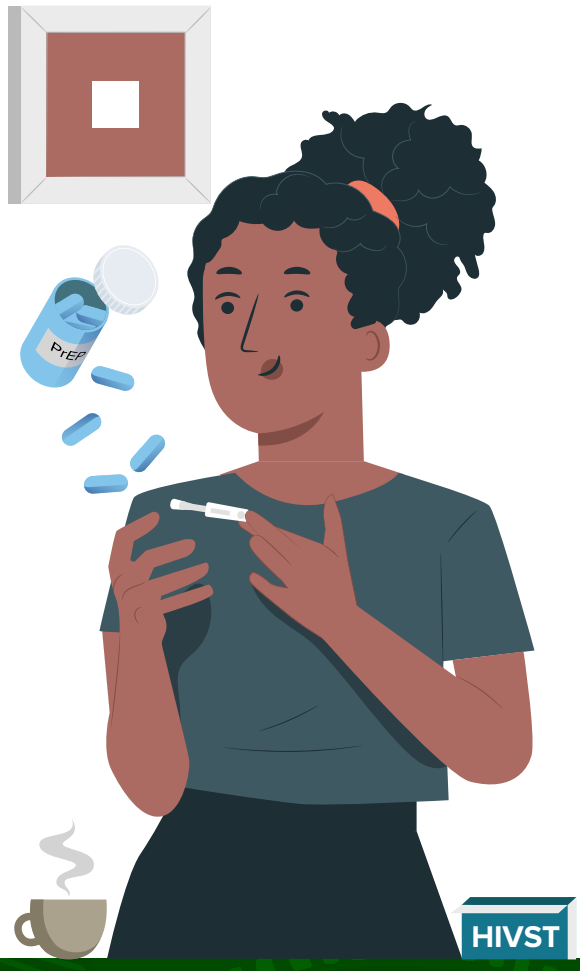
2. Strengthened self-efficacy in the use of HIVST kits, and confidence of users in the use of PrEP.

3. Increased demand for and use of HIVST and PrEP, especially among individuals exposed to a high/substantial risk of contracting HIV in Nigeria.

4. Enhanced retention in the use of PrEP among key and vulnerable populations that are at continuous risk of contracting HIV in Nigeria.

5. Strengthened health care worker/provider skills to provide quality and friendly HIVST and PrEP services.

6. Strengthened stakeholders' involvement in HIVST and PrEP programs to foster a sustainable environment for increased uptake.

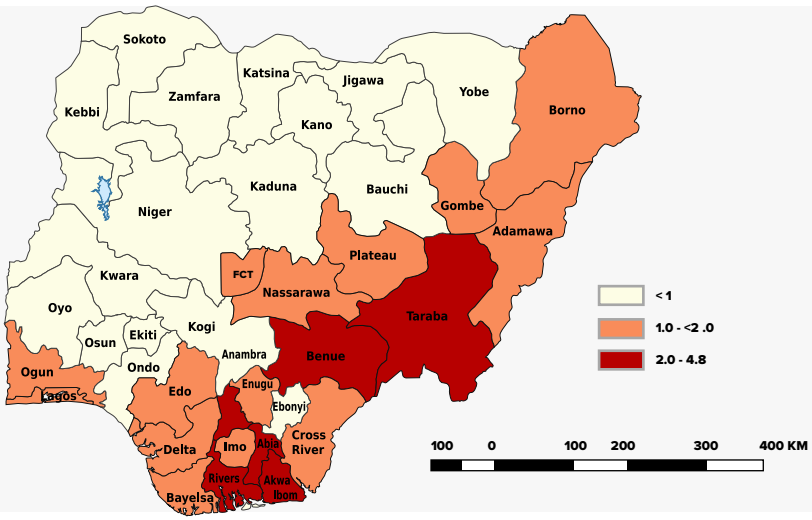


CHAPTER 2: SITUATION ANALYSIS

This section provides an insight into the current HIV situation in Nigeria, including PrEP, HIVST and an overview of audience analysis.

2.1 HIV SITUATION IN NIGERIA

NAIIS report 2018 indicates that approximately 1.9 million people are living with HIV accounting for an overall prevalence of 1.4%. The prevalence of HIV varies from one geopolitical zone to another in Nigeria. The South-South zone has the highest prevalence of 3.1% while the North-West Zone has the lowest prevalence of 0.6%.



National HIV Prevalence: **1.4%**
Total PLHIV in Nigeria: **1,970,557**
Number of PLHIV on ART: **1,114,064**
National ART Coverage: **57%**
National Treatment Gap: **856,513**

NAIIS Report 2018

Figure 1: Nigeria HIV Epidemiology

HIV Case finding among the populace constitutes the first critical step in the achievement of the UNAIDS 95:95:95 goals by 2030. In Nigeria, only 67% of people living with HIV know their status. Nigeria continued to report a significant number of new HIV infections annually with about 86, 000 new infections reported in 2018 [9]. HIV case finding among the population is challenging and this has worsened with the outbreak of COVID-19 [1]. Low HIV testing coverage among men, young people, and other vulnerable populations such as KPs remains a major challenge facing the HIV response in Nigeria [2,10-11]. These challenges include stigma and discrimination to HIV, poor attitude of the HCWs, the distance between communities and facilities, among others [10].

To address the gap in HIV case finding, innovative strategies must be deployed to rapidly increase the uptake of HIV testing services, especially for populations with low access and those at high risk that would otherwise not get tested due to one barrier or the other. One approach that shows promising outcome is the HIV self-testing launched by WHO in 2016, whereby a person collects his or her specimen (oral fluid/blood) and then performs an HIV test and interprets the result, often in a private setting, either alone or with someone he or she trusts. Evidence has shown that HIVST can increase the uptake of HIV testing in Nigeria and contribute significantly to achieving the first 95 of the UNAIDS 95:95:95 goal of ensuring 95% of all people living with HIV know their status by 2030 [10,12-13].

2.2 OVERVIEW OF HIVST AND PrEP IN NIGERIA

Nigeria, with the second-highest number of new HIV infections annually in Africa, needs to significantly slow down the epidemic to achieve the 95-95-95 UNAIDS goal of ending the AIDS epidemic as a public health threat by 2030. Nigeria has adopted the combination prevention strategies comprising of mutually reinforcing biomedical, behavioural and structural interventions. However, the uptake of HIVST and PrEP is generally low in Nigeria due to low awareness, knowledge and accessibility.

2.2.1 Focus on HIVST

In 2016, WHO published guidelines on HIV self-testing and partner notification services-supplement to consolidated guidelines on HIV testing services. According to CDC, HIV self-testing allows people to take an HIV test and find out their status in their own home or other private locations. The availability of HIV self-tests helps to increase awareness of HIV infection for people who wouldn't otherwise get an HIV test. While the commodities are available for retail purchase by consumers, HIVST should be considered as an additional testing strategy to reach persons at a high risk of contracting HIV.

Knowledge of one's HIV status is essential to the success of the global HIV response. In the context of HIVST, it is important to note that pre-test information and post-test counselling can be provided using a directly assisted approach (in-person demonstration and explanation by a trained provider or peer) or using an unassisted approach (use of manufacturer-provided instructions), as well as some other support tools, such as brochures, links to the Internet- or computer-based programs, videos, telephone hotlines, mobile phone applications or text message services.

HIVST came to the front burner in Nigeria in 2016 when WHO launched the new guidelines on HIV self-testing on World AIDS Day in 2016. The WHO highlighted the use of HIVST as an additional approach to HIV testing services. In 2017, Nigeria was part of the global team that attended the rollout of the WHO guidelines on HIVST in Kenya. The outcome of this WHO meeting led to the development of the first operational guidelines for the implementation of HIVST in Nigeria in 2018. Any reactive HIV result from self-testing must be confirmed by a health care worker in accordance with the existing national HIV testing algorithm in Nigeria.

Despite the progress that has been made with the first 95 using HTS, there exist gaps between the number of those living with the virus and the number identified. HIVST has the potential to scale up acceptability and access to HIV testing, both in the general and key populations, as well as other vulnerable populations, including sero-discordant couples (negative partner of positive individual), adolescents and men. It provides confidentiality and empowers users to be solely responsible for the process of determining their HIV status. It also appeals to potential users who may be reluctant to access HIV testing services (HTS) under the current provider-initiated HIV testing and counselling (PITC) and client-initiated HIV testing and counselling (CITC) options, whereby the test is conducted by a trained provider and results given to the client.

2.2.2 Focus on PrEP

In Nigeria, PrEP implementation has largely been at small scales in different parts of the country by the implementing partners with the government providing stewardship and coordination. To achieve the national target of reducing new HIV infections to less than 200,000 by 2030, there is a need to scale up and intensify PrEP services and interventions in the country. The number of individuals initiating PrEP services is currently estimated to be about 124,000 – 125,000 [14]. Some studies conducted in Nigeria that assessed awareness and willingness to use PrEP among gay, bisexuals and men who have sex with men (GBMSM) show that nearly half of the respondents had no prior awareness. Nevertheless, after being informed about its potential benefits, the majority were willing to use it. The studies recommended that educational messages are necessary to ensure appropriate scale-up, especially tailored towards GBMSM [2, 15].

Another study conducted among health workers showed high-level awareness (90%) about PrEP. However, many of the respondents (60%) could not give correct definitions of PrEP, as well as regimen, dosages and level of efficacy [16]. The knowledge of PrEP among healthcare workers, especially those in poor resource settings, should be increased through update courses, educational resources, campaigns/seminars, workshops, and job aids. Also, healthcare workers should be very comfortable carrying out HIV risk assessments of their clients and providing PrEP service to those who are eligible [16].

A cross-sectional survey was conducted in 2018 in two universities in Nigeria among 784 students, of which 76.9% were AGYW and adolescent boys and young men on awareness and use of PrEP. Findings showed a low level of awareness, knowledge, and use of PEP and PrEP among the study participants. Also, among those who were aware, recent HIV testing, knowledge of partner's HIV status, condom use, and exchange of nude pictures were the factors influencing the level of awareness [10]

2.2.3 Emerging Issues around PrEP

In the context of PrEP in Nigeria, the term 'emerging issues' is used to refer to those issues that have not been of concern in the past but have the potential to be of concern in the near future. Awareness of these issues is important to proactively prepare for and mitigate against them if they eventually arise. Some of these issues include:

a. Retention in care: PrEP adherence involves taking PrEP as prescribed over the period that individuals are at risk. PrEP initiation is most often measured by the uptake of PrEP among those who are eligible and offered PrEP. Ideally, it is important to distinguish between first-time users of PrEP and those who re-initiate after a period of discontinuation. Each time an individual starts PrEP, the person must meet the eligibility criteria again. Adherence and continuation on PrEP can be defined and measured in different ways, for example, by self-report or pill counts [17]. Side-effects, stopping (due to mobile nature of KPs) and re-starting PrEP, loss to follow up, risk perception, financial constraints have been highlighted as some of the issues associated with retention in PrEP care [2,18]

b. Event-driven PrEP: Event-driven PrEP (ED-PrEP) for MSM (excluding men that have vaginal and anal sex with women) consists of the use of a double dose (two pills, which serve as the loading dose) between 2 and 24 hours in advance of sex; then, a third pill 24 hours after the first two pills, and a fourth pill 48 hours after the first two pills. ED-PrEP has been described as "2+1+1" dosing [19]. However, ED-PrEP is not recommended for MSM with chronic hepatitis.

2.3 PROBLEM STATEMENT

The WHO has proven the efficacy of PrEP in preventing HIV and the use of HIVST as an innovative, additional HIV testing approach. Being relatively new in Nigeria, and the fact that the awareness creation activities on these commodities are sub-optimal, uptake of these commodities is low amongst both the Key and general populations. This poses a challenge towards achieving the national target of reducing new HIV infections by 2030 [20]. Table 1 outlines in detail the key barriers that contribute to low HIVST and PrEP service uptake among the different target audiences.

2.4 PROPOSED CHANGES TO ADDRESS THE IDENTIFIED PROBLEM

The effective use of this strategy in HIVST and PrEP interventions will:

- Increase knowledge of the risk of HIV infection among key and general populations.
- Increase knowledge of benefits associated with HIVST and PrEP services as well as the efficacy of PrEP for HIV prevention amongst people at substantial risk.
- Address myths and misconceptions around the side effects of PrEP and increase confidence in the efficacy of PrEP for the prevention of HIV.
- Increase efforts to ensure availability and accessibility of HIVST and PrEP by key populations and general populations.
- Increase efforts to promote friendly policies and societal support for persons seeking HIVST and PrEP.
- Reduce associated stigma as well as gender inequalities in health care decision-making, especially for HIVST and PrEP delivery.

2.5 THEORETICAL FRAMEWORK

Social and behaviour change (SBC) is a strategic process that uses a deep understanding of human and societal behaviour to design evidence-based interventions to increase the adoption of healthy behaviours by individuals and influence the social norms that underpin those behaviours. Therefore, social and behavioural programming is mostly an inclusive way of addressing the cultural contexts within which behaviours occur. This is important as these contextual factors, such as gender inequality, stigma and punitive laws, often influence the HIV epidemic [21]. There are some models which attempt to address behaviour change such as the health belief model, socio-cognitive model, trans-theoretical model, socio-economic model among others. However, this HIVST and PrEP communication strategy is guided by the socio-ecological model of behaviour change based on the target audiences.

2.5.1 Socio-ecological Model

The core concept of a socio-ecological model is that behaviour has multiple levels of influences, often including intra-personal (biological, psychological), inter-personal (social, cultural), organizational, community, physical environmental, and policy. Ecological models are believed to provide comprehensive frameworks for understanding the multiple and interacting determinants of health behaviours. For instance, the sexual orientation of KPs places them in conflict with both the so-called accepted values in societies and the policies of the government that guide social conduct. Thus, in addressing barriers to the uptake of HIVST and PrEP among KPs, the influence of environment and policies, social and psychological contexts should be considered [21].

CHAPTER 3: COMMUNICATIONS STRATEGY

3.1 TARGET AUDIENCE

This section provides the essential characteristics of the different target audiences to be served with this document. It highlights the HIV prevalence, predisposing factors to HIV infection, barriers and motivators to the uptake of HIVST and PrEP services of the primary audience.

3.1.1 Primary Audience and Profiling

a. Female Sex Workers

Female Sex Workers (FSWs) are considered a key population and a core group for the transmission of HIV and other sexually transmitted infections (STIs). This is mainly due to the large numbers of sexual partners and high infection rates [22]. Globally, sex workers are 13 times more at risk of being infected with HIV compared with the general population. This is partly due to their economic vulnerability, and inability to negotiate consistent use of a condom with their clients [23]. In Nigeria the HIV prevalence among FSW is 15.5% [24].

FSWs in Nigeria have a high likelihood of being marginalized, criminalized and stigmatized [25]. Structural risk factors such as violence and abuse, increase the risk for HIV infection and STIs for FSWs. They also experience economic, physical, sexual and psychological abuses from clients, brothel managers and law enforcement agents. Those with lower educational status are also at higher risk of being HIV positive [23].

FSWs have critical needs for effective HIV prevention tools. The frequency of condom use among FSWs as an HIV preventive measure was recorded at 98.1% in 2019 [24], however, non-consistent use of condom and the use of psychoactive drugs increase the risk for HIV infection. While condom use as a preventive tool among FSW is high, there is still a gap in HIVST awareness and uptake among FSW, as well as low PrEP uptake among this group. Stigma and discrimination have been identified as barriers to their uptake and use of PrEP [8].

Profiling of female sex worker in rural setting (Bukky)

Bukky, a 34-year-old female resides in 9th Mile Ngwo where she offers protected sex for money to clients who are mainly tanker drivers, touts, and travellers in transit. Bukky is constantly under pressure from her family as her siblings and parents depend on her financially. Also, she offers unprotected sex to special clients (high-paying boyfriends). She wears a charm to protect her from contracting HIV/STIs. Despite this, she experiences recurring itchy vagina and painful urination. On one of the nights out with a client, Bukky heard a health talk on the radio, discussing HIV/STI symptoms and prevention including HIVST and PrEP use that she was not well informed about. Thereafter, Bukky attempted to access HIVST and PrEP, however, the commodities were not available within her immediate environment. The next available service point would require a 3-hour road trip. Moreover, Bukky has constantly heard rumours in her brothel of the terrible side effects associated with taking PrEP. This discourages her from making the extra effort needed to access the drugs even when she knows she is at risk of HIV.

Barriers to be addressed:

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

- Some FSWs are not adequately informed about HIVST and PrEP services therefore there are misconceptions associated with accessing these services.
- The drive to cater for family financial demands exposes some FSWs to the risk of contracting HIV by having unprotected sex for money and other benefits.
- Some FSWs do not have the confidence and skills to negotiate safe sex in relationships.
- Difficulties with accessing HIVST and PrEP services discourage FSWs from opting in.

Profiling of female sex worker in the urban setting (Margaret)

Margaret is a 20-year-old undergraduate who engages in transactional sex with rich classy guys. She is active on Instagram and Snapchat where she meets most of her clients. As a student, Margaret is constantly making trips which makes her miss schoolwork, thus making her engage in sex for grades with some of her lecturers. Margaret is knowledgeable about and can afford HIVST and PrEP, however, she does not consider herself at risk despite unprotected sex with some of her clients owing to their socio-economic status.

Barriers to be addressed:

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

- Some FSWs do not use condoms with special clients.
- Some FSWs do not consider themselves at risk of contracting HIV especially from high profile clients.

b. Men who have sex with men (MSM)

MSM are males, regardless of age, who engage in sexual and/or romantic relations with other males irrespective of their sexual orientation. MSM in Nigeria are conservatively estimated to be less than 1% of the Nigerian population. Nonetheless, the prevalence of HIV among this group is estimated at 22.9% [26] and they account for about 20% of new HIV infections nationally [27]. MSM account for one of the highest HIV incidences among the key populations. While there has been a decline in the prevalence of HIV among other key populations, the HIV incidence for MSM is increasing globally and in Nigeria [11]. Risk factors associated with the rising HIV epidemic among MSM include unprotected receptive anal intercourse [10], numerous lifetime male partners, injection and non-injection drug use, and high viral load in the index partner [26].

There has been a national interest in enhancing the access of key populations, including MSM, to HIVST and PrEP, nevertheless, the laws in Nigeria makes it challenging for MSM and other key populations to access HIV prevention services. The Same-Sex Marriage Prohibition Act proscribes associations between MSM and other persons; those associating with MSM risk being jailed without the option of fines. This poses challenges in the provision of HIVST and PrEP services by service providers to MSM even as they are also less willing to identify and access appropriate services for HIV prevention [8].

A study on the characterization of pre-exposure prophylaxis (PrEP) cascade among Nigerian MSM conducted in April 2018 showed a relatively low uptake of PrEP in this population with younger individuals less likely to use PrEP. Only about 50% of the KPs were aware of HIVST services (out of which 60% are MSM), although this proportion varied across the geographic locations. Thus, strengthening HIV prevention education and encouraging young MSM to take up PrEP services is critical to prevent new infections [29].

Profiling men who have sex with men, MSM (Strawberry)
Strawberry is an 18-year-old MSM, who is an orphan. He is currently a 100-level student of a tertiary institution. He lives with Ade, his 50-year-old sexual partner. Ade is an HIV-positive MSM and not on ART. Ade likes having unprotected sex with Strawberry and pays his bills as his sponsor. Strawberry knows about the use of condoms for HIV prevention from his participation in an HIV prevention program but would not use one with Ade because he feels Ade is rich, influential and classy.

His peer whom he met in school told him about the efficacy of HIVST and PrEP use. Strawberry was motivated by his peers to take up HIVST and PrEP services but he does not know where and how to access the services. Ade threatened to break up with him should he take up the services, giving reasons that they are lovers and trust each other, unless he (Strawberry) is having other affairs. Ade also warned him to quit his relationship with his school peer. Strawberry, who does not want to risk his sponsorship from Ade acquiesced wholly to the warning.

Barriers to be addressed:

What are the most important barriers to consider in Strawberry's situation?
- Some MSM do not use condoms with their partners.
- Some MSM have limited knowledge of HIVST and PrEP services
- Some MSM have no or low risk perception of HIV infection
- Some MSM do not know where to access HIVST and PrEP services even when they might be interested.
- Some MSM experience intimate partner violence (IPV).

Profiling male sex worker, MSW (Thomas)
Thomas, a 20-year-old sex worker lost his 'besty' to HIV/AIDS in 2019. He uses condoms with most of his male clients but not with a few high-paying ones (high-class MSM). Thomas heard of HIVST and PrEP services from an MSM-social media closed group and feels it can offer him additional protection. He conducted an HIV test using HIVST and started the use of PrEP for event-driven vulnerability. He is also facing stigma from PrEP use among some of his clients, which has led to his loss of some high-profile clients. Some of his rivals (fellow sex workers) who are envious of his high-profile clients, spread false information that anyone who uses PrEP is HIV positive, as PrEP is an ARV from their Wikipedia search. Thomas travels away from his station for sexual work and most times does not have access to PrEP.

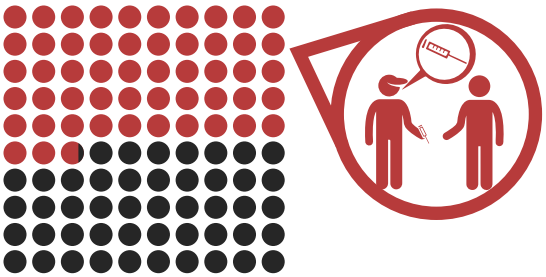
Barriers to be addressed:

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

- Some MSM do not use condoms with high paying clients.
- Stigma discourages some MSM from PrEP use.
- Some MSM have limited knowledge about PrEP which fuels misconceptions (a person taking PrEP is HIV positive).
- Some MSM have confusion between PrEP and ART.
- The high mobility of some MSM discourages PrEP use among some MSM.

c. People who inject drugs (PWID)

A person who injects drugs is defined as any person, 15 years and above, who has injected drugs recreationally at least once in the past 12 months [30]. The National Survey on Drug Use and Health, 2018 report shows that an estimated 14.4% of drug users are HIV positive. This corresponds to 14.3 million people aged 15-64 years who had used psychoactive substances in the past year for non-medical purposes. Notably, 20% of people who use drugs are injection drug users [31]. HIV prevalence among PWID in Nigeria was recorded at 3.4% in 2020 [32]. More than half (52.7%) of the people who inject drugs share needles and account for I9% of new HIV infections in Nigeria [33]. Generally, FSWs who inject drugs have the highest HIV prevalence at 43%. Injection drug use has been identified as a risk factor for HIV infection. Unsafe injection practices, such as sharing contaminated needles [28], are a major risk factor for transmission of blood-borne infections such as hepatitis B and C, and HIV.



52.7%

of people who inject drugs share needles and account for **I9% of new HIV infections** in Nigeria

Oral (PrEP) is clinically efficacious and recommended to mitigate the transmission of HIV among PWID. Studies have shown low uptake of PrEP among KPs. Some of the barriers include:

- Limited knowledge of HIVST and PrEP
- Low HIV risk perception
- Concerns about PrEP side effects
- Competing health priorities and needs due to drug use and dependence.
- Negative experiences with healthcare providers
- HIV-related stigma within social networks
- Poor infrastructure and capacity for PrEP delivery to PWID
- Homelessness and criminal justice system involvement
- Lack of money or identification to get prescriptions [34].

Other than low uptake of PrEP among PWID, support services are limited, and, where they exist, they may not cater to the needs of HIV-positive persons. Less than half of high-risk drug users have received HIV testing and counselling while in treatment. HIV testing is lower among PWID than in all high-risk drug users [31].

Profiling people who inject drugs, PWID (Jerry)

Jerry is a 25-year-old male wheelbarrow pusher who injects drugs and shares syringes (needles) with his peers in the drug bunk as a practice of oneness or brotherly love. The last time he tried to test for HIV was in 2018 in a healthcare facility, where the healthcare provider told him that they had limited test kits and that they prefer to use the limited kits to test important people, not drug users. His experience at that facility discouraged him from accessing HTS in healthcare facilities afterwards. He heard of HIVST over the radio and how one can test for HIV alone. He became interested in using HIVST kits to know his HIV status. However, Jerry does not know where to access free HIVST kits since he does not have money to buy from the pharmacy as mentioned on the radio. He is also concerned that he may not be able to adequately use the kit owing to his low literacy.

Barriers to be addressed:

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

- Some PWIDs are discouraged from HIV service uptake because of the judgmental attitude of healthcare providers.
- Some PWIDs have low knowledge of HIVST and PrEP services.
- Some PWIDs have no or low risk perception of HIV infection.
- Some PWIDs do not know where to access free HIVST and PrEP services even when they have interest.

Profiling people who inject drugs, PWID (Barbara)

Sodom is a semi-urban settlement with a high concentration of persons who inject drugs. Drug use has been the stock in trade among young people, including 24-year-old Barbara. Notably, the community treats women as rags and places them at the receiving end. Barbara took to drug use at age 16 when she was raped by a notorious gang. Her friend Jennifer had asked her to smoke ganja to forget the sorrows. She wanders around and has graduated to injectable drugs in search of a better 'high' and to belong, having lost her family. Barbara has, on several occasions, been held by law enforcement agents for drug use and associated crimes. She has little resistance to peer influence and has become an all-men's babe and engages in anal and vaginal sex without condoms for drugs or money. She does not know HIVST and PrEP services. As her health condition deteriorates, she does not know where to access care, as well as how to overcome stigma and gender inequalities.

Barriers to be addressed:

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

- Some PWIDs have no information about the existence and benefits of HIVST and PrEP.
- Some PWIDs have low self-esteem and hence do not have the confidence and skills to negotiate safe sex in the context of their environment.
- Some PWIDs have no or low risk perception of HIV infection.

d. Transgender

A transgender (TG) is a person whose sense of personal identity and gender does not correspond with the sex at birth. Globally, TG people are around 13 times more likely to be HIV-positive than other adults of reproductive age [35]. In Nigeria, there has been an increasing awareness of the need to provide HIV/AIDS services specific to key populations including FSWs, MSM, PWID, and transgenders (TG). There is little or no relevant data on demographic information, including the prevalence of HIV among TG persons. This group experiences social challenges including violence, legal barriers, stigma and discrimination which leads to low access to health and HIV services. Furthermore, transgender people may experience family rejection, violation of their rights to education, employment and social protection as well as experience higher rates of unemployment, poverty, housing insecurity and marginalization which puts them at higher risk of HIV infection [35].

Profiling transgender (Biodun)

Biodun is a transgender woman from one of the south-south states in Nigeria. She discovered that she is more comfortable identifying as a transgender woman sometime in 2004. Her family was against her new status and initially took her to spiritual homes where she was subjected to many inhumane treatments, including a cut in her wrist that almost made her bleed to death. In 2018, she visited a health care facility for HIV testing services and PrEP, but the attitude of healthcare workers in the facility deterred her from visiting the facility ever again. Considering her risk perception, she decided to source for HIVST kit and PrEP in the nearby pharmacy but could not get PrEP because it is not sold over-the-counter. She paid ₦2000 for one HIVST kit and vowed not to spend such a huge amount on a single screening test. Consequently, Biodun could not bother herself with PrEP and HIVST services again.

Barriers to be addressed:

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

- Some TG face rejection from parents and society.
- There are myths and misconceptions about transgender.
- There is low knowledge of sexual diversity among healthcare workers serving TG
- Unfriendly attitude of health providers towards transgender persons.
- Unavailability of PrEP over the counter.
- High cost of HIVST kit.

e. Persons in custodial centres

Persons in custodial centres and other closed-door facilities are considered as key populations for HIV and other sexually transmitted infections (STIs). As of July 2018, the total population of people in custodial centres in Nigeria was 75,772. Of these, the males were 74,186 while females accounted for 1,586 [36]. In 2019, the prevalence of HIV in Nigerian custodial centres was recorded at 2.8%, compared to 1.3% in the general population [36]. This implies that people in the centres are two times more likely to be living with HIV than people in the community. This high HIV prevalence poses a threat to people in custodial centres as well as those who manage the facilities. Figures on mortality in the centres from 2007 to 2017 were recorded at 1066 deaths with 85 being AIDS-related deaths [36].

While Nigeria is making a headway in controlling the HIV epidemic, the prevalence in custodial centres is a concern, especially due to the interaction between centres and the host communities. The environment, infrastructure, management and the criminal justice system, as well as the poor health care and living conditions, contribute to the prevalence of HIV in these facilities. The high HIV prevalence is further compounded by high risk behaviours among inmates, including unprotected anal sex between males, rape, sharing of drug injecting material, alcohol abuse, tattooing and the use of contaminated cutting instruments. Also, female inmates are sexually abused by other inmates and custodial centre guards [36]. Thus, if inmates become HIV infected while in the centres, they increase the risk of new infections among the general population upon their reintegration into the communities.

There are reported gaps in HIV prevention interventions in custodial centres in Nigeria due to the absence of services that mitigate the spread of HIV, including HIV testing services (HTS), reproductive health and harm reduction services, thus necessitating the need for implementing tailored prevention interventions in Nigeria Correctional Services, as well as improving the availability and quality of health services [36]. Available program information shows that provision of HIV care and services, like distribution of condoms/compatible lubricants, syringes/needles, provision of HTS, etc to inmates, are not allowed in the Nigerian custodial centres. This is based on the denial/false belief that inmates do not engage in risky behaviours capable of predisposing them to infections, including sexual intercourse. This contradicts the United Nations Healthcare Services Rule 24 (Nelson Mandela Rules), which state that:

1. *The provision of health care for prisoners is the responsibility of the state. Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status.*

2. *Healthcare services should be organized in close relationship to the general public health administration and in a way that ensures continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases, as well as for drug dependence.*

The current healthcare service provision practice in the Nigerian correctional centres poses a barrier to the implementation of HIV prevention interventions, including the uptake of HIVST and PrEP services by inmates. This will further undermine the attainment of the national target of eliminating new HIV infections in the country by 2030.

Profiling of a person in closed setting (Monday)

Monday, a 29-year-old man, was arrested in 2018 at his residence in Ajegunle community of Lagos State, after his girlfriend, Chioma, died in his room from unexplained health issues. He has been awaiting trial for over 3 years. While in prison, he met and bonded with Akin and Ade, who advised him that he needed to identify with a partner to help cater for his sexual needs, in same manner as other inmates. Monday opposed the idea, and due to this, he was molested and raped continually. He reported the matter to one of the correctional officers, Jude, who did not address the issue, but rather affirmed that the molestation was well deserved as he was paying for his crime.

Afraid that he may have been infected with HIV, Monday requested severally to be tested for HIV, but was denied by the officers. One day he became ill and was admitted to the healthcare facility in the custodial centre, where he also requested for HIV test, but the healthcare provider told him there is no such service in the facility, and that, he was admitted to take paracetamol till he gets well. A few weeks after, Heartland Alliance Limited by Guarantee, a HIV implementing organization, came to the custodial centre to provide HIV and other STI prevention information, including HIVST and PrEP. Excited about HIVST and PrEP, Monday, requested for these services, but was told that the custodial centre authority does not permit the provision of HIV prevention services to inmate.

Barriers to be addressed:

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

- Some inmates lack or have low knowledge of HIVST and PrEP.
- HIVST and PrEP services are unavailable in healthcare facilities in custodial centres.
- Inmates in custodial centres are denied access to HIV prevention services.
- People in custodial centres experience inhumane treatment by some healthcare providers.
- The belief that some inmates are condemned and should not have right to health services

Profiling of a person in closed setting (Zaza)

Zaza, a 23-year-old female, is serving a 2-year prison sentence for petty theft. As she is a regular injecting drug user, she quickly bonded with three other prison inmates who are also drug users. They occasionally engage in drug use in their cell, sharing syringes and needles. To sustain the funding of her drug use, Zaza engages in transactional sex with fellow inmates and custodial center officers for money or drugs, most times without the use of condoms. Sometimes Zaza and other female inmates are raped by warders. As Zaza is educated, she has some knowledge on HIV infection and its prevention (especially around HTS services). However, due to her current status as an inmate, her health became less of a priority to her. Thus, she engages in risky behaviours without thinking about the repercussions. While Zaza is aware of HTS services, she is not aware of PrEP and HIVST services as preventive commodities. Moreover, these services are currently unavailable in the custodial centre.

Barriers to be addressed:

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

- Some inmates lack awareness of HIVST and PrEP.
- Some inmates lack or have low knowledge of HIVST and PrEP.
- Some inmates have poor health-seeking behaviour.
- HIVST and PrEP services are unavailable at healthcare facilities in correctional centres

f. Sero-Discordant Couples (SDCs)

A few sero discordant couples (SDC) are aware of their discordance (that one of them has HIV and the other does not) and have had their relationship disrupted by it in some way. They may be experiencing blame about who brought HIV in their relationship, discouragement around sex and/or about conceiving. The discordance may be so disruptive that some may face "discordance" dilemma. They see avoidance of HIV transmission at odds with the preservation of their relationships. Others preserve their discordant relationship with love and commitment, but the risk of HIV transmission is still disruptive, complicating the things they want in the relationship – intimacy and children.

For SDC, enrolling for PrEP is often more burdensome than helpful. Bringing up PrEP may resurface undesirable negative feelings such as blame, guilt and even violence as well as being labelled HIV positive and stigmatized by others. Therefore, when SDC compare PrEP to other prevention tools like condoms, many struggle to be convinced of its relative effectiveness and appeal. Among sero-discordant couples (SDC), poor spousal communication and HIV disclosure, gender-based inequality characterized by male dependence and intimate partner violence, and unprotected sexual intercourse are some of the major factors associated with HIV transmission.

Profiling sero discordant couple (Jerry and Julie - J&J)

Jerry and Julie have been married for twelve years and both lived happily until Julie was diagnosed HIV positive during her antenatal visit at Ngodo Primary Health Care (PMC) Centre. She was asked to bring her husband to the next clinic visit. Jerry's blood sample was tested for HIV and the result came out negative. Consequently, Jerry started accusing his heartthrob of committing infidelity. This resulted in several gender-based violence against Julie. Jerry was worried about how to protect himself from being infected by Julie.

During a couple counselling session he was introduced to prevention services including HIVST and PrEP, but both services in the PHC centre were provided by an implementing partner (IP) who is more interested in key population interventions than sero-discordant couple. Hence, he only had the option of sourcing for PrEP and HIVST kits through out-of-pocket payment. Initially, he was unwilling to be on PrEP due to the stigma of it being mistaken as anti-retroviral (ARV). Jerry could barely afford one dose of PrEP in a month until a PHC centre staff introduced him to where he could procure the drug at a subsidized price.

Barriers to be addressed:

What are the most important barriers to consider in Jerry and Julie's situation?

- Some SDCs have low knowledge of HIV prevention services (PrEP and HIVST).
- Some SDCs experience gender-based and intimate partner violence.
- Some suffer HIV related stigma and discrimination.
- There is lack of access to HIVST kits and PrEP due to inadequate programming for sero-discordant couples.

g. Adolescent Girls and Young Women (AGYW), who are at Substantial Risk of HIV Infection

Nigeria is among the countries of Africa in which adolescent girls and young women are highly affected. Behavioural factors related to HIV risk among adolescent girls and young women include individual and relational factors linked to both young women and their male partners, social and gender norms on relationships, sexuality and marriage, as well as other structural factors (such as population mobility and gender inequality) [37, 38].

Adolescent girls and young women face multiple barriers in accessing PrEP due to their age, gender and lifestyle. They are disproportionately affected by HIV and can face many personal, social, and systemic barriers to access, uptake, and use of traditional HIV prevention methods, such as accessing and negotiating the use of condoms. Widespread gender-based violence and harmful gender norms further undermine HIV testing and prevention efforts and exacerbate risk for AGYW.

Vulnerability factors to HIV transmission among AGYW include STIs, unprotected sex, transactional sex, intergenerational sex, low HIV risk perception/knowledge, low HTS uptake, low educational levels, multiple sex partner, substance use, incest, gender-based violence, poverty, teen pregnancy, early sex debut, early marriage, rape, and limited access to SRH services [39-41].

Besides, social norms place pressure on girls to demonstrate their alignment with virginity until marriage. But there are indications that girls' lived experiences often do not mirror these norms: while the average age of marriage has risen in the last 30 years (from 17.8 to 19), the age at sexual debut (17) has stayed the same [42]. These data imply a lengthening period of sexual activity prior to marriage for girls and young women, introducing heightened need for protection from HIV, unintended pregnancy and STIs.

Further insights from the human-centred design approach (HCD) activity conducted by the Jhpiego/Collaboration for HIV Prevention Options to Control the Epidemic (CHOICE) Nigeria, 2021, indicate that many AGYW do not know about PrEP; would be interested in PrEP but are concerned about its accessibility; and are concerned about being stigmatized and the non-supportive socio-cultural environment that stigmatizes discussions about sex. Concerns about stigma often lead to concealed use of PrEP, which can lower adherence. They also indicated concerns about side effects and how they will affect their day-to-day activities, societal perception, fear of developing addiction, and the possibility of PrEP affecting their fertility.

AGYW are very fearful of being perceived as having HIV and concerned that it will affect how they are perceived in the community. They also feel that it will affect their ability to attract partners. They fear that if someone sees them taking oral PrEP or visiting a health facility, they will think they have HIV. The opportunity here is to remove PrEP from the context of "sickness" (e.g. as a treatment at the facility) and positioned at the community level (e.g. as a lifestyle product) and understood as a smart and responsible way to maintain wellness rather than a treatment signalling illness.

Girls feel alone in their experiences, particularly when seeking or disclosing sensitive information to secure the social or clinical support they need. AGYW have a passionate need to be accorded status and respect but have few support channels that demonstrate this respect. They generally believe they should be in control of their decisions and life choices in varying degrees. They also seek to be powerful and heard in various aspects of life. Girls who are under the legal age may be concerned about providers reporting their sexual behaviour or PrEP prescription to their parents and guardians. Fear of stigma and discrimination can dissuade AGYW from accessing PrEP, both from providers who may perceive the request for PrEP as an indication of sexual activity or promiscuity and due to the concern that the ARV could falsely indicate that they are HIV-positive' [43].

Additional insights suggest that AGYW are generally more concerned about maintaining a positive relationship than preventing HIV. A summary of the insights can be paraphrased as follow

'Relationships are important to me. They make me feel cared for, special, and they give me support. I want to feel confident and respected but sometimes I am more worried about keeping the relationship safe than myself; sometimes I find myself doing things that I know are risky but so far it's okay in the relationship'.

While AGYW do worry about negative health outcomes like HIV or unplanned pregnancy, relationship preservation generally carries a much greater influence than healthy sexual behaviours. Making prevention decisions (like using condoms) during a state of neurological arousal further complicates these decisions. This Hot/Cold cognition phenomenon leads people of all ages to do things they wouldn't expect or predict. The opportunity here for PrEP is in helping AGYW choose safer ways to achieve their relationship goals at a time when they can think more logically.

AGYW are worried about creating conflict within an existing relationship. Using PrEP may indicate distrust or that she is being unfaithful. Like many groups, fear that an HIV positive result may lead to conflict or end a relationship may keep an AGYW from getting tested. Insisting on using prevention methods is perceived to cause relationship conflict. AGYW are particularly intolerant of relationship dissonance. The HCD process also revealed that HIV management is not an explicit goal or priority for AGYW—at best, it is a sub-goal embedded within relationship management. HIV prevention strategies must therefore align with relationship goals to be relevant to them.

Motivation segmentation of AGYW audiences:
The AGYW audiences were also segmented based on qualitative user-centred research through the HCD-lite approach. The key segments were by relational motivations which stay consistent over time. The key differentiating factor between these segments is what they seek in their relationships. Using personas and journey maps, the research identified 5 segments, each with unique relationship motivations and, therefore, unique pathways to effective HIV prevention in the context of relationship management. The segments are as follow:

1. Respect seeker: always wants her partner to respect her emotions and opinions, seeking respect and equality in relationships.
2. Affection seeker: craves being appreciated, always wants to be involved in her partner's life, seeking sustained affection and safety.
3. Lifestyle seeker: seeking relationships that align with and support her lifestyle needs, often uses relationships to enhance status or achieve goals, such as education.
4. The newbie: new to relationships and tends to have an idealistic view. Thus, lives her life to please her partner so everything can go smoothly, seeking to be accepted and trusted.
5. The survivor: uses relationships as a survival strategy, not very optimistic about her future, ready to do anything to make sure her relationships (these can be informal sex work) remain friction free because they are a lifeline.

Profiling adolescent girl & young woman (Kate)
Kate is a 16-year-old secondary school graduate who is currently seeking admission to the university. Her parents are strict disciplinarians and very religious too. Her parents constantly decry the moral decadence in the present society. Kate's parents are very certain that their daughter is at no risk of being infected with HIV or any other STI and would never discuss issues on sex and HIV prevention with her. Although she has had a few advances from her classmates and a few men on her street, Kate never brings up such topics for discussion as it would certainly suggest that she was becoming wayward. Kate prefers to discuss deep and intimate issues with Ella, her friend.

Being two years older than Kate, Ella seemed to have answers to every question without reprimanding her. In addition, she is in multiple relationships, has had sex a few times and would always discuss with Kate how sweet love, relationship and sex was. Kate is very curious and feels like she is missing out on a significant aspect of life for her age. With Ella's support, she hooked up with Yemi, a young banker, who showers her with so much love and attention. She has had her first kiss and sex with Yemi, which became more frequent as the relationship progressed. Besides Yemi, Kate has other toasters, among whom were a baskeballer and an older man. She had related this to Ella who encouraged her to catch fun and enjoy herself. She then got entangled in multiple relationships.

Kate is quite uninformed on the importance of consistent condom use and has multiple unprotected sexual encounters. She doesn't pay attention to adverts on the radio and messages on billboards. A lot, however, changed when she chanced on a movie that depicted a 23-year-old emaciated HIV patient, who shared her experiences and how practising safe sex would have helped prevent her situation. Kate is now very uncomfortable and afraid as she falls in the same lifestyle category. The lady in the movie had talked about condoms, PrEP and HIV self-testing, but Kate wondered how she could have missed out on such messages.

Now, very aware of her vulnerability to HIV, STIs and the prevention options, she discussed this with Ella. Fortunately, Ella was aware of those options and shared her experiences including information from her peers accessing HIVST and PrEP services. The tales ranged from the condescending and disapproving looks of healthcare providers to how some of the girls who tested positive were sent out of the home by their parents. In addition, taking PrEP would imply routine hospital visits and some health providers would also often query why they would access such services at such a young age. Kate is now at crossroads, as she worries about confidentiality in assessing HIVST and PrEP and what would happen if she tested positive for HIV. It would shatter her parents to learn of her experience with HIV prevention services, which would torchlight her secret lifestyle. Coming from a religious and strict family, she would be considered a disgrace and a shame. Should she test positive, her dreams of pursuing a university education would never be achieved, amidst other fears and concerns.

Barriers to be addressed:

What are the most important barriers to consider in Kate's case?

- Some AGYW are not informed about SRH, HIVST, and PrEP and have difficulty discussing issues relating to sex and HIV prevention with their parents or older adults.
- Some AGYW fall victim to peer pressure in relation to risky lifestyle and behavior.
- Some AGYW have high risk and vulnerability factors to HIV transmission such as unprotected sex, transactional sex, intergenerational sex, low HIV risk perception/knowledge, low HTS uptake, multiple sex partners, gender-based violence, poverty, early sex debut, and poor access to SRH services.
- Some AGYW lack access to HIVST kits and PrEP due to judgement, discrimination and stigma from healthcare providers, as well as inadequate programming for AGYW.
- Some AGYW may lack the confidence and skills to negotiate safe sex in the context of the relationship.
- The cost of HIVST kits and PrEP may be a barrier to accessing such services for AGYW
- Some AGYW have low knowledge of HIV prevention services (HIVST and PrEP)

3.1.2 Secondary Audience

This target audience has a direct influence on the primary targets in the uptake of HIVST and PrEP services. They are intermediaries in getting the message across to the primary audience.

a. Clients/Sexual Partners of KPs

KPs have clients and special partners with who they have unprotected sexual intercourse. Clients are persons who pay with cash or other resources for sexual services and special partners are persons with which sexual relationships exist without fee or payment [44]. These clients/special partners are often considered key influencers of reproductive and sexual health choices of the KPs (45-46). The clients of FSWs and MSM also serve as a link between them and the general population as many of them are either married or have other sexual partners. [47].

b. Male Partners of Adolescent Girls and Young Women (AGYW)
Male partners of AGYW, including adolescent boys and men, play a significant role in AGYW's access and uptake of health services. In Nigeria, gender norms that confer certain superiority on the male child over the female have been shown to affect the ability of the females to assert their right to negotiate sex or use HIV prevention commodities. Adolescent boys and men also provide emotional, financial and other forms of support to the AGYW making them a necessary consideration in the decision making by AGYW. It is, therefore, important to consider the male partners of the AGYW in the communication for HIVST and PrEP.

c. Role Model and Champions of AGYW
Mentor mothers are HIV-positive women who play roles as peer counsellors for AGYW and PMTCT clients. They provide guidance, provide basic education on HIV prevention and also support in keeping appointments, promoting antiretroviral adherence and retention-in-care [48-49]. Mentoring interventions, including those involving the use of mentor mothers, have proven to be useful in circumventing poor reproductive health outcomes in AGYW [50]. Adolescent girls and young women have expressed interest in group education programs supported by young peer and mentor mothers who share similar experiences with them [48]. One on one support programs using mentor mothers has also shown improved sexual and reproductive health knowledge, attitudes and intentions amongst AGYW [50].

d. Parents/Guardians of AGYW
Parents/guardians have an enormous influence on their children and wards. Their influence can be in the form of education, mentorship or otherwise. In Nigeria, the involvement of parents in different health interventions for adolescents and young people (AYP) has proven to be effective. The involvement of parents of sexually active AGYW in HIVST and PrEP intervention will help support the uptake of these services for HIV prevention. This involvement will include providing the correct information about HIVST and PrEP in HIV prevention, including their use, safety, efficacy and availability. Parents can also act as home health teachers to AGYW, accompany them to points of care for HIVST and PrEP, remind them when to conduct HIV tests and when to take their daily PrEP pill.

e. Custodial Centre Personnel
Custodial centre personnel are trained individuals who oversee persons in closed settings, who have been arrested and are awaiting trial or who have been sentenced to serve time in jail or prison. In Nigeria, there are indications that some custodial centre personnel maltreat the inmates including the denial of access to some essential healthcare and information. The delivery of health services to persons in closed settings is influenced by actions taken at various decision-making levels-from individual correctional staff to the top management of the Nigerian Correctional Service.

Improving the health status of persons in closed settings and reducing the incidence of diseases, including HIV/AIDS, will benefit both the inmates, the NCS personnel, and the general population and contribute to achieving the national target of eliminating new HIV infection by 2030. The personnel can be trained as facilitators of IPC and HIV prevention activities, including HIVST and PrEP, in the custodial centres. This will create a cultural environment in the custodial centres, in which inmates can request HIV control services freely, thus, enhancing HIVST and PrEP services uptake.

f. Healthcare Providers

Healthcare providers are trained to provide health care services and ensure the well-being of their clients. PrEP is a bio-behavioural intervention with the healthcare providers playing a critical role in its implementation. They need to be well-informed about PrEP, and be willing to prescribe it to eligible clients. They also need to be trained on the eligibility criteria and screening for PrEP use, and equipped with job aids and counselling tools for effective PrEP implementation. Providers' attitudes, and the provider-client interaction and communication, can significantly affect the uptake and adherence to PrEP. Quality interpersonal communication and counselling is a critical factor for successful PrEP implementation.

g. Community Gate Keepers

Community gatekeepers such as brothel chairladies, bar managers, drug bunk owners, among others are an influential group within the immediate social and physical environments of the key populations. KPs have mutually beneficial relationships with the gatekeepers. For instance, in brothels, gatekeepers rely on FSWs to make money, while FSWs depend on the gatekeepers for financial opportunities [51]. The support of the gatekeepers is, therefore, crucial and should be explored in the KPs' HIV prevention services including PrEP and HIVST.

3.1.3 Tertiary Audience

The tertiary audiences have no direct influence in the uptake of HIVST and PrEP services by the primary audience, but play a key role in providing the enabling and supportive environment for the implementation of HIVST and PrEP. They include the media (traditional and social), community and religious leaders, private sector players and the policymakers. They have the power to raise awareness and influence attitudes, behaviours and practices, especially at the family and community level. Through their authority and influence, they can shape social values and are becoming more involved in health advocacy in Nigeria. If these audiences are properly engaged in HIVST and PrEP interventions, they can help to create a supportive and enabling environment for the implementation of HIVST and PrEP.

3.2. Strategies

There are communication strategies for each audience.

3.2.1 Strategies for primary audience

a. Inter-personal communication and health talk

Inter-Personal Communication (IPC) is a form of the face-to-face approach of communication. It is a tailored exchange of sharing of information, thoughts, ideas and feelings between two or more people to address behavioural determinants of health. It is influenced by attitudes, values, social norms and the individual's immediate environment. IPC is best for addressing fears and obstacles, building and strengthening self-efficacy and skill to perform an action(s), and to dispel myths about a subject. It will enhance or complement effective service delivery for different sub-population groups and can be employed in reaching different population groups in a wide range of settings. IPC can be in the form of one-on-one interactions (at clinic or community), small group interactions, large group discussions, hotlines, supportive supervision visits, peer education, and parent-child or inter-spousal communication. One-on-one form of IPC is recommended for the following primary target audience:

- FSW, MSM, PWID, TG, SDCs and persons in closed settings. The use of this communication approach is also critical at one-stop shops, health facilities, religious gatherings, brothel routine meetings, inter-brothel meetings, chairladies' meetings, hotspots, night clubs, bunks, and motor parks as well as social events like birthday, couple joining, burial and special night ceremonies.

- Sero-discordant couples in healthcare facilities, peer support groups and religious gatherings.

- Adolescent girls and young women - Communication interventions for HIVST and PrEP can be targeted at adolescent girls in secondary and post-secondary learning institutions including extra-moral sessions (Joint Admissions and Matriculation Board-JAMB lessons); social events including birthdays, send-forth/off parties; at beautification spots e.g. hairdressing salons and spas; healthcare facilities; market places; homes; religious gatherings, etc. This strategy also recommends the leverage of other existing structures like the in-school Family life and HIV education (FLHE).

- Adult male and female in a post-secondary learning institution, motor and motorbike parks, bars and clubs at social events including birthdays, send-forth/off parties; beautification spots including barbershops and hair salons; artisan centres; youth-friendly centres including football fields, game and gamble spots; healthcare facilities; source of water points; market places; religious gatherings, etc.

This strategy also recommends, where possible, the use of PrEP champions, peers, change influencers and area sisters, who are influential as IPC and health talk facilitators. Others are healthcare workers, community gatekeepers like brothel chairladies, MSM key opinion leaders, peer educators, youth leaders, religious leaders, teachers, boss (artisans), mentor mothers etc. IEC materials (pocket guide and pamphlets) can be distributed during or after IPC and health talk sessions.

b. Peer education

Peer educators have proven to be very effective at engaging with priority populations, especially FSWs, PWID and MSM. Peer educators and peer outreach teams require initial and refresher training and continued support on how to conduct outreach, use SBCC materials and answer questions from potential and current PrEP users. Ideally, peer educators should come from the local community. These can include PrEP champions; they are satisfied clients selected because they have successfully used and adhered to PrEP and are often effective at reaching these populations and building trust, as well as addressing stigma and other concerns around using PrEP by relying on their first-hand experience.

Peer education is defined by the Nigerian Peer Education Plus Model as "a way of communicating HIV prevention and other sexual and reproductive health information to peer groups with the aim of positively changing the undesirable behaviour of the groups". The sessions are facilitated by a peer educator who is a trained peer among the peers.

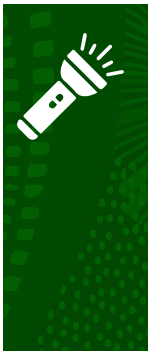
Peer education could be in any of the following forms:

Physical peer education is one of the most preferred channels of communication by the FSWs, MSM and PWID communities. This approach is recommended as one of the ways to reach the brothel-based FSW, MSM, Transgender, PWID and persons in correctional centres. The approach does not only create avenues for peers to ask questions and get messages clarified, it also allows peers to build their skill and confidence (self-efficacy) in performing a task by watching and learning from fellow peers. This strategy will be useful in distributing IEC materials, such as pocket guide containing graphics and other information on HIVST and PrEP.

Closed-WhatsApp peer education is an approach whereby peer education sessions are conducted in closed-WhatsApp groups. This approach is recommended for the more literate KPs like MSM and non-brothel based FSWs, adolescent girls and young women, and adult males and females who own and can operate smart phones. Messages can easily be disseminated to a large number of persons in a short period. It is also a cost-effective means of message dissemination. This strategy recommends as much as possible the use of HIVST and or PrEP champions as peer educators.

c. Social media

The use of social media platforms in disseminating health information has been proven to be efficient in reaching adolescent and young people, adult males and females and KPs. This strategy proposes the use of social media platforms such as Facebook, Instagram, Twitter, Grinder, Tinder, WhatsApp, Closed-Chatrooms and YouTube in disseminating messages. Short video clips, tweets, blogs, pop-ups and graphics of light megabits on HIVST and PrEP can be deployed through the social media platforms. Community members can share their testimonies and experiences on social media.

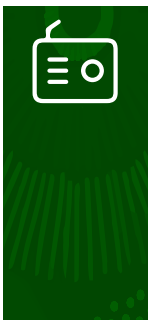


d. Priority for local AIDS control efforts (PLACE)

PLACE, as an approach, is used to reach KPs and their clients who are referred to as nocturnal clients due to their work schedules. These clients include on-shore workers, bankers and fishermen whose work schedules allow them leisure mainly at night. A trained pair (male and female) venue outreach facilitator (VOF), who wears a reflective vest (for easy recognition), conducts IPC sessions to KPs and their clients, usually moving from one table to another in hot spots and providing health information at night using an IPC manual and torchlight for ease of illumination. This approach is recommended for MSM, non-brothel based FSW and their clients in hot spots and for adolescent girls and women.

e. Outreaches and roadshows

Outreaches and roadshows (HIVST and PrEP campaigns) done in strategic locations like markets, motor parks, busy junctions, workshop arena (mechanic village), and schools have proven to be effective in passing information, including health information to the general populations in Nigeria. These approaches are recommended for reaching all the target audiences (primary and secondary). Inter-personal communication sessions could be interwoven into outreaches and roadshow activities.



f. Traditional media

The media approach is recommended for all the target audiences (primary and secondary) listed in this strategy document, including persons the custodial centres. Subtle messages can be transmitted via appropriate media channels conveying the need to self-test and/use ARVs for PrEP especially by people who feel they are at risk of contracting HIV. This approach could be used to provide phone numbers like toll-free lines (NACA toll-free call centre-6222 and phone contacts of HIVST and PrEP service delivery points) which clients can call to access HIVST and PrEP services or receive guidance on where to access services.

g. Short message services (SMS)

The use of SMS to provide information on HIVST and PrEP is recommended for all the target audiences, except persons in custodial centres. The messages could be disseminated by a trained service provider, peer educator, support group, role model mother or champion, area sister, change influencer, CBOs, CSOs, FBOs, youth-friendly centre, etc.

h. Small group discussions (SGDs)

Small group discussion is recommended for MSM, FSWs, PWID, sero-discordant couples transgenders, adult males and females, and girls and women. Discussion on HIVST and PrEP should be facilitated by influential persons.

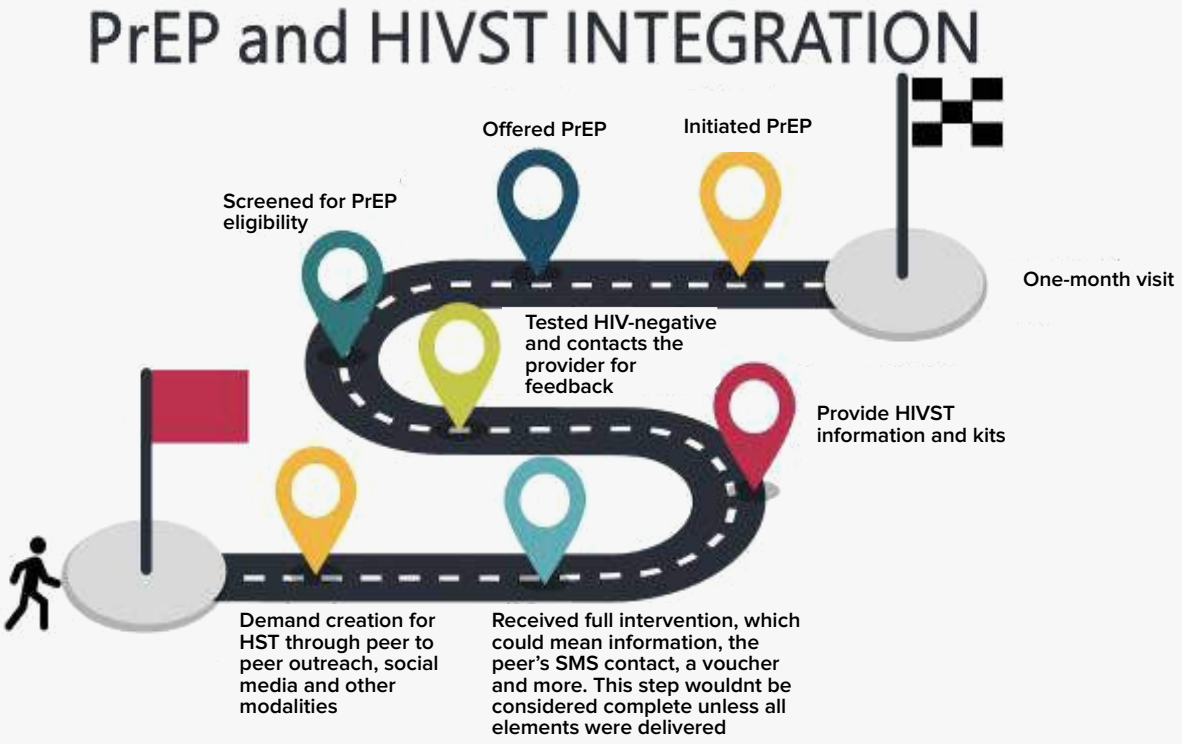
3.2.1.1 Sub-Strategies for Primary Audience

a. Referral and Linkage to Care

Any of the approaches mentioned above could be used to refer the target population for HIVST and PrEP services. Where possible, accompanied linkage should be done to encourage service uptake especially among adolescent girls and young women.

b. Integration of HIVST and PrEP into HTS and other HIV Services

Basic information on HIVST and PrEP should be provided to any of the target audiences during counselling sessions of HTS and other HIV services.



Source: Heartland Alliance Nigeria.

3.2.2 Strategies for Secondary and Tertiary audience

a. Advocacy and community outreach

Advocacy is a set of activities targeted at appropriate individuals/bodies who have the power to influence a course or program. Advocacy efforts, guided by advocacy strategy and kit, should target policymakers, healthcare providers, Correctional Service officers, KP community gate-keepers, support groups for PLHIV, community and religious leaders, media organizations/influencers and private sector players. The advocacy should aim at fostering a supportive environment, increase acceptability of HIVST and PrEP, and reduce stigma. The advocacy effort for PLHIV should emphasize disclosure of HIV status to partners to encourage PrEP use by the negative partners. In addition, the engagement and collaboration of both the public and private sector players in HIVST and PrEP interventions will play a significant role in expanding and shaping the market for these commodities, thereby improving their availability, accessibility, affordability and sustainability.

Advocacy to the management of custodial centres should emphasise the need to allow the provision of HIV prevention services including the periodic distribution of HIVST kits in the centres. This will increase the number of people in closed settings who know their HIV status and the number of persons placed in care (ART) if diagnosed with the virus.

b. PrEP campaign using mass/social media

Mass and social media play a significant role in information dissemination. They help create awareness and educate the general population on a subject, including health interventions. Media campaigns at the community and national levels can help promote widespread knowledge of HIVST and PrEP services. Promotion of HIVST and PrEP campaigns through these media platforms can create awareness and provide knowledge on HIVST and PrEP. This can positively change negative perceptions, beliefs, attitudes and behaviours of the general population, including policymakers, healthcare providers, Correctional Service officers, KP community gate-keepers, PLHIV, community and religious leaders, media organizations/influencers, and private sector players, towards accepting and supporting HIVST and PrEP interventions.

c. Sensitization and training of healthcare workers and custodial centre officers

The attitude of healthcare workers is essential in healthcare service delivery. Sensitization and training of healthcare workers on KP and AGYW interventions will positively influence their attitude and address biases in providing HIVST and PrEP services to KPs and AGYW. It will also help strengthen their skills in providing equitable services, create a non-discriminatory healthcare environment, maintain the confidentiality of service delivery, foster KP/AGWY-friendly HIVST and PrEP service delivery and increase uptake.

The correctional centre personnel and their management should also be sensitized to the risky behaviours that take place among persons in closed settings, and between persons in closed settings and custodial centre personnel, which can lead to new HIV infection and other transmittable diseases.

3.3 Communication Matrix

This section details the major barriers and motivators that contribute to low uptake and use of HIVST and PrEP services among the primary target populations. It also itemizes the barriers at the levels of the secondary and tertiary audiences that negatively impact their attitudes and influence on the primary audience in the uptake of HIVST and PrEP services. This section also describes the social and behaviour change communication strategies, including desired changes, behavioural objectives, communication objectives, supporting statements, etc. for the target audience.

Table 1: Communication matrix (barriers and motivators)

Target audiences	PrEP		HIVST	
	Barriers	Motivators	Barriers	Motivators
Primary audience				
MSM, FSW, PWID.	-Low awareness of PrEP among MSM, FSW, PWID, and TG [2, 52] --Low-risk perception of HIV among MSM, FSW, and PWID [52] --Low knowledge of PrEP among MSM, FSW, and PWID [2, 52] -Lack of clarity between PrEP and PEP [2, 15, 55] --Fear of side effects or drug interaction [2] --Pill and medication schedule and burden (including daily use) among MSM, and FSWs [2] -The notion among MSM and FSW that one shouldn't use PrEP since condoms can prevent HIV [2] -Low financial capacity to purchase PrEP among MSM and FSWs [2] --Migration of MSM from points of care [2] -Unaffordability and inaccessibility of PrEP among FSWs and MSM [2] -- MSM and FSWs who use PrEP are perceived as being HIV positive [2] -- Intimate partner violence among MSM and FSW - Fear of disclosure to partner among MSM and FSW [2]	-Availability of free PrEP and its accessibility in the MSM networks are likely to motivate its uptake among MSM [55]	-Low awareness of HIVST among MSM and FSW [2,53] -Low-risk perception of HIV among MSM, FSW and PWID [30] --Low knowledge of HIVST among MSM, FSW and PWID [2] -Low literacy level to read instructions [2] - Doubt on the efficacy of test kits among MSM and FSWs [2] - Low financial capacity to purchase HIVST among MSM and FSWs [2] --Unaffordability and inaccessibility of HIVST among FSWs and MSM [2] -- MSM and FSWs who purchase HIVST could be perceived as being HIV positive by society [2] -- Intimate partner violence among MSM and FSWs - Fear of disclosure to partner among MSM and FSWs [2]	-HIVST allows for privacy and easy to conduct (convenience), non-invasive, confidential among MSM [53-54] -One-on-one, peer-to-peer distribution strategies and retail outlets that facilitate anonymous pick-up as HIVST distribution channels among MSM [56]
TGs	-Low awareness of PrEP [52] -Fear of side effects or drug interaction among transgender (TG) on hormonals [55] -Burden of dosing [57] -Stigma from service provider -Mistrust of TG on healthcare providers (sexuality secrecy) [57]	-Desire to stay HIV negative [59]		

Persons in closed settings	-There is a lack or low awareness of PrEP -There is a lack or low knowledge of PrEP -PrEP services not allowed in custodial centres -Belief by custodial centre personnel that Inmates do not engage in risky behaviours that can lead to HIV infection -Poor healthcare provider attitude in providing healthcare to inmates -HIV control services not allowed in custodial centres		- There is lack or low awareness of HIVST -There is lack or low knowledge of HIVST -Inaccessibility of HIVST services due to -Belief by custodial centres that inmates do not engage in risky behaviours which can lead to HIV infection -HIV control services not allowed in custodial centres	
Sero-discordant (negative partner)	-Acceptability is low due to low self-perceived risk [15 56, 58] -Fear of drug-drug interactions and side effects may lead to non-adherence to PrEP uptake [59] - High knowledge of PrEP, requiring increased frequency of HIV testing, clinical care and drug-drug interactions is a barrier for uptake [8]. -There is low knowledge about the availability and basic information on PrEP [2,15] - Religious beliefs by the HIV negative partner on immunity to HIV infection prevents access to services [61]. -Beliefs associated with the use of PrEP and ART -Fear of violence in relationships when placed on PrEP, when PrEP use is unknown to partner, might lead to separation, physical violence where couples have a pre-existing history of domestic violence. - Having to choose condom over PrEP -Preference to protect relationships. - Powerplay interference/bargaining power in discordant relationships -Lack of education and purchasing power	-Desire to have more children -Desire to stay healthy and have HIV negative children -PrEP allows couples to have unprotected sex and provide a renewed form of intimacy	- Perceived health status of partner may deter acceptance of HIVST -Partner living with an unknown disclosed HIV positive/ undisclosed HIV status of partner -Misinterpretation of HIVST result outcomes - Low knowledge of the availability of HIVST services [60] -Low knowledge of the use of HIVST kits [60] - Fear that self-testing might lead to separation, physical violence where couples have pre-existing history of domestic violence. -Beliefs surrounding the contents of the Oral HIVST (the buffer) being harmful to health - Existing preference for HIV testing at the facility over HIVST [60] -Labour status' contributes to reasons for HIVST uptake -Powerplay interference/bargaining power in discordant relationships -Cost of accessing HIVST services	

	- Associated cost of accessing PrEP services (e.g. transportation, cost of product) - Location/ distance of service delivery points - Unavailability of PrEP at the point of need - Challenges associated with drug refills (e.g. load of clients in a facility) at the point of service -Limitation due to the program/policy implementation guidelines for PrEP provision -Lack of service not incorporated into Health Insurance Scheme -Inadequate governmental/ public and private sector support for PrEP implementation -Lack of policy to integrate PrEP into ANC for pregnant women in sero-discordant partnerships -Poor self-efficacy among sero-discordant partners to convince each other on the use of PrEP - The stigma attached to the use of ART rubbing off on PrEP use -Social stigma of an HIV negative partner in a discordant relationship - providers Judgmental attitude of service providers: assessing prospective clients as those engaging in risky behaviour - Disrespectful care by service providers There is limited knowledge on PrEP amongst service providers (use of PrEP and its side effects) - Misconceptions around the use of PrEP (e.g. duration of use, side effects etc). -Program implementation: lost-to follow up [54] -High cost of making PrEP available for use (registration and authorization of PrEP, marketing, advertisement)		-Secrecy about partner's HIV status - Unavailability of HIVST in some settings -Inaccessible locations of facilities to access HIVST -Inadequate information about where to access HIVST -Limitation due to the program/policy implementation guidelines for HIVST provision -HIVST service not incorporated into Health Insurance Scheme - Societal/cultural expectations from partners may affect the uptake of HIVST -Inadequate governmental/ public and private sector support for HIVST implementation - Existing stigma associated with HIV testing and result outcomes. - The fear of visiting a health facility for a confirmatory test may deter people from accessing HIVST - There is limited knowledge on HIVST amongst service providers (use of product, outcome of results for HIVST) - Inadequate information on the referral facilities for HIVST users Inadequate/unavailability of HIVST supplies High cost of making HIVST available for use (registration and authorization of HIVST, marketing, advertisement,)	

	-Inadequate/unavailability of PrEP supplies - Little or no knowledge and information on service providing facilities			
AGYW	-Gender-based violence -Gender discrimination -Low-risk perception of HIV infection - No/low knowledge of PrEP -Socio-cultural belief that anyone who seeks PrEP services especially, unmarried young persons are promiscuous -Believe that HIV is a spiritual attack -Fear of PrEP affecting fertility -Fear of developing addiction to PrEP usage -Fear of side effects of PrEP -Fear of losing relationship due to PrEP use -Lack of psycho-social support to seek health services -Fear of service provider disclosing AGYW's PrEP service uptake to parents/guardians -Socio-cultural environment that stigmatizes discussions about sex, HIV and its preventive methods -Notion that use of PrEP may indicate unfaithfulness -Stigma linked to use of PrEP, which encourages concealment of PrEP use -Low priority for HIV prevention - Preference for consistent and correct condom use to PrEP due to its additional protection against STIs and unintended pregnancy - Cost of PrEP affect uptake	-Desire to preserve relationships. -PrEP is seen as a lifestyle product used for maintaining wellness, rather than treatment of illness -	-Low-risk perception -Inadequate program data on the target population risk -Non-prioritization of the group in HIV program -Poor health-seeking behaviour - Fear of losing social standing and sexual desirability if diagnosed HIV positive -Fear of abandonment by partner if tested positive - Low awareness of HIVST - Socio-cultural belief that anyone who seeks HTS services, especially unmarried young persons, is promiscuous (for AGYW) -Believe that HIV is a spiritual attack -Cultural beliefs that prohibit women and girls from seeking health care services without the consent of their father or husband -Cost of HIVST affect uptake - HIVST services are relatively unavailable in some locations and difficult to access by the target population. - Logistics cost and distribution barriers especially in hard-to-reach areas affect the availability of HIVST kits to AGYW -Religious and societal prejudice	-Desire to preserve relationship.

	-Low level of income among the target groups - PrEP is only accessed on medical prescription -Non availability of PrEP in all facilities offering HTS -Stock-out of PrEP in some facilities -Limited accessibility to PrEP services -Lack of comprehensive SRH program which limits their access to HTS including PrEP - Fear of use of PrEP being mistaken as ART and the client labelled as HIV positive - Age of consent affects the uptake of PrEP. -Some programs do not include AGYW as beneficiaries of HIV interventions, including PrEP services -Inadequate program data on the target population risk		- Fear of social harm e.g. GBV and IPV affects the uptake of HIVST services especially among AGYW - Perceived unreliability of HIVST results -Fear of loss relationship -Fear that a positive HIV test may lead to conflict or end a relationship -Low priority for HIV prevention - Anxiety and fear of HIVST results - Age of consent affects the uptake of HIVST	
Secondary audience				
Healthcare provider	-Low awareness and knowledge -Cultural/religious belief that PrEP uptake promotes promiscuity, just like condoms - Judgmental and unfriendly attitude in providing PrEP services, especially to AGYW and KPs -Age of consent affects the uptake of PrEP -Correctional centre healthcare provider's negative attitude in providing services to persons in closed settings		-Low awareness and knowledge of HIVST -Judgmental and unfriendly attitude in providing HIV testing services, especially to AGYW and KPs	
Clients/special partners of KPs	-Low awareness and knowledge of PrEP. -MSM and FSWs who use PrEP are perceived as being HIV positive [2]		-Low awareness and knowledge of HIVST.	

Male partners of AGYW (Adolescent boys and men)	-Low awareness and knowledge of PrEP -AGYW experience gender-based violence and gender discrimination from partners of AGYW -Notion that PrEP uptake promotes promiscuity, just like condoms -Cultural beliefs that prohibit women and girls (AGYW) from seeking health care services without the consent of their father or husband		-Low awareness and knowledge of HIVST -Cultural beliefs that prohibit women and girls (AGYW) from seeking health care services without the consent of their father or husband. - Social harm e.g. GBV and Intimate Partner Violence affects the uptake of HIVST services especially among AGYW -AGYW experience gender-based violence and gender discrimination from partners of AGYW	
Role model mother of AGYW	-Low awareness and knowledge of PrEP		-Low awareness and knowledge of HIVST	
Parent/guardians of AGYW	-Low awareness and knowledge -Gender-based violence and gender discrimination from parents/guardians of AGYW -Cultural/religious belief that PrEP uptake promotes promiscuity, just like condoms -Socio-cultural environment that stigmatizes discussions about sex, HIV and its preventive methods -Age of consent affects the uptake of PrEP -Cultural beliefs that prohibit women and girls (AGYW) from seeking health care services without the consent of their father or husband		-Low awareness and knowledge of HIVST -Belief that HIV testing is for people who have sex -Cultural beliefs that prohibit women and girls (AGYW) from seeking health care services without the consent of their father or husband -Gender-based violence and gender discrimination from parents/guardians of AGYW	
Community gate keepers (eg. Brothel chairladies, bar managers, drug bunk owners, etc) for KPs. and People living with HIV (PLHIV)	-Low awareness and knowledge of PrEP -MSM and FSWs who use PrEP are perceived as being HIV positive [2] -Non-disclosure of HIV positive status for PLWHIV (-PLHIV support groups to promote the use of PrEP for SDCs)		-Low awareness and knowledge of HIVST	

Custodial centre officers/warders	-Low awareness and knowledge of PrEP -Command structure that impede access to HIV control messaging and activities in custodial centres -Notion that persons in closed setting have no right to information and healthcare		-Low awareness and knowledge of HIVST	
Community and religious leaders	-Low awareness and knowledge of PrEP -Cultural/religious belief that PrEP uptake promotes promiscuity, just like condom -Socio-cultural environment that stigmatizes discussions about sex, HIV and its preventive methods		-Low awareness and knowledge of HIVST	
Tertiary Audience				
Media (Traditional/social)	-No or low awareness and knowledge of PrEP among the tertiary audience.	-Achieving HIV epidemic control by 2030	-No or low awareness and knowledge of HIVST among the tertiary audience.	-Achieving HIV epidemic control by 2030
Policy makers/Programmers	-Inadequate political will to implement HIV/AIDS policies -No inclusion of HIV prevention services (including HTS and PrEP) in the national health insurance scheme -Lack of comprehensive SRH program for AGYW, which limits their access to HTS including PrEP.	-Achieving HIV epidemic control by 2030	-Inadequate political will to implement HIV/AIDS policies	-Achieving HIV epidemic control by 2030
Private sector players	-Low participation of the private sector in PrEP services	-Maximizing revenue	-Low participation of the private sector in HIVST services	-Maximizing revenue

Table 2: Social and behaviour change communication matrix for HIVST

Desired Changes	Key Barriers *(that communication can address)*	Behavioural Objectives	Communication Objectives	Key Benefits	Supportive Statements	Considerations	Intervention Mix		
							Channel	***Activities***	***Tools/ Materials***
 **Female Sex Workers (FSW)**									
Increased uptake of HIVST services **-access HIV testing services every 3 to 6 months**	-Low-risk perception of HIV infection -Low awareness -Low knowledge of HIVST -Fear of HIV test result	By the end of 2030, 95% of FSW: -Will take up HIVST services periodically -Will be able to use HIVST kits correctly to conduct HIV test	By the end of 2030, 95% of FSW would have: - Known the benefits of HIVST - Know how to perform the test correctly and interpret the test results - Know how to manage test results -Know where to access HIVST kits and where to seek further services	-HIVST is a simple and easy way to know your HIV status -It allows one know his/her HIV status in private	-HIVST ensures confidentiality of your HIV status	-HIVST is a screening test. This means that HIV positive results need to be confirmed in a facility using the national HTS algorithm	IPC, health talk, WhatsApp, Facebook, rally, roadshow, radio, television, SMS, PLACE, peer education and other appropriate media	-Facility/OSS Health talk -IPC by peers in brothels, -Small group discussions in brothels - Use of PrEP champions within the sexual networks	IPC/peer education manual, IEC materials, discussion guide/electronic content (e-content), posters, short videos, short messages, other appropriate tools,

Men who have Sex with Men MSM

Increased uptake of HIVST services **-access HIV testing Services every 3 months**	-Low-risk perception of HIV infection -Low awareness of HIVST -Low knowledge of HIVST -Fear of HIV test result	By the end of 2030, 95% of MSM: -Will take up HIVST services periodically. -Will be able to use HIVST kits correctly to conduct HIV tests.	By the end of 2030, 95% of MSM would have: - Known the benefits of HIVST - Known how to perform the test correctly and interpret the test results - Known how to manage test results -Know where to access HIVST kits and where to seek further services.	-HIVST is a simple and easy way to know your HIV status -It allows one know his/her HIV status in private	-HIVST ensures confidentiality of your HIV status	-HIVST is a screening test. This means that HIV positive results need to be confirmed in a facility using the national HTS algorithm.	IPC, health talk, WhatsApp, Facebook, Grindr, Manger, rally, roadshow, SMS, peer education, and other appropriate media	-Facility/OSS Health talk. -IPC by peers, -Small group discussions. -Use of PrEP champions within the sexual networks -Peer support group meeting -PrEP campaign -Integrate PrEP into HTS (pretest counselling) at the community level -use of MSM KOLs to provide information PrEP.	IPC/peer education manual, IEC materials, discussion guide/electronic content (e-content), posters, short videos, Short messages, other appropriate tools

People Who Inject Drugs PWID

Increased uptake of HIVST services **-access HIV testing services every 3 months**	-Low risk perception of HIV infection -Low awareness of HIVST -Low knowledge of HIVST -Fear of HIV test result	By the end of 2030, 95% of PWID: -Will take up HIVST services periodically -Will be able to use HIVST kits correctly to conduct HIV test	By the end of 2030, 95% of PWID would have: - Known the benefits of HIVST - Known how to perform the test correctly and interpret the test results - Known how to manage test results -Know where to access HIVST kits and where to seek further services	-HIVST is a simple and easy way to know your HIV status. -It allows one know his/her HIV status in private	-HIVST ensures the confidentiality of your HIV status.	-HIVST is a screening test. This means that HIV positive results need to be confirmed in a facility using the national HTS algorithm	IPC, health talk, radio, television, rally, Roadshow, SMS, Peer education and other appropriate media	-Facility/OSS Health talk. -IPC by peers, -Small group discussions. - Use of PrEP champions within the sexual networks -PrEP campaign	IPC/peer education manual, IEC materials, Radio and TV jingles /spots. Discussion guides. Posters, Short messages, other appropriate tools

Transgender (TG)

Increased uptake of HIVST services **-access HIV testing services every 3 months**	-Low-risk perception of HIV infection -Low awareness and low knowledge of HIVST -Fear of HIV test outcome (result)	By the end of 2030, 95% of TGs: -Will take up HIVST services periodically -Will be able to correctly use HIVST kits in conducting HIV test	By the end of 2030, 95% of TGs would have: - Known the benefits of HIVST - Known how to correctly perform and interpret the test results - Known how to manage test results -Known where to access HIVST kits and where to seek further services	-HIVST is a simple and easy way to know his/her HIV status -It allows people to know their HIV status in private	-HIVST ensures the confidentiality of your HIV status	-HIVST is a screening test. This means that HIV positive results need to be confirmed in a facility using the national HTS algorithm	IPC, health talk, WhatsApp, Facebook, rally, roadshow, SMS, peer education and other appropriate media	-Facility/OSS Health talk -IPC by peers, -Small group discussions -Use of PrEP champions within the sexual networks -Peer support group meeting -PrEP campaign -Integrating PrEP into HTS (pretest counselling) at the community level -use of TG KOLs to provide information PrEP	IPC, health talk, WhatsApp, Facebook, rally, roadshow, SMS, peer education and other appropriate media

Persons in Closed Settings

-Inmates take up HIV testing services every 3 months	-There is a lack or low awareness of HIVST -There is a lack or low knowledge of HIVST	By the end of 2030, 95% of inmates will use HIVST	By the end of 2030, 95% of inmates would have: - Known the benefits of HIVST - Known how to correctly perform and interpret test results. - Known how to manage test results -Know when to request HIVST services	-HIVST is a simple and easy way to know one's HIV status -It allows people to know their HIV status in private.	-HIVST ensures the confidentiality of one's HIV status	-HIVST is a screening test. This means that HIV positive results need to be confirmed in a facility using the national HTS algorithm.	IPC, health talk, peer education, small group discussion	-Health talk by correctional centre healthcare providers, IPs, Warders -IPC by peers -Small group discussions. -Use of HIVST champions	IEC, IPC/peer education manuals

Sero Discordant Couple (SDC)

- Increased uptake of HIVST services **-access HIV testing services every 3 months**	-Low-risk perception of HIV infection -Low awareness of HIVST -Low knowledge of HIVST -Fear of HIV test (outcome) result	By the end of 2030, 95% of SDC: -Will take up HIVST services periodically -Will be able to correctly use HIVST kits in conducting HIV test	By the end of 2030, 95% of SDC would have: - Known the benefits of HIVST - Known how to correctly perform the test and interpret the results - Known how to manage test results -Known where to access HIVST kits and where to seek further services	-HIVST is a simple and easy way to know one's HIV status -It allows people one know their HIV status in private	-HIVST ensures the confidentiality of one's HIV status	-HIVST is a screening test. This means that HIV positive results need to be confirmed in a facility using the national HTS algorithm	IPC, health talk, WhatsApp, Facebook, rally, roadshow, television, radio, SMS, peer education, and other appropriate media	-Facility Health talk -IPC by peers, -Small group discussions - Use of PrEP champions	IPC/peer education manual, IEC materials, radio and TV jingles /spots. discussion guide, posters, short message, and other appropriate tools.

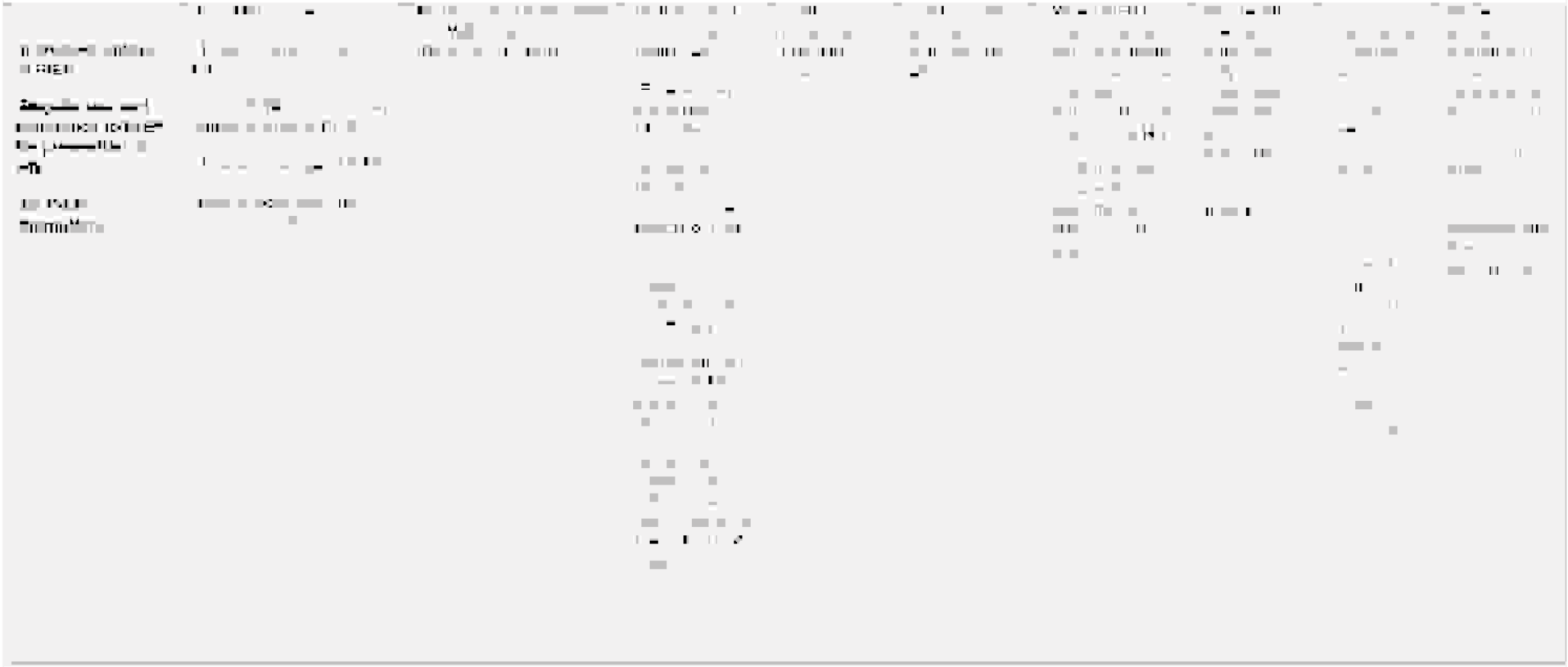
Adolescent Girls and Young Women (AGWY)

Increased uptake of HIVST services **-access HIV testing services every 3 months** **-Be HIVST ambassadors**	-Low-risk perception -Poor health-seeking behaviour -Anticipated loss of social standing and sexual desirability if diagnosed HIV positive -Fear of abandonment by their partners if tested positive [20] - Low awareness of HIVST - Socio-cultural belief that anyone who seeks HTS services, especially unmarried young person, is promiscuous [20] -Believe by some that HIV is a spiritual attack - Fear of social harm e.g. GBV and intimate partner violence affects the uptake of HIVST services, especially among AGYW - Perceived unreliability of HIVST results -Fear of loss relationship -Fear that a positive HIV test may lead to conflict or end a relationship.	By the end of 2030, 95% of AGYW: -Will take up HIVST services -Be able to correctly use HIVST kits in conducting HIV test	By the end of 2030, 95% of AGYW would have: - Known the benefits of HIVST - Known how to correctly perform the test and interpret the results - Known how to manage test results and -Have confidence in the HIVST result -Known where to access HIVST, other support services -Build and strengthen the confidence of AGYW to seek consent for HIVST service uptake.	-HIVST is a simple and easy way to know ones HIV status in private.	-HIVST ensure confidentiality of your status	-HIVST is a screening test. This means that HIV positive results need to be confirmed in a facility using the national HTS algorithm.	IPC, health talk, WhatsApp, Facebook, Rally, Roadshow, Radio, Television, SMS, PLACE, peer education, FLHE and other appropriate media	- Health talk at AYP-friendly centres; beach parties -IPC by peers and ambassadors -Small group discussions. -PrEP campaign -Integrate PrEP into HTS (pretest counselling) at the community level	IPC/peer education manual, IEC materials, radio and TV jingles /spots, discussion guides, posters, T-shirts, wrist bands, hats, electronic content, short messages, short video clips, NACA toll-free call centre (6222)

Table 3: Social and behaviour change communication matrix for PrEP

Men who have Sex with Men (MSM)

People Who Inject Drugs (PWID)



Transgenders (TGs)

Persons in Closed Settings

Sero Discordant Couples (SDCs)

Adolescent Girls and Young Women (AGWY) who are at Substantial Risk


PrEP

Chapter 4: Monitoring and Evaluation

4.1 Monitoring and Evaluation Framework

The National HIVST and PrEP communication strategy aligns with the National Strategic Framework on HIV and AIDS 2017–2021, National HIV/AIDS Prevention Plan 2018-2021, National HIV/AIDS Prevention, Treatment, Care and Support Guidelines, 2020, National Guidelines for HIVST, 2021 and the Monitoring and Evaluation Frameworks outcome indicators of improved coordination and increased HIVST and PrEP uptake in Nigeria. It provides the framework for periodic monitoring of progress, implementation and evaluation of this strategy.

Chapter four provides the monitoring and evaluation processes, including measurement indicators, means of verification, assumptions.

Table 4: Monitoring and Evaluation Framework for HIVST

	Project/Program Summary	Indicators	Source (Means of Verification)	Risk/Assumptions
Impact	• 95% of primary audience know where to access HIVST services by 2030	• % of key population who report knowing where to access HIVST services (disaggregated by FSW, MSM, PWID, TG)	IBBSS	Political and security climate remains stable throughout the period
	• 95% of primary audience have used HIVST by 2030.	• % of key population who report to have ever used HIVST (disaggregated by FSW, MSM, PWID, TG)		
Output	• Primary audience take up HIVST service	• Number of individual HIVST Kits distributed (directly assisted) • Number of individual HIVST Kits distributed (unassisted)	HIV Self – testing Register	• Peer sessions will help the peers to conquer self-stigma • HIVST services may not be readily available in communities.

Table 5: Monitoring and Evaluation Framework for PrEP

	Project/Program summary	Indicators	Source (Means of Verification)	Risk/Assumptions
Impact	• 95% of primary audience (FSW, MSM, PWID, TG, SDC, AGYW) are aware of PrEP	• % of key population who are aware of PrEP (disaggregated by FSW, MSM, PWID, TG • % of AGYW who are aware of PrEP	IBBSS Source for this indicator for AGYW is unknown	Political and security climate remains stable throughout the period
	• 95% of primary audience (FSW, MSM, PWID, TG, SDC, AGYW) know where to access PrEP services by 2030	• % of key population who report knowing where to access PrEP services (disaggregated by FSW, MSM, PWID, TG) • % of AGYW who are aware of PrEP	IBBSS Source for this indicator for AGYW is unknown	
Outcome	• Increased awareness on where to access PrEP services.	• Number of primary audiences who report awareness on were to access PrEP		Double counting of target audience reached from multiple channels/activities
	• Increased use of PrEP	• Number of key populations newly enrolled for PrEP (disaggregated by FSW, MSM, PWID, TG.)	PrEP Register	
Output	• Healthcare workers have required skills and attitude to provide PrEP friendly service to target audience	• Number of healthcare workers sensitized/trained to provide PrEP	Training reports	

4.2 Community-led Monitoring

Literature has shown that placing the communities and clients at the centre of HIV response is critical to ensuring efficiency and effectiveness. For this communication strategy for HIVST and PrEP interventions in Nigeria, a Network of key populations will lead the monitoring and evaluation of the behaviour change communication interventions.

Adaptive monitoring approaches that will allow KP networks to design, implement, and analyze the performance of the SBCC interventions will be adopted. KP networks will adopt mid-process and intermediate evaluations to analyze performance. The findings will be used to improve the communication strategic plan. KP networks will lead annual performance reviews with the public sector institutions (NACA and NASCP) and other implementing partners.

The annual review meetings will facilitate the presentation of milestones, challenges and gaps by each stakeholder, and a discourse on the impacts of the communication interventions on the key populations. KP networks will lead after-action reviews of HIVST and PrEP events, workshops, meetings, and training. After-action reviews will lead to the production and dissemination of newsletters, success stories, and nuggets.

4.3 Data Collection Methodology

Data will be generated at different sources (quantitative and qualitative) using community-led adaptive monitoring techniques. Data on improvements in interpersonal communication needs and messaging as well as improvement in provider behaviours will be generated using both qualitative exploratory and survey methods and conducted annually to improve on the implementation strategy.

Quantitative data will be collected and analyzed from service delivery points monthly to determine HIVST kits and PrEP access rate, enrolment rate, referrals, the proportion of clients receiving counselling, adverse events reporting rates, etc. For social media (WhatsApp, Facebook, Twitter, and Instagram), a process evaluation will be conducted each year to determine its sustained effectiveness and impacts in reaching the KPs, through an opinion poll deployed electronically.

Small group discussions with KPs will be conducted annually to identify gaps, resolutions, and new year implementation plans. This will be supported by a policy dialogue with policy, decision-makers, and program managers to discuss lessons learned and improve the implementation cycle.

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ANNEXES

Annex 1: Sample monitoring guides for program implementers

In alignment with the National Strategic Framework on HIV and AIDS 2017–2021, and the National HIV/AIDS Prevention Plan 2018-2021, program implementers can use the Tables 6 and 7 below as programme level guides for measuring the effectiveness of their communication interventions, in line with this strategy. It can also be used to make adjustments to programme implementation as needed. While this guide aligns with this strategy, it may not fully reflect the national monitoring and evaluation framework. This is because as HIVST and PrEP are relatively new program areas in Nigeria, harmonization of the comprehensive national indicators is still ongoing.

Table 6: Sample Monitoring and Evaluation Guide for HIVST

	Project/Program Summary	Indicators	Means of Verification	Risk/Assumptions
Outcome	• Increased awareness among the target audience • Increased knowledge of HIVST	• Number of primary audience who report sources of messaging for HIVST services disaggregated by a channel of communication. • Number of target audience who have knowledge (use and benefit) of HIVST	• Feedback from IPC studies • Adaptive monitoring report of the peer session • HMIS analyses • Survey • HIVST kits distribution, client intake register • Others as applicable	• Double counting of target audience reached from multiple channels/activities
	• Increased awareness on where to access HIVST services.	• Number of primary audiences who report awareness on where to access HIVST		
	• Increased self-efficacy of the target audience in the use of HIVST.	• Number of primary audiences who report self-efficacy in the use of the HIVST kits		
	• Increased use of HIVST	• Number of primary audiences who use HIVST kits		
	• Reduced incidence of social stigma and discrimination	• Number of primary audiences who report social stigma and discrimination. ○ Perceived as being HIV positive due to HIVST use		
	• Secondary and tertiary audiences' support for HIVST intervention	• Number of secondary and tertiary who support HIVST interventions		
Output	• Primary audience exposed to HIVST messaging.	• Number of HIVST messaging sessions conducted (IPC, peer education, etc) • Number of primary audiences reached with HIVST messaging, disaggregated by sex and channel of communication • Number of HIVST IEC distributed by channels • Number of primary audiences who have knowledge of HIVST, disaggregated by sex and channel of communication • Number of primary audiences who know where to access HIVST services, disaggregated by sex and channel of communication	• Database of peer sessions • Referral forms • Attendance and training reports • Social media platform analytics	• Peer sessions will help the peers to conquer self-stigma • HIVST services may not be

		• Number of primary target audience who report having self-efficacy in the use of HIVST, disaggregated by sex and channel of communication • Number of primary audiences who request for HIVST services, disaggregated by sex and channel of communication		readily available in communities
	• Primary target audience linked to HIVST access points.	• Number of primary target audience referred for HIVST services, disaggregated by sex and channel of communication.		
	• Target audience take up HIVST service	• Number of HIVST Kits distributed • Number of primary targets who take-up HIVST service, disaggregated by sex and point of care.		
	• Community gate keepers, religious and community leaders, parents/guardians of AGYW, media organizations, policy makers, etc become aware of HIVST and its benefit in HIV prevention. • Pledges pport for HIVST implementation • Private sector investment in HIVST services	• Number of people who heard/viewed/read HIVST messages • Number of stakeholders reached with HIVST advocacy visits. • Number of stakeholders who pledge to support HIVST implementation • Number of private sector players who invest in HIVST commodities. • Number of HIVST commodity points of access.		
Activities (to promote HIVST uptake)	• Facilitation of facility/OSS health talk	• Number of health talk sessions facilitated	• Health talks/group discussion attendance	Political and security climate remains stable throughout the period
	• Conduct of IPC and small group discussions.	• Number of IPC and small group sessions conducted.	• Social media analytics	
	• Conduct of peer education	• Number of peer education sessions conducted	• Training attendance and reports	
	• Train HIVST champions within target audience networks as IPC and health talk facilitators, peer educators	• Number of HIVST champions trained • Number of sessions facilitated by HIVST champions •	• Training attendance and reports	
	• Integrate HIVST into HTS (pretest counseling) at the community level	• Number of target audience linked to HIVST services during HTS.		
	• Dissemination of HIVST messages through social media platforms.	• Number of HIVST messages disseminated via social media platforms.		
	• Conduct of advocacy visits to KP community gate-keepers, community and religious leaders, healthcare workers, media organizations, policy makers, private sector players, etc to support HIVST interventions	• Number of advocacy visits conducted	• Advocacy attendance and reports • Advocacy kits	
	• Implement HIVST campaign using mass/social media to reach clients/special partners of KPs, male partners of AGYW, parent/guardians and role model mothers of AGYW, KP community gate-keeper, religious and community leader, healthcare worker and private sector players, etc	• Number of HIVST media messages disseminated through mass/social media.	• Survey • Media coverage • Social media platform analytics • HIVST market retail audit reports	

Table7: Sample Monitoring and Evaluation Guide for PrEP

	Project/Program Summary	Indicators	Means of Verification	Risk/Assumptions
Outcome	• Increased awareness among the target audience	• Number of target audience who report sources of messaging for PrEP services disaggregated by a channel of communication.	• Feedback from IPC studies • Adaptive monitoring report of the peer session • HMIS analyses • Survey • PrEP enrolment register • Others as applicable	Double counting of target audience reached from multiple channels/activities
	• Increased knowledge of PrEP	• Number of target audience who have knowledge on: o The benefit of PrEP use o PrEP eligibility criteria (at least 2) o PrEP regimen/dosage o Common side effects of PrEP use (at least 2)		
	• Confidence of the target audience in PrEP use.	• Number of target audience who have confidence in PrEP use o Willingness to use PrEP o Adherence to PrEP use as prescribed o Recommending PrEP to other potential users		
	• Increased awareness on where to access PrEP services.	• Number of primary audiences who report awareness on were to access PrEP		
	• Increased use of PrEP	• Number of target audience enrolled for PrEP		
	• Reduced incidence of social stigma and discrimination	• Number of target audience who report social stigma and discrimination. o Perceived as being HIV positive due to PrEP use o Healthcare worker refusal to offer PrEP or being judgmental		
	• Strengthened skills and attitude of healthcare workers in providing PrEP friendly services.	• Number of target audience who report satisfactory PrEP service offered by healthcare workers		
	• Secondary and tertiary audiences' support for PrEP intervention	• Number of secondary and tertiary audience who support PrEP interventions		
Output	• Primary target audience exposed to PrEP messaging	• Number of PrEP messaging sessions conducted (IPC, peer education, etc). • Number of primary audiences reached with PrEP messaging, disaggregated by sex and channel of communication • Number of PrEP IEC distributed by channels • Number of primary audiences who have comprehensive knowledge of PrEP, disaggregated by sex and channel of communication • Number of primary audiences who know where to access PrEP services, disaggregated by sex and channel of communication • Number of primary target audience report having confidence in the use of PrEP, disaggregated by sex and channel of communication • Number of primary audiences who request for PrEP services, disaggregated by sex and channel of communication	• Database of peer sessions • Referral forms • Attendance and training reports • Social media platform analytics	• Peer sessions will help the peers to conquer self-stigma PrEP services may not be readily available in communities
	• Primary target audience linked to PrEP access points	• Number of primary target audience referred for PrEP services, disaggregated by sex and channel of communication		
	• Target audience enrolled on PrEP services	• Number of primary targets who take-up PrEP services, disaggregated by sex and channel of communication		

	• Healthcare workers have required skills and attitude to provide PrEP friendly service to target audience	• Number of healthcare workers sensitized/trained • Number of healthcare workers who demonstrate understanding of the required skills to provide PrEP friendly services based on pre and post assessment • Number of healthcare workers reached through advocacy visits	• Pre and post test assessments • Advocacy visit attendance. • Training attendance	
	• Community gate keepers, religious and community leader, parents/guardians of AGYW, media organizations, policy makers, etc become aware of PrEP and its benefit in HIV prevention. • Pledge support for PrEP implementation • Private sector investment in PrEP services	• Number of people who heard/viewed/read PrEP messages • Number of stakeholders reached with PrEP advocacy visits • Number of stakeholders who pledge to support PrEP implementation • Number of private sector players who invest in PrEP commodities. • Number of PrEP commodity points of access	• Survey • Media coverage • Social media platform analytics • PrEP market retail audit reports	
Activities (to promote PrEP uptake)	• Facilitation of facility/OSS health talk	• Number of health talk sessions facilitated	• Health talks/group discussion attendance • Social media analytics • Training attendance and reports • Advocacy attendance and reports • Advocacy kits	Political and security climate remains stable throughout the period
	• Conduct of IPC and small group discussions	• Number of IPC and small group sessions conducted		
	• Conduct of peer education	• Number peer educations sessions conducted		
	• Train PrEP champions within target audience networks as IPC and health talk facilitators, peer educators.	• Number of PrEP champions trained. • Number of sessions facilitated by PrEP champions		
	• Integrate PrEP into HTS (pretest counseling) at the community level	• Number of target audience linked to PrEP services during HTS		
	• Dissemination of PrEP messages through social media platforms.	• Number of PrEP messages disseminated via social media platforms.		
	• Conduct of advocacy visits to KP community gate-keepers, community and religious leaders, healthcare workers, media organizations, policy makers, private sector players, etc to support PrEP interventions.	• Number of advocacy visits conducted	• Training manual, presentation, curriculum etc	
	• Implement PrEP campaign using mass/social media to reach clients/special partners of KPs, male partners of AGYW, parent/guardians and role model mothers of AGYW, KP community gate-keeper, religious and community leader, healthcare worker and private sector players, etc.	• Number of PrEP media messages disseminated through mass/social media		
	• Conduct sensitization and capacity building sessions for healthcare workers on providing KP/AGWY friendly PrEP services.	• Number of sensitization and capacity building sessions conducted for PrEP healthcare providers.		

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