# PMTCT Demand Creation for Accelerated Uptake of Services

## A National Prevention of Mother-to-Child Transmission (PMTCT) of HIV Communication Strategy, Nigeria

April 2014


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# PREFACE

Nigeria, with a population of about 170 million [1] people and a HIV sero-prevalence of 3.4% [2] is estimated to have the third largest number of People Living with HIV and AIDS globally. The nation also bears the second largest burden of Prevention of Mother-to-Child transmission (PMTCT) globally. More than 90% of the children living with HIV are infected through mother-to-child transmission.

The country has committed to the elimination of Mother-To-Child Transmission (eMTCT) of HIV by 2015. The Presidential Comprehensive Response Plan (PCRP) proposes to scale up PMTCT service coverage to 90.0% of national need (6 million pregnant women tested for HIV and received results, 244,000 positive pregnant women receive ART to prevent transmission of HIV to their unborn babies) towards achieving the eMTCT by 2015 in line with the global plan. This has created renewed efforts towards the aggressive scale-up of PMTCT services nationwide. Currently, Antiretroviral Therapy (ART) through PMTCT services have been made available by the Government of Nigeria (GoN) and donor agencies. The services are now being rolled out at primary healthcare facilities nation-wide. However, uptake of HIV Counseling and Testing (HCT), the entry point for these services, is low while that of PMTCT services is also very low.

The need to increase demand for PMTCT services has therefore become very urgent and critical not only for the GoN but also for key Partners and stakeholders. Against this backdrop, the development of the evidence-informed National PMTCT Demand Creation Strategy is not only timely but also on point.

The document outlines a unified, strategic and clear-cut direction for designing and implementing campaigns to promote the uptake of PMTCT services. It provides guidance on the principles, procedures and activities to develop, implement and evaluate evidence-based PMTCT demand creation programs in Nigeria.

It is envisioned that this National PMTCT Demand Creation Strategy will facilitate scale-up of campaigns at all levels to enhance awareness and promote uptake of PMTCT services. It will also contribute to ensuring that everyone who is involved in providing communication support for PMTCT programming does so in a consistent and coordinated fashion.

I encourage partners at all levels to adopt and utilize the document as a blueprint for designing and executing demand creation campaigns for PMTCT in the country.

I thank all the stakeholders who participated in the development of this strategy and look forward to its successful implementation.

Prof. John Idoko
Director-General, National Agency for the Control of AIDS (NACA)

1 Population Reference Bureau 2012.
2 National HIV/AIDS and Reproductive Health Survey (NARHS Plus II, 2012). Federal Ministry of Health Nigeria

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The technical and editorial support provided by the FHI 360/C-Change is highly appreciated. They all demonstrated a high degree of professionalism and commitment to ensure the development and production of the strategy document.

NACA sincerely hopes that all the effort put into the development and implementation of this strategy will lead to increased uptake of PMTCT services and reduce the incidence of HIV among children.

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# ACRONYMS

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| ANC | Antenatal Care |
| APIN | AIDS Prevention Initiative in Nigeria |
| ART | Antiretroviral Therapy |
| ARV | Antiretroviral |
| ASWHAN | Association of Women Living with HIV/AIDS in Nigeria |
| BCC | Behavior Change Communication |
| CCCRN | Center for Clinical Care and Research in Nigeria |
| CCFN | Catholic Caritas Foundation Nigeria |
| C-Change | Communication for Change |
| CDC | Centers for Disease Control and Prevention |
| CFID | Center for Information & Development |
| CHEW | Community Health Extension Worker |
| CIHP | Center for Integrated Health Program |
| CiSHAN | Civil Society for HIV/AIDS in Nigeria |
| EID | Early Infant Diagnosis |
| eMTCT | Elimination of Mother-to-Child transmission of HIV |
| FMOH/ HAD | Federal Ministry of Health (HIV/AIDS Division) |
| FMOH/ HPU | Federal Ministry of Health (Health Promotion Unit) |
| HCT | HIV Counselling and Testing |
| HCW | Health Care Worker |
| HIV | Human Immunodeficiency Virus |
| HIV+ | Human Immunodeficiency Virus-positive |
| IHVN | Institute of Human Virology Nigeria |
| IP | Implementing Partner |
| IPC | Interpersonal Communication |
| JAAIDS | Journalists Against AIDS |
| JAPIN | Journalists Alliance for PMTCT in Nigeria |
| LGA | Local Government Area |
| MDG | Millennium Development Goals |
| MSH | Management Sciences for Health |
| MSS | Midwives Service Scheme |
| MTCT | Mother-to-Child Transmission of HIV |
| NACA | National Agency for the Control of AIDS |
| NASCP | National AIDS and STIs Control Programme |
| PHC | Primary Health Care Center |
| PLHIV | People Living with HIV and AIDS |
| PMTCT | Prevention of Mother-to-Child Transmission of HIV |
| QI | Quality Improvement |
| SBCC | Social and Behavior Change Communication |
| SFH | Society for Family Health |
| SGD | Small Group Discussion |
| SIDHAS | Strengthening Integrated Delivery of HIV/ AIDS Services |
| SOP | Standard Operating Procedure |
| SRH | Sexual and Reproductive Health |
| SURE-P | Subsidy Reinvestment and Empowerment Program |
| TBA | Traditional Birth Attendant |
| TV | Television |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNICEF | United Nations Children's Fund |
| UN | United Nations |
| USAID | United States Agency for International Development |
| USDOD WRP-N | United States Department of Defense Walter Reed Project-Nigeria |

# 1 BACKGROUND

Nigeria, with a population of about 170.1 million[1] people and a national HIV prevalence rate of 3.4 percent[2], ranks second after South Africa among countries in the world with the highest total burden of HIV infections. The country also accounts for about 32 percent[3] of the global burden of mother-to-child transmission (MTCT) of HIV.

The high burden of MTCT in Nigeria is due to a high rate of heterosexual transmission, a higher prevalence of HIV in women of reproductive age, high total fertility rates and poor access to PMTCT interventions. In 2011 it was estimated that about 6.7 million pregnant women (birth rate 41 per 1,000)[4] required HIV counselling and testing (HCT). Of this population, about 222,129 were estimated to be HIV-positive and would give birth to 58,495 HIV-infected babies.[5] In the same year only 17 percent of pregnant women received HCT, while only 16 percent of HIV-positive pregnant women received antiretroviral (ARV) prophylaxis to prevent transmission of the virus to their unborn babies.[6]

Over 90 percent of HIV infections in children are acquired through MTCT. As more women become infected, the number of infected infants will grow. Studies indicate that without appropriate PMTCT interventions followed by early infant diagnosis (EID) and pediatric antiretroviral therapy (ART) for infected babies, about 50 percent of those infants born with HIV will die before their second birthdays.[7] Experiences from programs in more technologically advanced countries and a number of African countries have shown that PMTCT programs can reduce the risk of MTCT of HIV to as low as 2 percent. Interventions include the use of ARVs as either prophylaxis or therapy for HIV-positive women in pregnancy, labor and during breastfeeding.[6]

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[1] Population Reference Bureau 2012.

[2] National HIV/AIDS and Reproductive Health Survey (NARHS Plus II, 2012). Federal Ministry of Health Nigeria

[3] World Health Organization. Global HIV/AIDS Response: Epidemic Update and Health Sector Progress Towards Universal Access: Progress Report 2011. Geneva: WHO 2011.

[4] Population Reference Bureau 2011.

[5] National Agency for the Control of AIDS: Global AIDS Response Country Progress Report: Nigeria GARPR 2012.

[6] National Agency for the Control of AIDS. 2011 Annual Report. Abuja: NACA 2012.

[7] World Health Organization. Strategic Vision 2010-2015: Preventing mother-to-child transmission of HIV to reach the UNGASS and Millennium Development Goals. Geneva: WHO 2011.

The PMTCT program in Nigeria was initiated in 2002 in six tertiary health facilities (one in each of the geopolitical zones of the country) by the Federal Ministry of Health (FMOH) with support from development partners. With continued support, the number of facilities providing PMTCT has increased over the years, with services decentralized to secondary and primary health facilities and some involvement of private institutions. As at December 2012, a total of 1,320 health facilities[8] offered PMTCT services across the country. However, this figure represents a small fraction of the total health facilities in the country.

The public health care system in Nigeria is not without challenges. A 2011 baseline survey of primary health care services in Nigeria depicts challenges such as poor health infrastructure with inadequate buildings and equipment and inadequate human resource capacity and supervision.[9] There are also weak referral links between different levels of care and weak logistic systems for health care commodities.

In June 2011, at the United Nations (UN) High Level Meeting on AIDS, Nigeria and other member nations launched and committed to the Global Plan towards the Elimination of New HIV Infections in Children by 2015 and Helping Mothers Stay Healthy. Through the National Scale-up Plan Towards Elimination of Mother-to-Child Transmission (eMTCT) of HIV, the country is already aligned with the global targets of reducing new HIV infections in children by 90 percent and reducing AIDS-related maternal deaths by 50 percent by 2015. In order to achieve these ambitious targets, national and state governments; the organized private sector; public, private and traditional health care providers; civil society; networks of people living with HIV and AIDS (PLHIV); and community structures will work collaboratively to improve health care delivery systems, particularly at the primary health care levels where the majority of the people live and the need is greatest.

Other achievements in the scale-up of PMTCT services in Nigeria include the development of key policy documents and plans—the National HIV/AIDS Policy, National HIV/AIDS Strategic Plan 2010-2015 and the National Scale-up Plan Towards eMTCT of HIV—all of which prioritize PMTCT as a major focus for the country. National PMTCT guidelines (aligned with the 2010 WHO guidelines) have been developed to guide service provision. The country and its partners have, through extensive analysis, selected 12+1 States (that account for about 70 percent of the PMTCT burden) for accelerated scale-up of services through a strategy of decentralization and integration of services at primary health care levels.

The Joint UN Programme on HIV/AIDS (UNAIDS) outlines a comprehensive four-prong approach for PMTCT, as follows:

- Primary prevention of HIV among women of child bearing age
- Preventing unintended pregnancy among women living with HIV
- Preventing HIV transmission from women living with HIV to their infants (including providing HIV testing and counseling to pregnant women and providing ARV prophylaxis to

[8] NACA fact sheet, 2011

[9] National Baseline Survey of Primary Health Care Services and Utilization in Nigeria Survey Report. April 2011.

pregnant mothers living with HIV and their infants); this approach will also include a strong community outreach component to create demand for services and to support partner involvement and testing

- Providing appropriate treatment, care and support to mothers living with HIV and their children

There is strong evidence that a combination of the four prongs of PMTCT, if fully implemented for sustained periods, can bring about the eMTCT of HIV, a goal that the global community including Nigeria is now committed to achieving by 2015. This will entail coordinated interventions and activities at multiple levels of the health system, from community and providers to policy makers.

It is against this backdrop and an understanding of the importance of involving the different groups that make up communities to strategically scale up PMTCT services, that this *National PMTCT Demand Creation Communication Strategy* has been developed. The purpose of the document is to outline strategies to address primary, secondary and tertiary audiences:

Primary:

- Increase knowledge about, accessibility of and demand for sexual and reproductive health (SRH) and ANC/PMTCT services
- Encourage attendance and completion of ANC services

Secondary:

- Increase involvement of male partners to support utilization of SRH/ANC/PMTCT services
- Involve communities to encourage acceptability of ANC/PMTCT

Tertiary:

- Involve policy makers, communities, health care providers and families to encourage health-seeking behavior among pregnant women
- Mitigate stigmatization, misconceptions and inaccurate beliefs regarding PLHIV
- Create a supportive environment for increasing uptake of ANC
- Inform the public and share information about the benefits of ANC/PMTCT services

In order to achieve the above, there is need for integration of demand creation efforts across regions, offering new ways to address cross-regional issues. This is because knowledge, demand and health-seeking behavior, as well as social and gender norms surrounding service uptake, differ across regions. Integration of efforts will result in increased efficiency and improved quality of care for clients through delivery of high quality services.

The Midwives Service Scheme (MSS) is an MDG-supported project that seeks to mobilize midwives—including those newly qualified from Nigerian basic schools of midwifery, unemployed midwives and retired but able midwives—for deployment to health facilities in rural communities to undertake one year of community service. The one-year service will be mandatory for the newly graduated basic midwives, preparatory to their being fully licensed to practice midwifery in Nigeria. This service scheme will increase skilled attendance at birth and reduce maternal, newborn and child morbidity and mortality.[10]

The Subsidy Reinvestment and Empowerment Programme (SURE-P) is a Nigerian Government initiative aimed at reinvesting the Federal Government's share of savings arising from the reduction of subsidies on petroleum products into people-oriented programs and initiatives. The fund is applied to critical infrastructure projects and social safety nets such as the Maternal and Child Health Care Programme. Components of the later include: screening and recruitment of midwives and community health extension workers (CHEWs), assessment of 500 primary health care centers (PHCs) and 125 general hospitals under SURE-P, orientation and development of 200 midwives, orientation and development of 2000 CHEWs in six geo-political zones.

## JUSTIFICATION FOR EXPECTED INCREASE IN PERCENTAGE

The global PMTCT target, adopted as Nigeria's target, aims to ensure that 90 percent of pregnant women have access to comprehensive PMTCT services.[11] This national PMTCT demand creation document aligns the global and national response to PMTCT in the communication strategy outlined here.

During extensive consultations (C-Change-supported Social and Behavior Change Training, March 2013) with key national stakeholders—FMOH and the National Agency for the Control of AIDS (NACA); international stakeholders—United States Government Implementing Partners (USG/IPs) and the U.S. Centers for Disease Control and Prevention; and local partners, six priority audiences were identified for national strategic PMTCT communication interventions. Regional differences including the influence of religion and religious practices (Christian and Muslim), use of traditional birth attendants (TBAs) and (harmful) cultural practices were also identified.

The national focus of PMTCT services is primarily women of reproductive age (15-49 years old). In addition, the first approach/pillar of PMTCT programming is "prevention of unintended pregnancies" for this target cohort. Specific audiences directly and indirectly influence women's decision making. In order to segment audiences appropriately, PMTCT demand creation in Nigeria is being addressed with a proven and comprehensive Social and Behavior Change Communication (SBCC) approach. The SBCC model, as well as related and widely recognized methods of strategy development, has been utilized. These strategies consider primary audiences to be those directly affected by the problem, secondary audiences to be those who directly influence the decision making of primary audiences and tertiary audiences to be those who indirectly influence primary and secondary audiences.[12]

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[10] 2012 National primary healthcare development agency of Nigeria

[11] 2011 NACA fact sheet

[12] For further information on the SBCC approach see: http://www.c-changeprogram.org/focus-areas/capacity-strengthening/SBCC-Toolkit

There is evidence that 54 percent of Nigerian women visit ANC clinics during pregnancy (NACA 2012). They form the primary audience for PMTCT communication. Their husbands, partners and family members are secondary audiences due to their direct influence on HIV-positive pregnant women. The tertiary audiences include community/religious leaders and policy makers who indirectly influence the HIV-positive women, pregnant women and their direct influencers.

# 2 SITUATION ANALYSIS

## AUDIENCE SELECTION

An "Ecological model" of SBCC was used to guide the process of segmenting audiences. The model provides clear guidance on the relationship between the primary, secondary and tertiary audiences.

### Primary Audiences (directly affected)

#### *Pregnant women*

Pregnant women will be the focus of high impact interventions including messages to generate and sustain demand for ANC/PMTCT services. With 6.8 million pregnancies and a birth rate of 40 births per 1000 population annually, opportunities for real impact on MTCT are great. The challenge is to ascertain availability of ARVs and prophylaxis once demand has been generated across the country. Early and appropriate attendance at ANC is important as only 35 percent of pregnant women deliver at health facilities.

### Secondary Audiences (directly influencing)

#### *Husbands/Partners*

Correct knowledge of HIV transmission and methods of HIV prevention are low (52.5 percent) among adult men in Nigeria. Poor male involvement and poor ANC support by men reduces the chances of women accessing ANC/PMTCT services. Even though spouses/partners generally support pregnant women, they do not accompany them to ANC due to gender-based misconceptions. (This is perceived as a woman's role and to accompany them would imply weakness or that they are jobless.)[13] The focus for communication strategies for men will be on increasing knowledge of ANC services and HIV risks and on providing active support for their wives to attend ANC. Men will be engaged at the community level in men-only dialogues to address norms affecting effective involvement of men in ANC/PMTCT.

[13] NARHS Plus, 2007

### *Family Members: Mothers, mothers-in-law and siblings*

Mothers-in-law and family members stand out as high influencers of pregnant women in the North Western and South Western parts of Nigeria. Family members, especially mothers and mothers-in-law, play pivotal roles in the health of pregnant women.

### *TBAs*

TBAs play a key role in the antenatal and post-natal experiences of women. An estimated 43 percent of women in Nigeria give birth under the supervision of a skilled birth attendant[14]. With TBAs, payment options can be negotiated in-kind or via cash, which is attractive for many poor rural women. The bonds that exist between TBAs and many of their patrons are cultural and strong. Efforts shall be made to facilitate partnerships with TBAs in order to identify the limitations of their services that can be filled through ANC uptake and adherence without upsetting the birthing processes they offer. Further, communication strategies will address the goal of healthy mothers and babies through effective referrals to nearby health facilities.

## *Health Care Workers (HCWs)*

HCWs include medical doctors, nurses, midwives and CHEWs. Rural women prefer CHEWs who live in their communities and make time to discuss their health concerns. However, many health providers are unskilled in interpersonal communication and come across to clients as rude and unfriendly. Poor provider skills and attitudes may contribute to the fact that only 27 percent of rural women access services in PHCs. Improving the attitudes and interpersonal communication (IPC) skills of HCWs are essential for successful PMTCT demand creation.

### Tertiary Audiences (indirectly influencing)

### *Community and Religious Leaders*

Community and religious leaders have roles in forming and maintaining opinions in the community on issues that will ensure the wellbeing of members. They are classic gatekeepers for new ideas and their support is crucial to mobilize community support for PMTCT service utilization. Community and religious leaders will be engaged in community dialogues to address issues around stigma and discrimination, as well as effective involvement of males in ANC/PMTCT.

### Policy Makers at the national, state and local government area (LGA) level

Policy makers to be focused on include: State Governors and Commissioners (Health and Women Affairs) as well as Health Management Boards, Hospital Boards and Local Government Councils. These groups must be sensitive to issues of PMTCT in order to enact policies, allocate and disburse necessary resources and be accountable at the different levels of government to ensure and sustain demand for PMTCT services.

[14] National HIV/AIDS and Reproductive Health Survey (NARHS Plus, 2007). Federal Ministry of Health Nigeria

## Problem Statement

### Six major issues have been identified regarding PMTCT services in Nigeria:

1. Pregnant women have low knowledge of PMTCT services. This lack of knowledge and related action contributes to the increase in HIV-positive babies and infant morbidity and mortality.
2. Pregnant women have low knowledge of benefits associated with SRH as well as ANC/PMTCT services. Lack of trust in HCWs contribute to low motivation to access services.
3. Distance to health facilities, difficult terrains, long waiting periods at clinics before being seen by a provider and lack of transportation and/or fare also contribute to low turnout at ANC/PMTCT services.
4. Unavailability of ANC/PMTCT services in health care facilities in some communities is a major factor that contributes to low participation.
5. Some women lack the full support of partners, families, communities and religious leaders in seeking ANC/PMTCT services due to associated HIV-related stigma as well as gender inequalities in health care decision-making.
6. There are deep cultural preferences for home births and births in religious houses, as well as deliveries by TBAs.

## Proposed Changes to Address the Identified Problems

### The major issues identified above shall be addressed by the following:

1. Increase in knowledge among pregnant women. This is likely to improve their ability to seek ANC/PMTCT services.
2. Increased knowledge among spouses/partners and family members, as well as addressing HIV-related stigma and deep gender inequalities in decision making. This is expected to increase support and encouragement for women's care-seeking behaviors.
3. Improved interpersonal communication (IPC) skills of HCWs will increase trust and motivation on the part of clients to utilize ANC/PMTCT services. In addition, establishing, strengthening and sustaining linkages among HCWs, TBAs and faith houses has the potential to provide a supportive network for pregnant women. A TBA/HCWs forum will be established to foster linkages, synergies and coalition building.
4. Community and religious leaders will support health service utilization by constantly reiterating to their community and congregants that PMTCT will improve the health of pregnant women and greatly benefit the community.
5. Policy makers will continue to positively influence rules and regulations in support of PMTCT rollout and accessibility. This will address issues like limited resources (under-equipped facilities) and commodity insecurity, lack of HCT services at rural clinics, understaffed facilities and under-paid personnel.

# 3 COMMUNICATION STRATEGY

## STRATEGIC APPROACH*

A strategic approach will drive PMTCT demand creation program coherence and map out how communication objectives will be achieved. It focuses on promoting on-going efforts to improve quality of service delivery and IPC between HCWs and their clients during ANC/PMTCT services in order to motivate more clients to use PMTCT services.

This can be achieved through:

- Facilitating friendly services for women seeking ANC/PMTCT services by working to improve IPC skills of HCWs. Offer trained and qualified 'friends' (facility workers) whom women can chat with about their life plans, especially their health and that of their babies. Promote *Caring services tailored to your needs.*
- Encouraging partnerships among HCWs, TBAs and faith houses through dialogues and trainings for HCWs and motivational materials (e.g., merit badges and awards).
- Engaging community mobilizers/volunteers to educate women of reproductive age on the benefits of ANC/PMTCT services through facilitated community dialogues and *Men.Care* fora. Position ANC/PMTCT clinics as *Trusted Health Centers* for women.
- Branding ANC/PMTCT clinics with appropriate logo and a slogan such as *Friendly care, healthy babies.*
- Educating pregnant women about the benefits of ANC/PMTCT services and where they can be accessed. Providing incentives for uptake of ANC/PMTCT services (e.g., *Happy baby packs)* leveraged through individual sponsorship or private/public partnerships.
- Engaging HIV-positive mothers as mentors to newly diagnosed and expectant mothers.
- Promoting male involvement by establishing male-only roundtables in communities to discuss family health and wellbeing. Each forum *(Men.Care)* will articulate family and community health needs and participants will take collective action to address identified needs and challenges, with ANC/PMTCT and reproductive health as priorities.

* The strategic approach refers to the packaging and framing of communication interventions into a single program, campaign, or platform. It holds together the different interventions, channels and materials and combines them into a synergistic program.

- Training journalists on the benefits of ANC/PMTCT services, so they use media to educate the public and keep ANC/PMTCT on the front burner in media programs.
- Addressing HIV-related stigma and disclosure by working directly with influencing audiences (e.g., husbands, community and religious leaders) to support and encourage pregnant women to seek ANC/PMTCT services.

## POSITIONING STATEMENT

Pregnant women can only deliver healthy babies if we support them to access and complete ANC/PMTCT visits.

## AUDIENCE SEGMENTATION

**Primary Audience (people directly affected):**

- Pregnant women in rural and urban Nigeria

**Secondary Audience (people directly influencing pregnant women):**

- Partners and husbands of pregnant women
- Other family members such as mothers and mothers-in-law
- HCWs in clinics that offer ANC/PMTCT services
- TBAs

**Tertiary Audience (people indirectly influencing the primary audience):**

- Community leaders
- Religious leaders
- Policy makers

## Desired Changes, Barriers, Communication Objectives and Possible Interventions by Audience

| PRIMARY AUDIENCE: PREGNANT WOMEN IN RURAL AND URBAN NIGERIA | | |
|---|---|---|
| **DESIRED CHANGES** | **KEY BARRIERS** | **COMMUNICATION OBJECTIVES** |
| Attend and complete ANC/PMTCT visits | • Low knowledge of benefits of ANC/PMTCT services<br>• Many local health centers do not offer PMTCT as part of ANC services<br>• Distance to health facilities for rural women<br>• Long waiting period at clinics before being seen by a provider<br>• Contrary to 'policies,' some providers still levy costs for care and services delivery | By the end of 2015, there will be a 90 percent increase in the number of pregnant women who:<br>• know about ANC/PMTCT and its benefits in order to make an informed decision<br>• know which clinics offer PMTCT as part of ANC services<br>• trust that these benefits will outweigh their fears and bad experiences at service delivery point<br>• are motivated to seek ANC/PMTCT services and make four or more ANC/PMTCT visits during pregnancy<br>• are motivated to go for ANC, e.g. because of the *Happy Baby Packs* or other incentives |
| **SECONDARY AUDIENCE: PARTNERS AND HUSBANDS OF PREGNANT WOMEN** | | |
| **DESIRED CHANGES** | **KEY BARRIERS** | **COMMUNICATION OBJECTIVES** |
| Support and encourage wives and partners to access ANC/PMTCT services | Low knowledge of the benefits of ANC/PMTCT | By the end of 2015, there will be a 90 percent increase in the number of husbands and partners of pregnant women who know about ANC/PMTCT and its benefits |
| | Social norms currently do not support male involvement in ANC/PMTCT settings | By the end of 2015, there will be a 90 percent increase in the number of husbands and partners actively involved and engaged in the ***Men.Care forum*** who are motivated to support their pregnant wives and partners to access ANC/PMTCT services |

| SECONDARY AUDIENCE: FAMILY MEMBERS (MOTHERS-IN-LAW AND SIBLINGS) | | |
|---|---|---|
| **DESIRED CHANGES** | **KEY BARRIERS** | **COMMUNICATION OBJECTIVES** |
| Support pregnant women to access ANC/ PMTCT services (financial support, adherence support) | Low knowledge of ANC/PMTCT on the part of husbands, mothers-in-law, and siblings | By the end of 2015, there will be a 90 percent increase in the number of family members who know about ANC/PMTCT and its benefits |
| | HIV-related stigma is intractable in many communities (fear of the unfamiliar) | By the end of 2015, there will be a 90 percent increase in the number of mothers-in-law and siblings who:<br>• are able to discuss relevant benefits and issues related to ANC/PMTCT<br>• support pregnant women to attend ANC/PMTCT services<br>• contribute to ANC care-seeking for pregnant women by accompanying/ providing resources to enable such a visit |
| **SECONDARY AUDIENCE: HCWs** | | |
| **DESIRED CHANGES** | **KEY BARRIERS** | **COMMUNICATION OBJECTIVES** |
| Friendly attitude towards clients | Lack of IPC skills<br>Limited resources (under-equipped facilities) and commodity insecurity<br>Many rural clinics lack ability to provide HCT<br>Healthcare providers are overwhelmed and under paid<br>Lack of adequate human resources (over-loaded personnel) | By the end of 2015, there will be a 90 percent increase in the number of HCWs who:<br>• demonstrate basic IPC skills<br>• know how communicating more effectively with patients can save them time and make them feel more appreciated |
| Develop partnership with TBAs and faith houses | Many HCWs view TBAs and faith houses as competitors | By the end of 2015, there will be a 90 percent increase in the number of HCWs who accept TBAs as partners |
| Promote improved and high quality services through facilities with trained providers who have been branded as *friendly and trustworthy* | Lack of standard operation procedures (SOP) and where available, poor utilization for improved quality*<br>Inadequate capacity to mentor staff trained in IPC skills<br>**Requires close collaboration with quality assurance interventions to find out which services can be branded* | By the end of 2015, there will be a 90 percent increase in the number of facilities utilizing SOPs for ANC/PMTCT services<br>By the end of 2015 there will be a 90 percent increase in the number of HCWs with adequate IPC skills |

| SECONDARY AUDIENCE: TBAs | | |
|---|---|---|
| **DESIRED CHANGES** | **KEY BARRIERS** | **COMMUNICATION OBJECTIVES** |
| Know when and how to refer pregnant women for ANC/PMTCT services<br>Refer pregnant women for ANC/PMTCT services | While TBAs admit to low knowledge of PMTCT, they view each referral to a health center as potential loss of income. | By the end of 2015, there will be a 90 percent increase in the number of TBAs who:<br>• have acquired knowledge about HCT/ PMTCT referral<br>• are motivated to refer pregnant women for HCT/PMTCT services<br>• partner with HCWs and faith houses to increase the number of women referred to health facilities. |
| | TBAs are not motivated to refer clients to health centers for fear of income losses (for current and future pregnancies)*<br>**The more the number of clients, the higher the accrued income* | |

| SECONDARY AUDIENCE: COMMUNITY LEADERS | | |
|---|---|---|
| **DESIRED CHANGES** | **KEY BARRIERS** | **COMMUNICATION OBJECTIVES** |
| Support ANC/PMTCT uptake | Community leaders do not know the benefits of ANC services for women in their communities<br>Community leaders are custodians of cultural and community norms who have allowed HIV-related stigma to exist and grow | By the end of 2015, there will be a 90 percent increase in the number of community leaders who:<br>• know the benefits of ANC/PMTCT services<br>• support uptake of ANC/PMTCT services in their communities<br>• enable and promote community dialogues on cultural practices that adversely affect use of ANC/PMTCT services |

| SECONDARY AUDIENCE: RELIGIOUS LEADERS | | |
|---|---|---|
| **DESIRED CHANGES** | **KEY BARRIERS** | **COMMUNICATION OBJECTIVES** |
| Support and help in mobilizing congregations for ANC/PMTCT uptake | Religious leaders do not know the benefits of ANC/PMTCT;<br>Religious leaders invoke punitive doctrines that promote HIV-related stigma and label PLHIV as condemnable sinners | By the end of 2015, there will be 90 percent increase in the number of religious leaders who:<br>• know the benefits of ANC/PMTCT services<br>• discuss ANC/PMTCT services with their congregations |
| | HIV-related stigmatization by religious groups | By the end of 2015 there will be a 90 percent increase in the number of religious leaders who:<br>• support their congregants to seek ANC/PMTCT services<br>• promote genuine dialogue based on support for neighbors despite diagnoses.<br>• promote congregation dialogue on misconceptions and negative beliefs about ANC/PMTCT |
| **TERTIARY AUDIENCE: POLICY MAKERS (STATE, LOCAL AND WARDS)** | | |
| **DESIRED CHANGES** | **KEY BARRIERS** | **COMMUNICATION OBJECTIVES** |
| Consistent implementation of ANC/PMTCT programs | Policy makers lack political will to allocate and ensure adequate resources aligned with national policy for free ANC services for women in public facilities | By the end of 2015, there will be a 90 percent increase in the number of policy makers who are motivated to allocate resources to and support ANC/PMTCT programs as priority in public facilities |
| | Policy makers lack political will to fund and support adequate numbers of HCWs in state and local government facilities | Provide adequate resources, training and remuneration to HCWs to support ANC/PMTCT in public health facilities |

## KEY CONTENT

### Primary Audience: Pregnant Women

- Benefits of ANC/PMTCT: Pregnant mothers who complete their ANC visits and HIV-positive mothers who access PMTCT services, are healthy and deliver healthy babies. *Healthy Mother, Healthy baby*
- ANC/PMTCT requirements (e.g., at least four visits, ARV adherence)

**KEY BENEFIT:**
***Completing ANC visits is a sure way to ensure a healthy mother and baby. Attend antenatal services consistently. HIV-Free Baby—It's possible. Friendly Care, Healthy baby!***

### Secondary Audiences: Husbands/Partners, Families, Community and Religious Leaders, HCWs and TBAs

#### *Husbands/Partners*

- Provide resources and support your wife to enroll to receive ANC/PMTCT services
- Follow up on your wife's ANC/PMTCT schedule
- Remind (and if possible accompany or designate someone else in the family to accompany) your wife to attend every ANC/PMTCT appointment scheduled
- (When you visit the health center with your wife) ask questions about any confusing aspects of your wife's care
- Discuss the benefits of ANC/PMTCT with health care team, your wife and your peers
- Encourage your wife to take her prescribed medication

**KEY BENEFIT:**
***If you support your wife to attend and complete her ANC visits, you will have a healthy baby, healthy mother and happy family.***

#### *Families (e.g., Mothers or Mothers-in-law)*

- Encourage pregnant women to seek and complete ANC/PMTCT services at the nearest health facility
- Provide financial support to enable pregnant women to receive adequate ANC/PMTCT services at the clinic

**KEY BENEFIT:**
***If you support early uptake of ANC/PMTCT services, you will have a healthy baby and happy family.***

### *HCWs*

- Link ANC visits to PMTCT services in facilities and make appropriate referrals for women who make ANC visits but also need PMTCT services.
- Maintain a warm, friendly and supportive attitude to encourage ANC visits and to gain clients' confidence and respect

**KEY BENEFIT:**
***If you are friendly to clients, you will be highly regarded and respected as a professional.***

### *TBAs*

- Know the benefits of HCT/PMTCT services for pregnant women—above and beyond the services provided by TBAs
- Work collaboratively with HCWs for the benefit of pregnant women, their families and the larger community; this collaboration will ensure healthy mothers and HIV-negative babies
- Pregnant women in your care must be referred to health facilities for HCT/PMTCT services

**KEY BENEFIT:**
***You will be seen as a responsible TBA.***

## Tertiary Audiences:

### *Community and Religious Leaders*

- Learn about the benefits that pregnant women in your communities and congregations can receive through ANC/PMTCT services
- Ensure acceptance and normalization of ANC/PMTCT as a pathway to reduce HIV-induced stigma for PLHIV in communities and congregations; this will enable women congregants have safe deliveries and healthy babies

**KEY BENEFIT:**
***Supporting pregnant women to utilize ANC/PMTCT services ensures a healthy community. You are sure of having healthy babies and mothers in your congregation if you support pregnant women to access and utilize ANC/PMTCT services and to complete at least 4 visits during the course of her pregnancy.***

***Policy Makers***

- Know about ANC/PMTCT services, benefits of the services, knowledge of basic facts about HIV/AIDS, information on sero-prevalence of HIV among women and youth in Nigeria and information on the negative contribution of Nigeria to the global burden of HIV and MTCT
- Understand the socio-economic impact of HIV for Nigeria, the prevalence of HIV, its effects on the community and effects of negative socio-cultural norms on ANC/PMTCT
- Know the benefits of ANC/PMTCT services including a woman's being sure of having a healthy baby and being able to manage her own future and health better

## CHANNELS, ACTIVITIES AND MATERIALS BY AUDIENCE SEGMENT

| | CHANNELS | ACTIVITIES | MATERIALS |
|---|---|---|---|
| **PRIMARY AUDIENCE** | | | |
| **Pregnant women in rural and urban Nigeria** | • IPC from HCWs to pregnant women<br>• Community mobilization<br>• Mass media | • Facility health talk by trained HCWs<br>• Small group discussions (SGDs) at support group level<br>• Mentor-to-mother model | • Radio and TV jingles/spots<br>• Discussion guide<br>• Posters |
| **SECONDARY AUDIENCE** | | | |
| **Partners and husbands of pregnant women** | • IPC from HCWs to pregnant women<br>• Community mobilization<br>• Mass media | • ***Men.Care*** forum meetings | • Radio and TV jingles/spots<br>• *Men.Care* Discussion<br>• Posters |
| **Families** | • IPC with HCW/community mobilizers/volunteers<br>• Mass media | • Meetings/dialogues | • Posters |
| **HCWs** | • IPC<br>*Develop motivational materials such as badges and conduct hospitality awards etc. | • Health talk<br>• Seminars and meetings<br>• Trainings<br>• Dialogues | • Posters<br>• Job aid<br>• Community conversation toolkit<br>• Training manuals<br>• Motivational items |
| **TBAs** | • IPC training for TBAs to effectively communicate with pregnant women on the need to get tested for HIV at the facilities | • Sensitization meeting/ dialogues, capacity building, (HIV, HCT/ PMTCT, referral) | • Photo cards<br>• Training manuals<br>• Motivational items<br>• Referral directory |
| **Community Leaders** | • IPC by the partners and NACA | • Advocacy meetings<br>• Sensitization meetings | • Talking points,<br>• Leaflets<br>• PowerPoint slides<br>• Advocacy toolkits |
| **Religious Leaders** | • IPC by the partners and NACA<br>• Supreme Islamic Council of Nigeria<br>• Christian Association of Nigeria | • Advocacy meetings<br>• Sensitization meetings | • Talking points,<br>• Leaflets<br>• PowerPoint slides<br>• Advocacy toolkits |

| | CHANNELS | ACTIVITIES | MATERIALS |
|---|---|---|---|
| **TERTIARY AUDIENCE** | | | |
| **Policy Makers** | • IPC by the partners and NACA<br>• Federal Executive Council<br>• National Assembly | • Advocacy meetings<br>• Sensitization meetings | • Talking points,<br>• Leaflets<br>• PowerPoint slides<br>• Advocacy toolkits |

# 1 APPENDIX

# ZONE-SPECIFIC COMMUNICATION STRATEGIES

Strategies are tailored to suit each of the six geo-political zones. The primary audience is consistent across all the zones, but influencers of the primary audience vary in the different zones. Channels, tools, activities and materials are proposed to aptly target each audience with the requisite message/s in the most beneficial way.

## A. COMMUNICATION STRATEGY FOR NORTH-CENTRAL ZONE PMTCT DEMAND CREATION IN NIGERIA

### Problem Statement: Low uptake of ANC/PMTCT

In North-Central Nigeria, in 2008, 65 percent of pregnant women attended the initial ANC/PMTCT visit and 41 percent delivered at health facilities. Pregnant women and women of childbearing age in the zone said they preferred to deliver at home, mostly attended by a TBA or by another woman (perhaps a co-wife, female neighbor).[15] These practices are contributing to the increase in HIV-exposed babies as well as the infant morbidity/mortality rates. Factors that contribute to high vertical transmission of HIV in this part of the country include the social and cultural orientation, preference for TBA services, lower literacy level of the majority of adults (especially women), level of violence and attacks on government facilities and structures (insecurity), attitude of HCWs and inaccessibility of health care facilities.

### Contextual Analysis

In North-Central Nigeria, husbands and partners are a higher priority audience due to strong cultural, religious and patriarchal structures and the economic reliance of wives/partners on husbands/partners. Use of ANC/PMTCT services is dependent on the willingness of husbands/partners to provide financial support for transportation or for incidental costs associated with clinic visits. Often, many husbands do not give permission or approve for their wives to visit health care facilities.

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## Communication Strategy: North-Central Zone

### *Audience selection and segmentation*

| AUDIENCES | |
|---|---|
| **Primary Audience** | • Pregnant Women |
| **Secondary Audience 1** | • Husbands/Partners |
| **Secondary Audience 2** | • HCWs |
| **Secondary Audience 3** | • TBAs |
| **Tertiary Audience 1** | • Community & Religious Leaders |
| **Tertiary Audience 2** | • Policy Makers |

## Desired Changes, Barriers, Behavioral and Communication Objectives, and Channel Mix by Audience Segment Communication Strategy: North-Central

### *Primary Audience: Pregnant Women*

| PRIMARY AUDIENCE | PREGNANT WOMEN |
|---|---|
| **Desired changes** | • Regular attendance and completion of ANC/PMTCT visits |
| **Barriers** | • Low knowledge of the benefits of ANC/PMTCT<br>• Long distance of clinics to potential users<br>• Self-stigma as well as stigma and discrimination by family, community and HCWs against HIV-positive pregnant women<br>• Unfriendly attitude of HCWs |
| **Behavioral objective** | By the end of 2015, increase by 90 percent the number of pregnant women who access ANC/PMTCT services |
| **Communication objectives** | By the end of 2015, there will be a 90 percent increase in the number of pregnant women who:<br>• know the benefits of ANC/PMTCT services<br>• are motivated to access ANC/PMTCT services<br>• confirm existence of a nearby ANC/PMTCT clinic<br>• perceive HCWs as being friendly and trustworthy |

| | CHANNELS | ACTIVITIES | TOOLS and MATERIALS |
|---|---|---|---|
| **Intervention mix** | • IPC<br>• Mass media | • Facility health talks<br>• IPC by HCWs/volunteers<br>• SGDs at support group level<br>• Use of role models | • Radio and TV Jingles/spots<br>• Posters<br>• Happy birth packs |

### *Secondary Audience: Husbands/Partners*

| SECONDARY AUDIENCE 1 | HUSBANDS/PARTNERS |
|---|---|
| **Desired changes** | • Support and encourage wives/partners to access and complete ANC/PMTCT visits |
| **Barriers** | • Low knowledge of benefits of ANC/PMTCT services<br>• Peer pressure |
| **Behavioral objective** | By the end of 2015, increase by 90 percent in 2015, the number of husbands/partners who support their wives/partners to uptake ANC/PMTCT services |
| **Communication objectives** | By the end of 2015, there will be a 90 percent increase in the number of husbands/partners of pregnant women who:<br>• know the benefits of ANC/PMTCT services<br>• are motivated to discuss the benefits of ANC/PMTCT services with their peers<br>• are motivated to discuss the benefits of seeking ANC/PMTCT services with their wives/partners |

| | CHANNELS | ACTIVITIES | TOOLS and MATERIALS |
|---|---|---|---|
| **Intervention mix** | • IPC<br>• Mass media | • IPC by HCWs/volunteers<br>• *Men.Care* forum meetings | • Discussion guide<br>• Posters<br>• Radio and TV spots/jingles |

### *Secondary Audience: HCWs*

| SECONDARY AUDIENCE 2 | HCWs (CHEWs AND NURSES/MIDWIVES) |
|---|---|
| **Desired changes** | • Friendly attitude towards clients<br>• Improved relationships between HCWs and TBAs |
| **Barriers** | • Lack of IPC skills<br>• Competition between TBAs and HCWs over clients<br>• Pregnant women's preference for home-delivery and TBAs<br>• Stigma and discrimination |
| **Behavioral objective** | By the end of 2015, increase by 90 percent the number of HCWs who provide friendly services to clients<br>By the end of 2015, increase by 90 percent the number of HCWs who developed cordial relationships with TBAs |
| **Communication objectives** | By the end of the 2015, there will be a 90 percent increase in the number of HCWs who:<br>• are skilled in effective IPC skills and utilize them with ANC/PMTCT clients<br>• are motivated to establish linkages with TBAs<br>• are providing friendly services<br>• have comprehensive knowledge of HIV and AIDS and are favorably disposed to providing friendly services to HIV-positive pregnant women |

| | CHANNELS | ACTIVITIES | TOOLS and MATERIALS |
|---|---|---|---|
| **Intervention mix** | • IPC | • Trainings<br>• IPC by IPs and other partners<br>• Seminars and meetings | • Posters<br>• Training manuals<br>• Job aid |

*Secondary Audience: TBAs*

| SECONDARY AUDIENCE 3 | TBAs |
|---|---|
| **Desired changes** | • Refer pregnant women for HCT/PMTCT services<br>• Understand the usefulness as well as the limitations of the services they provide and how collaborations with HCWs can improve their work |
| **Barriers** | • Low knowledge of HCT/PMTCT services and its benefits for their clients/patients<br>• Fear of losing clients to HCWs |
| **Behavioral objective** | By 2015, there will be a 90 percent increase in the number of TBAs who refer and link pregnant women to facilities |
| **Communication objectives** | By the end of 2015 there will be a 90 percent increase in the number of TBAs who:<br>• know about the benefits of HCT/PMTCT<br>• are motivated to refer women for HCT/PMTCT services |

| | CHANNELS | ACTIVITIES | TOOLS and MATERIALS |
|---|---|---|---|
| **Intervention mix** | • IPC | • Sensitization meeting/dialogues<br>• IPC by volunteers and IPs<br>• Capacity building (HIV, HCT/PMTCT, referral) | • Photo cards<br>• Training manual |

*Tertiary Audience: Community and Religious Leaders*

| TERTIARY AUDIENCE 1 | COMMUNITY AND RELIGIOUS LEADERS |
|---|---|
| **Desired changes** | • Support ANC/PMTCT services and encourage pregnant women to attend |
| **Barriers** | • Low knowledge on the benefits of ANC/PMTCT services<br>• Myths and misconceptions such as the belief that HIV is a punishment from God |
| **Behavioral objective** | By the end of 2015, increase by 90 percent the number of community and religious leaders who support ANC/PMTCT service uptake |
| **Communication objectives** | By the end of 2015, there will be a 90 percent increase in the number of community and religious leaders who have increased knowledge on benefits of ANC/PMTCT services |

| | CHANNELS | ACTIVITIES | TOOLS and MATERIALS |
|---|---|---|---|
| **Intervention mix** | • IPC | • Advocacy meetings<br>• IPC by volunteers/HCWs<br>• Community dialogue | • Talking points<br>• Leaflets<br>• Community conversation toolkit |

*Tertiary Audience: Policy Makers*

| TERTIARY AUDIENCE 2 | POLICY MAKERS | | |
|---|---|---|---|
| **Desired changes** | • Establish more facilities providing ANC/PMTCT services closer to the communities in need<br>• Provide adequate human resources for facilities providing ANC/PMTCT services<br>• Ensure availability of adequate commodities and equipment at the facilities | | |
| **Barriers** | • Low knowledge of the benefits of ANC/PMTCT services<br>• Low knowledge of ANC/PMTCT service coverage and gaps<br>• Other competing needs | | |
| **Behavioral objective** | By the end of 2015, increase by 90 percent the number of policy makers who make adequate budgetary provisions to support ANC/PMTCT services | | |
| **Communication objectives** | By the end of 2015, there will be a 90 percent increase in the number of policy makers who:<br>• know the benefits of ANC/PMTCT services | | |
| | **CHANNELS** | **ACTIVITIES** | **TOOLS and MATERIALS** |
| **Intervention mix** | • IPC | • Advocacy meetings<br>• IPC by volunteers, IPs, SACAs | • Talking points<br>• Advocacy kits<br>• PowerPoint slides |

## Positioning Statement, North-Central Zone

Pregnant women can only deliver healthy babies if we all support them to access and complete ANC/PMTCT services.

## KEY CONTENT, NORTH-CENTRAL ZONE

### Primary Audience: Pregnant Women

- Understand benefits of ANC/PMTCT
- Know what ANC/PMTCT entails (e.g., four visits, ARV adherence)
- Negotiate accessing services with Husband/Partner, Mother-in-Law and family
- Attend and complete ANC/PMTCT services
- Demand for services at the clinic

### Secondary Audience 1: Husbands/Partners

- Provide resources and urge your wife to enroll in ANC/PMTCT services
- Follow up on your wife's ANC/PMTCT schedule
- Remind your wife to attend every ANC/PMTCT appointment scheduled
- Visit the health center to ask questions whenever you are confused about your wife's care
- Discuss the benefits of ANC/PMTCT with health care team, your wife and your peers
- Ensure she completes her ANC/PMTCT visits and delivers at the clinic

### Secondary Audience 2: HCWs

- Know where ANC/PMTCT services can be accessed
- Know the benefits of the services
- Understand what optimum ANC/PMTCT entails (e.g., at least four visits, ARV adherence)
- Understand and practice IPC skills to improve client relations
- Understand the benefits of linking with TBAs
- Work positively with TBAs
- Be friendly, respectful, helpful and empathetic
- Be professional in delivering services
- Ensure all pregnant women at your clinic obtain correct and consistent information about PMTCT

### Secondary Audience 3: TBAs

- Know the benefits of HCT/PMTCT
- Know when to refer pregnant women to health facilities for HCT/PMTCT services
- Work positively with HCWs
- Refer pregnant women for HCT
- Ensure they get to the facility
- Hand her over to a health worker at the facility
- Work positively with health care workers

### Tertiary Audience 1: Religious and Community Leaders

- Know the benefits that pregnant women in your communities and congregations can receive through ANC/PMTCT services
- Ensure acceptance and normalization of ANC/PMTCT as pathway to reduce stigma for PLHIV in communities and congregations
- Encourage pregnant women to attend and complete ANC/PMTCT
- Constantly talk about the benefits of ANC/PMTCT to community and religious group members
- Pay visit to clinics on ANC days to express your support and encourage women to constantly attend ANC clinics

### Tertiary Audience 2: Policy Makers

- Knowledge of basic facts about HIV/AIDS transmission (including mother-to-child)
- Knowledge of sero-prevalence of HIV among women and youth in Nigeria
- Knowledge of contribution of Nigeria to the global burden of HIV and MTCT
- Knowledge of socio-economic impact of HIV for Nigeria
- Knowledge of effects at community level of HIV
- Knowledge of benefits of ANC/PMTCT services for mother and baby
- Knowledge of optimum practices related to ANC/PMTCT (e.g., number and timing of visits, adherence to ARV)
- Knowledge of availability/accessibility of ANC/PMTCT services at the community level
- Knowledge of effects of negative socio-cultural norms on utilization of ANC/PMTCT services
- Knowledge of other barriers (e.g., financial charges, lack of adequate human resources and positive IPC)
- Motivation to give ANC/PMTCT issues priority in the budgetary allocation
- Ensure that the health of women, unborn and born infants are priority for policy and funding
- Ensure all health facilities are well staffed, equipped and supplied with essentials like drugs.
- Be concerned about reducing the rate of maternal and infant mortality in Nigeria.

## B. COMMUNICATION STRATEGY FOR NORTH-EAST ZONE PMTCT DEMAND CREATION IN NIGERIA

### *Problem Statement: Low uptake of ANC/PMTCT services*

In 2008 in the North-East part of Nigeria, only 15.5 percent of pregnant women delivered with the help of a professional and only 12 percent delivered in a health facility.[16] This grossly low uptake of ANC/PMTCT services by pregnant women is contributing to an increase in HIV-exposed babies as well as an increase in infant morbidity and mortality. The low uptake is a result of lack of trust/confidence in Western medicine, coupled with a belief that men who follow their wives to ANC are *weak*. For the few women who attend ANC services, there are inadequate incentives to encourage them to return. Lack of knowledge regarding the benefits of ANC/PMTCT as well as insecurity in the region are major challenges.

### *Contextual Analysis*

Home delivery is predominant in the North-East Zone of Nigeria. TBAs are not as popular as evident in other zones; the cultural tradition is for women to deliver at home without assistance or with the assistance of a TBA, neighbor or family member. When complications arise, the health facility is the last resort. For this reason, HCWs are designated as the first secondary audience in this strategy. Health care workers have a lot of influence in this region of the country, although they are known for having poor attitudes and are often rude to patients who seek services in clinics and health care centers. The poor attitude of HCWs are dis-incentive for women and many tend not to return for the rest of their pregnancy after the initial well-baby visit. This means they do not come back to receive the entire ANC services.

In the North-East region secondary audiences, in order of importance, include: HCWs, religious leaders, Husbands/Partners and community leaders. The tertiary audience is policy makers.

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## Communication Strategy: North-East Zone

### *Audience selection and segmentation*

| AUDIENCES | |
|---|---|
| **Primary audience** | • Pregnant Women |
| **Secondary Audience 1** | • HCWs |
| **Secondary Audience 2** | • Religious Leaders |
| **Secondary Audience 3** | • Husbands/Partners |
| **Tertiary Audience 1** | • Community Leaders |
| **Tertiary Audience 2** | • Policy Makers |

## Desired Changes, Barriers, Behavioral and Communication Objectives and Channel Mix by Audience Segment

### *Primary Audience: Pregnant Women*

| PRIMARY AUDIENCE | PREGNANT WOMEN |
|---|---|
| **Desired changes** | • Regular attendance and completion of ANC/PMTCT visits |
| **Barriers** | • Low knowledge of the benefits of ANC/PMTCT<br>• Long distance of clinics to potential users<br>• Self-stigma as well as stigma and discrimination by family, community and HCWs against HIV-positive pregnant women<br>• Unfriendly attitude of HCWs |
| **Behavioral objective** | By the end of 2015, increase by 90 percent the number of pregnant women who access ANC/PMTCT services |
| **Communication objectives** | By the end of 2015, there will be a 90 percent increase in the number of pregnant women who:<br>• know the benefits of ANC/PMTCT services<br>• are motivated to access ANC/PMTCT services |

| | CHANNELS | ACTIVITIES | TOOLS and MATERIALS |
|---|---|---|---|
| **Intervention mix** | • IPC<br>• Mass media | • Facility health talks<br>• IPC by HCWs/volunteers<br>• SGDs at support group level<br>• Use of role models | • Radio and TV Jingles/spots<br>• Posters |

*Secondary Audience: HCWs*

| SECONDARY AUDIENCE 1 | HCWs (CHEWs AND NURSES/MIDWIVES) | | |
|---|---|---|---|
| **Desired changes** | • Friendly attitude towards clients<br>• Improved relationships between HCWs and TBAs | | |
| **Barriers** | • Lack of IPC skills<br>• Competition between TBAs and HCWs over clients<br>• Pregnant women's preference for home-delivery and TBAs<br>• Stigma and discrimination | | |
| **Behavioral objective** | By the end of 2015, increase by 90 percent the number of HCWs who provide friendly services to clients<br>By the end of 2015, increase by 90 percent the number of HCWs who developed cordial relationships with TBAs | | |
| **Communication objectives** | By the end of the 2015, there will be a 90 percent increase in the number of HCWs who:<br>• are skilled in effective IPC skills and utilize them with ANC/PMTCT clients<br>• are motivated to establish linkages with TBA<br>• have comprehensive knowledge of HIV and AIDS and are favorably disposed to providing services to HIV-positive women | | |
| | **CHANNELS** | **ACTIVITIES** | **TOOLS and MATERIALS** |
| **Intervention mix** | • IPC | • Trainings<br>• IPC by IPs and other partners<br>• Seminars and meetings | • Posters<br>• Training manuals<br>• Job aid |

*Secondary Audience: Religious Leaders*

| SECONDARY AUDIENCE 2 | RELIGIOUS LEADERS | | |
|---|---|---|---|
| **Desired changes** | • Increase in knowledge of the basic facts about HIV and AIDS<br>• Encourage pregnant women to attend ANC in facilities | | |
| **Barriers** | • Low knowledge on the benefits of ANC/PMTCT services<br>• Myths and misconceptions such as the belief that HIV is a punishment from God | | |
| **Behavioral objective** | By the end of 2015, increase by 90 percent the number of community and religious leaders who support ANC/PMTCT service uptake | | |
| **Communication objectives** | By the end of 2015, there will be a 90 percent increase in the number of community and religious leaders who have increased knowledge on benefits of ANC/PMTCT services | | |
| | **CHANNELS** | **ACTIVITIES** | **TOOLS and MATERIALS** |
| **Intervention mix** | • IPC<br>• Mass media | • Advocacy meetings<br>• Community dialogue<br>• IPC by volunteers/HCWs | • Talking points<br>• Leaflets |

### *Secondary Audience: Husbands/Partners*

| SECONDARY AUDIENCE 3 | HUSBANDS/PARTNERS |
|---|---|
| **Desired changes** | • Support and encourage wives/partners to access and complete ANC/PMTCT visits |
| **Barriers** | • Low knowledge of benefits of ANC/PMTCT services<br>• Peer pressure |
| **Behavioral objective** | By the end of 2015, increase by 90 percent in 2015, the number of husbands/partners who support their wives/partners to uptake ANC/PMTCT services |
| **Communication objectives** | By the end of 2015, there will be a 90 percent increase in the number of husbands/partners of pregnant women who:<br>• know the benefits of ANC/PMTCT services<br>• are motivated to discuss the benefits of ANC/PMTCT services with their peers<br>• are motivated to discuss the benefits of seeking ANC/PMTCT services with their wives/partners |

| | CHANNELS | ACTIVITIES | TOOLS and MATERIALS |
|---|---|---|---|
| **Intervention mix** | • IPC<br>• Mass media | • *Men.Care* forum meetings<br>• IPC by HCWs/volunteers | • Radio<br>• Posters |

### *Tertiary Audience: Community Leaders*

| TERTIARY AUDIENCE 1 | COMMUNITY LEADERS |
|---|---|
| **Desired changes** | • Support ANC/PMTCT uptake |
| **Barriers** | • Low knowledge of ANC/PMTCT services and benefits<br>• Strong attachments to negative socio-cultural norms that affect utilization of ANC/PMTCT |
| **Behavioral objective** | By the end of 2015, increase by 90 percent the number of community leaders who support ANC/PMTCT service uptake |
| **Communication objectives** | By the end of 2015 there will be an increase in the number of community leaders who:<br>• know the benefits of ANC/PMTCT services<br>• are motivated to engage in dialogue to address negative socio-cultural norms |

| | CHANNELS | ACTIVITIES | TOOLS and MATERIALS |
|---|---|---|---|
| **Intervention mix** | • IPC<br>• Mass media | • Advocacy meetings<br>• IPC by IPs, SACAs and volunteers<br>• Community dialogue | • Leaflets |

*Tertiary Audience: Policy Makers*

| TERTIARY AUDIENCE 2 | POLICY MAKERS |
|---|---|
| **Desired changes** | • To establish more facilities providing ANC/PMTCT services closer to the communities in need<br>• To provide adequate human resources for facilities providing ANC/PMTCT services<br>• To ensure availability of adequate commodities and equipment at the facilities |
| **Barriers** | • Low knowledge of the benefits of ANC/PMTCT service<br>• Low knowledge of ANC/PMTCT service coverage and gaps<br>• Other competing needs |
| **Behavioral objective** | By the end of 2015, increase by 90 percent the number of policy makers who make adequate budgetary provisions to support ANC/PMTCT services |
| **Communication objectives** | By the end of 2015, there will be a 90 percent increase in the number of policy makers who:<br>• know the benefits of ANC/PMTCT services<br>• know the ANC/PMTCT service coverage and gaps in the region<br>• are motivated to give ANC/PMTCT issues priority in their budget allocations |

| | CHANNELS | ACTIVITIES | TOOLS and MATERIALS |
|---|---|---|---|
| **Intervention mix** | • IPC | • Advocacy meetings<br>• IPC by IPs | • Talking points<br>• Advocacy kits<br>• PowerPoint slides |

**Positioning Statement, North-East Zone**

Pregnant women can only deliver healthy babies if we all support them to access and complete ANC/PMTCT services.

## KEY CONTENT, NORTH-EAST ZONE

### Primary Audience: Pregnant Women

- Understand benefits of ANC/PMTCT
- Know what ANC/PMTCT entails (e.g., four visits, ARV adherence)
- Negotiate accessing services with Husband/Partner, Mother-in-Law and family
- Attend and complete ANC/PMTCT services
- Demand for services at the clinic

### Secondary Audience 1: HCWs

- Know where ANC/PMTCT services can be accessed
- Know the benefits of the services
- Understand what optimum ANC/PMTCT entails (e.g., at least four visits, ARV adherence)
- Understand and practice IPC skills to improve client relations
- Understand the benefits of linking with TBAs
- Work positively with TBAs
- Be friendly, respectful, helpful and empathetic
- Be professional in delivering services
- Ensure all pregnant women at your clinic obtain correct and consistent information about PMTCT

### Secondary Audience 2/Tertiary Audience 1: Religious and Community Leaders

- Know the benefits that pregnant women in your communities and congregations can receive through ANC/PMTCT services
- Ensure acceptance and normalization of ANC/PMTCT as pathway to reduce stigma for PLHIV in communities and congregations
- Encourage pregnant women to attend and complete ANC/PMTCT
- Constantly talk about the benefits of ANC/PMTCT to community and religious group members
- Pay visit to clinics on ANC days to express your support and encourage women to constantly attend ANC clinics

### Secondary Audience 3: Husbands/Partners

- Provide resources and urge your wife to enroll in ANC/PMTCT services
- Follow up on your wife's ANC/PMTCT schedule
- Remind your wife to attend every ANC/PMTCT appointment scheduled
- Visit the health center to ask questions whenever you are confused about your wife's care
- Discuss the benefits of ANC/PMTCT with health care team, your wife and your peers
- Ensure she completes her ANC/PMTCT visits and delivers at the clinic

### Tertiary Audience 2: Policy Makers

- Knowledge of basic facts about HIV/AIDS transmission (including mother-to-child)
- Knowledge of sero-prevalence of HIV among women and youth in Nigeria
- Knowledge of contribution of Nigeria to the global burden of HIV and MTCT
- Knowledge of socio-economic impact of HIV for Nigeria
- Knowledge of effects at community level of HIV
- Knowledge of benefits of ANC/PMTCT services for mother and baby
- Knowledge of optimum practices related to ANC/PMTCT (e.g., number and timing of visits, adherence to ARV)
- Knowledge of availability/accessibility of ANC/PMTCT services at the community level
- Knowledge of effects of negative socio-cultural norms on utilization of ANC/PMTCT services
- Knowledge of other barriers (e.g., financial charges, lack of adequate human resources and positive IPC)
- Motivation to give ANC/PMTCT issues priority in the budgetary allocation
- Ensure that the health of women, unborn and born infants are priority for policy and funding
- Ensure all health facilities are well staffed, equipped and supplied with essentials like drugs.
- Be concerned about reducing the rate of maternal and infant mortality in Nigeria.

## C. COMMUNICATION STRATEGY FOR NORTH-WEST ZONE PMTCT DEMAND CREATION IN NIGERIA

### Problem Statement: Low uptake of ANC/PMTCT

In 2008 in the North-West Zone of Nigeria, about 10 percent[17] of pregnant women delivered at health facilities; the other 90 percent gave birth at home and mostly assisted by TBAs. This situation is contributing to an increase in HIV-exposed babies as well as an increase in infant morbidity and mortality. It is caused in part by cultural and religious beliefs that deny women the right to take decisions about their health and personal welfare.

Low levels of knowledge about the availability of ANC/PMTCT services and their benefits also contribute to low demand. For those who are willing to access services and have secured necessary permission from their husbands, insensitive HCWs with poor IPC skills, shortages in commodity supplies at facilities and long distances to travel also deter them from accessing these services and contribute to patronage of TBAs.

In addition, lack of support from government, community and religious leaders for ANC/PMTCT due to stigma around HIV and deep cultural norms around decision-making and preference for home births contribute significantly to low ANC/PMTCT uptake.

The insecurity situation in North-West Zone also contributes to low utilization of ANC/PMTCT services.

### Contextual Analysis

TBAs in the North-West Zone are the major influencers of pregnant women. A typical pregnant woman in the North-West Zone will prefer the services of a TBA, who is mostly paid for in-kind rather than cash. Strong cultural and religious beliefs uphold values that encourage high patronage of TBAs who are readily available and offer *culture-friendly services*. Family members (especially mothers and mothers-in-law) also play a major role in decision-making for a pregnant woman.

[17] NDHS 2008

## Communication Strategy: North-West

### *Audience selection and segmentation*

| AUDIENCES | |
|---|---|
| **Primary audience** | • Pregnant Women |
| **Secondary Audience 1** | • TBAs |
| **Secondary Audience 2** | • HCWs |
| **Secondary Audience 3** | • Husbands/Partners |
| **Secondary Audience 4** | • Family Members |
| **Tertiary Audience 1** | • Community Leaders |
| **Tertiary Audience 2** | • Religious Leaders |
| **Tertiary Audience 3** | • Policy Makers |

## Desired Changes, Barriers, Behavioral and Communication Objectives and Channel Mix by Audience Segment

### *Primary Audience: Pregnant Women*

| PRIMARY AUDIENCE | PREGNANT WOMEN |
|---|---|
| **Desired changes** | • Regular attendance and completion of ANC/PMTCT visits |
| **Barriers** | • Low knowledge of the benefits of ANC/PMTCT<br>• Long distance of clinics to potential users<br>• Self-stigma as well as stigma and discrimination by family, community and HCWs against HIV-positive pregnant women<br>• Unfriendly attitude of HCWs |
| **Behavioral objective** | By the end of 2015, increase by 90 percent the number of pregnant women who access ANC/PMTCT services |
| **Communication objectives** | By the end of 2015, there will be a 90 percent increase in the number of pregnant women who:<br>• know the benefits of ANC/PMTCT services<br>• perceive HCWs as being friendly and trustworthy<br>• confirm existence of a nearby ANC/PMTCT clinic |

| | CHANNELS | ACTIVITIES | TOOLS and MATERIALS |
|---|---|---|---|
| **Intervention mix** | • IPC<br>• Mass media | • Facility health talks<br>• IPC by HCWs/volunteers<br>• SGDs at support group level<br>• Mentor mothers | • Radio and TV jingles/spots<br>• Discussion guides<br>• Posters |

*Secondary Audience: TBAs*

| SECONDARY AUDIENCE 1 | TBAs | | |
|---|---|---|---|
| **Desired changes** | • Refer pregnant women for HCT/PMTCT services<br>• Understand the usefulness as well as the limitations of the services they provide and how collaborations with HCWs can improve their work | | |
| **Barriers** | • Low knowledge of HCT/PMTCT services and its benefits for their clients/patients<br>• Fear of losing clients to HCWs | | |
| **Behavioral objective** | By 2015, there will be a 90 percent increase in the number of TBAs who refer and link pregnant women to facilities | | |
| **Communication objectives** | By the end of 2015 there will be a 90 percent increase in the number of TBAs who:<br>• know about the benefits of HCT/PMTCT<br>• are motivated to refer women for HCT/PMTCT services | | |
| | **CHANNELS** | **ACTIVITIES** | **TOOLS and MATERIALS** |
| **Intervention mix** | • IPC | • Sensitization meeting/dialogues<br>• IPC by volunteers and IPs<br>• Capacity building (HIV, HCT/PMTCT, referral) | • Photo cards<br>• Training manual |

*Secondary Audience: HCWs*

| SECONDARY AUDIENCE 2 | HCWs (CHEWs AND NURSES/MIDWIVES) | | |
|---|---|---|---|
| **Desired changes** | • Refer pregnant women for HCT/PMTCT services<br>• Understand the usefulness as well as the limitations of the services they provide and how collaboration with HCWs can improve their work | | |
| **Barriers** | • Low knowledge of HCT/PMTCT services and its benefits for their clients/patients<br>• Fear of losing clients to HCWs | | |
| **Behavioral objective** | By the end of 2015, there will be a 90 percent increase in the number of TBAs who refer and link pregnant women to facilities | | |
| **Communication objectives** | By the end of 2015 there will be a 90 percent increase in the number of TBAs who:<br>• know about the benefits of HCT/PMTCT services<br>• are motivated to refer women for HCT/PMTCT services<br>• are motivated to establish linkages with TBA<br>• have comprehensive knowledge of HIV and AIDS and are favorably disposed to providing services to HIV-positive women | | |
| | **CHANNELS** | **ACTIVITIES** | **TOOLS and MATERIALS** |
| **Intervention mix** | • IPC | • IPC by IPs, SACAs and other partners<br>• Seminars and meetings | • Posters<br>• Job aid |

***Secondary Audience: Husbands/Partners***

| SECONDARY AUDIENCE 3 | HUSBANDS/PARTNERS |
|---|---|
| **Desired changes** | • Support and encourage wives/partners to access and complete ANC/PMTCT services |
| **Barriers** | • Low knowledge of benefits of ANC/PMTCT services<br>• Peer pressure |
| **Behavioral objective** | By the end of 2015, increase by 90 percent in 2015, the number of husbands/partners who support their wives/partners to uptake ANC/PMTCT services |
| **Communication objectives** | By the end of 2015, there will be a 90 percent increase in the number of husbands/partners of pregnant women who:<br>• know the benefits of ANC/PMTCT services<br>• are motivated to discuss the benefits of ANC/PMTCT services with their peers<br>• are motivated to discuss the benefits of seeking ANC/PMTCT services with their wives/partners |

| | CHANNELS | ACTIVITIES | TOOLS and MATERIALS |
|---|---|---|---|
| **Intervention mix** | • IPC<br>• Mass media | • *Men.Care* forum<br>• IPC by HCWs/volunteers | • Discussion guide<br>• Radio and TV spots/jingles |

### *Secondary Audience: Family Members*

| SECONDARY AUDIENCE 4 | FAMILY MEMBERS | | |
|---|---|---|---|
| **Desired changes** | To provide financial and psychosocial support to pregnant women to access ANC/PMTCT services | | |
| **Barriers** | • Low literacy<br>• Poor access to information on ANC/PMTCT<br>• HIV-related stigma | | |
| **Behavioral objective** | By the end of 2015, increase by 90 percent the number of family members who support pregnant women to access ANC/PMTCT services | | |
| **Communication objectives** | By the end of 2015, there will be a 90 percent increase in the number of family members, especially mothers-in-law of pregnant women, who:<br>• know where ANC/PMTCT services can be accessed<br>• know what ANC/PMTCT is and its benefits<br>• are motivated to initiate dialogue about ANC/PMTCT among family members<br>• are motivated to support pregnant women in the family to access and complete ANC/PMTCT visits | | |
| | **CHANNELS** | **ACTIVITIES** | **TOOLS and MATERIALS** |
| **Intervention mix** | • IPC<br>• Mass media | • IPC by HCWs and volunteers | • Radio and TV spots/jingles |

### *Tertiary Audience: Community Leaders*

| TERTIARY AUDIENCE 1 | COMMUNITY LEADERS | | |
|---|---|---|---|
| **Desired changes** | • Support ANC/PMTCT services and encourage women to attend | | |
| **Barriers** | • Low knowledge of ANC/PMTCT services and benefits<br>• Strong attachments to negative socio-cultural norms that discourage use of ANC/PMTCT services | | |
| **Behavioral objective** | By the end of 2015, increase by 90 percent the number of community leaders who support ANC/PMTCT service uptake | | |
| **Communication objectives** | By the end of 2015 there will be a 90 percent increase in the number of community leaders who:<br>• know the benefits of ANC/PMTCT services<br>• are motivated to engage in dialogue to address negative socio-cultural norms | | |
| | **CHANNELS** | **ACTIVITIES** | **TOOLS and MATERIALS** |
| **Intervention mix** | • IPC | • Advocacy meetings<br>• IPC by HCWs and volunteers<br>• Community dialogues | • Leaflets<br>• Community conversation toolkit<br>• Talking points |

*Tertiary Audience: Religious Leaders*

| TERTIARY AUDIENCE 2 | RELIGIOUS LEADERS | | |
|---|---|---|---|
| **Desired changes** | • Encourage pregnant women to access ANC/PMTCT services | | |
| **Barriers** | • Low knowledge about the benefits of ANC/PMTCT services<br>• Myths and misconceptions, such as the belief that HIV is a punishment from God | | |
| **Behavioral objective** | By the end of 2015, increase by 90 percent the number of religious leaders who support use of ANC/PMTCT services | | |
| **Communication objectives** | By the end of 2015, there will be a 90 percent increase in the number of religious leaders who have increased knowledge on the benefits of ANC/PMTCT services | | |
| | **CHANNELS** | **ACTIVITIES** | **TOOLS and MATERIALS** |
| **Intervention mix** | • IPC | • Advocacy meetings<br>• IPC by HCWs and volunteers<br>• Community dialogue | • Talking points<br>• Leaflets<br>• Community conversation toolkit |

*Tertiary Audience: Policy Makers*

| TERTIARY AUDIENCE 3 | POLICY MAKERS | | |
|---|---|---|---|
| **Desired changes** | • Establish more facilities providing ANC/PMTCT services closer to communities in need<br>• Provide adequate human resources for facilities providing ANC/PMTCT services<br>• Ensure availability of adequate commodities and equipment at the facilities | | |
| **Barriers** | • Low knowledge of the benefits of ANC/PMTCT service<br>• Low knowledge of ANC/PMTCT service coverage and gaps<br>• Other competing needs | | |
| **Behavioral objective** | By the end of 2015, increase by 90 percent the number of policy makers who make adequate budgetary provisions to support ANC/PMTCT services | | |
| **Communication objectives** | By the end of 2015, there will be a 90 percent increase in the number of policy makers who:<br>• know the benefits of ANC/PMTCT services<br>• know the ANC/PMTCT service coverage and gaps in the region<br>• are motivated to give ANC/PMTCT issues priority in the budgetary allocations | | |
| | **CHANNELS** | **ACTIVITIES** | **TOOLS and MATERIALS** |
| **Intervention mix** | • IPC | • Advocacy meetings<br>• IPC by IPs, SACAs and other partners | • Talking points<br>• PowerPoint slides<br>• Advocacy kits |

### Positioning Statement, North-West Zone

Pregnant women can only deliver healthy babies if we all support them to access and complete ANC/PMTCT services.

## KEY CONTENT, NORTH-WEST ZONE

### Primary Audience: Pregnant Women

- Understand benefits of ANC/PMTCT services
- Know what ANC/PMTCT entails (e.g., four visits, ARV adherence)
- Negotiate accessing services with Husband/Partner, Mother-in-Law and family
- Attend and complete ANC/PMTCT services
- Demand for services at the clinic

### Secondary Audience 1: TBAs

- Know the benefits of HCT/PMTCT
- Know when to refer pregnant women to health facilities for HCT/PMTCT services
- Work positively with HCWs
- Refer pregnant women for HCT
- Ensure they get to the facility
- Hand her over to a health worker at the facility
- Work positively with health care workers

### Secondary Audience 2: HCWs

- Know where ANC/PMTCT services can be accessed
- Know the benefits of the services
- Understand what optimum ANC/PMTCT entails (e.g., at least four visits, ARV adherence)
- Understand and practice IPC skills to improve client relations
- Understand the benefits of linking with TBAs
- Work positively with TBAs
- Be friendly, respectful, helpful and empathetic
- Be professional in delivering services
- Ensure all pregnant women at your clinic obtain correct and consistent information about PMTCT

### Secondary Audience 3: Husband/Partner

- Provide resources and urge your wife to enroll in ANC/PMTCT services
- Follow up on your wife's ANC/PMTCT schedule
- Remind your wife to attend every ANC/PMTCT appointment scheduled
- Visit the health center to ask questions whenever you are confused about your wife's care
- Discuss the benefits of ANC/PMTCT with health care team, your wife and your peers
- Ensure she completes her ANC/PMTCT visits and delivers at the clinic

### Secondary Audience 4: Family Members

Encourage pregnant women to seek ANC services at the nearest health facility for healthy grandchildren

### Tertiary Audience 1 and 2: Community and Religious Leaders

- Know the benefits that pregnant women in your communities and congregations can receive through ANC/PMTCT services
- Ensure acceptance and normalization of ANC/PMTCT as pathway to reduce stigma for PLHIV in communities and congregations
- Encourage pregnant women to attend and complete ANC/PMTCT
- Constantly talk about the benefits of ANC/PMTCT to community and religious group members
- Pay visit to clinics on ANC days to express your support and encourage women to constantly attend ANC clinics

### Tertiary Audience 3: Policy Makers

- Knowledge of basic facts about HIV/AIDS transmission (including mother-to-child)
- Knowledge of sero-prevalence of HIV among women and youth in Nigeria
- Knowledge of contribution of Nigeria to the global burden of HIV and MTCT
- Knowledge of socio-economic impact of HIV for Nigeria
- Knowledge of effects at community level of HIV
- Knowledge of benefits of ANC/PMTCT services for mother and baby
- Knowledge of optimum practices related to ANC/PMTCT (e.g., number and timing of visits, adherence to ARV)

## D. COMMUNICATION STRATEGY FOR SOUTH-EAST ZONE PMTCT DEMAND CREATION IN NIGERIA

### Problem Statement: Low uptake of ANC/PMTCT

Low uptake of ANC/PMTCT services in the South-East Zone contributes to an increase in HIV-exposed babies and in infant morbidity and mortality. Low levels knowledge about HIV transmission from mother-to-child contributes to low ANC/PMTCT service demand.

Other factors include: low male involvement, poverty, gender inequality, negative attitudes among HCWs, traditional and religious leaders, lack of proximity to health care facilities, inconsistent implementation of government policies, unwillingness of HCWs to work in rural health facilities, stigma/discrimination, cultural beliefs, high patronage of TBAs, lack of confidentiality amongst HCWs and issues with supply chain management services (commodity insecurity).

### Contextual Analysis

Husbands/partners of pregnant women in the South-East Zone greatly influence their wives/partners. Wives/partners are considered "the glory of the men." The wealth of a man is measured by the demeanour of his wife. Data from 2008 showed that mothers residing in the South-East Zone were the most likely in Nigeria to be attended at delivery by a health professional (82 percent) and the most likely to deliver in a health facility (74 percent).[18]

### Communication Strategy: South-East Zone Audience selection and segmentation

| AUDIENCES | |
|---|---|
| **Primary Audience** | • Pregnant Women |
| **Secondary Audience 1** | • Husbands/Partners |
| **Secondary Audience 2** | • TBAs |
| **Secondary Audience 3** | • HCWs |
| **Tertiary Audience 1** | • Community Leaders |
| **Tertiary Audience 2** | • Policy Makers |

18 NDHS 2008

## Desired Changes, Barriers, Behavioral and Communication Objectives and Channel Mix by Audience Segment

*Primary Audience: Pregnant Women*

| PRIMARY AUDIENCE | PREGNANT WOMEN | | |
|---|---|---|---|
| **Desired changes** | • Regular attendance and completion of ANC/PMTCT visits | | |
| **Barriers** | • Low knowledge of the benefits of ANC/PMTCT<br>• Long distance of clinics to potential users<br>• Self-stigma as well as stigma and discrimination by family, community and HCWs against HIV-positive pregnant women<br>• Unfriendly attitude of HCWs | | |
| **Behavioral objective** | By the end of 2015, increase by 90 percent the number of pregnant women who access ANC/PMTCT services | | |
| **Communication objectives** | By the end of 2015, there will be a 90 percent increase in the number of pregnant women who:<br>• know the benefits of ANC/PMTCT services<br>• perceive HCWs as being friendly and trustworthy<br>• confirm existence of a nearby ANC/PMTCT clinic | | |
| | **CHANNELS** | **ACTIVITIES** | **TOOLS and MATERIALS** |
| **Intervention mix** | • IPC<br>• Mass media | • Facility health talk<br>• IPC by peers, HCWs and volunteers<br>• small group discussions (SGDs) at support group level<br>• Use mentor mothers | • Radio and TV jingles/spots<br>• Discussion guides<br>• Posters |

### *Secondary Audience: Husbands/Partners*

| SECONDARY AUDIENCE 1 | HUSBANDS/PARTNERS | | |
|---|---|---|---|
| **Desired changes** | • Support and encourage wives/partners to access and complete ANC/PMTCT visits | | |
| **Barriers** | • Low knowledge of benefits of ANC/PMTCT services<br>• Peer pressure | | |
| **Behavioral objective** | By the end of 2015, increase by 90 percent in 2015, the number of husbands/partners who support their wives/partners to uptake ANC/PMTCT services | | |
| **Communication objectives** | By the end of 2015, there will be a 90 percent increase in the number of husbands/partners of pregnant women who:<br>• know the benefits of ANC/PMTCT services<br>• are motivated to discuss the benefits of ANC/PMTCT services with their peers<br>• are motivated to discuss the benefits of seeking ANC/PMTCT services with their wives/partners | | |
| | **CHANNELS** | **ACTIVITIES** | **TOOLS and MATERIALS** |
| **Intervention mix** | • IPC<br>• Mass media | • *Men.Care* forum meetings<br>• IPC by HCWs/volunteers | • Discussion guide<br>• Radio and TV spots/jingles |

### *Secondary Audience: TBAs*

| SECONDARY AUDIENCE 2 | TBAs | | |
|---|---|---|---|
| **Desired changes** | • Refer pregnant women for HCT/PMTCT services<br>• Understand the usefulness as well as the limitations of the services they provide and how collaborations with HCWs can improve their work | | |
| **Barriers** | • Low knowledge of HCT/PMTCT services and its benefits for their clients/patients<br>• Fear of losing clients to HCWs | | |
| **Behavioral objective** | By 2015, there will be a 90 percent increase in the number of TBAs who refer and link pregnant women to facilities | | |
| **Communication objectives** | By the end of 2015 there will be a 90 percent increase in the number of TBAs who:<br>• know about the benefits of HCT/PMTCT<br>• are motivated to refer women for HCT/PMTCT services | | |
| | **CHANNELS** | **ACTIVITIES** | **TOOLS and MATERIALS** |
| **Intervention mix** | • IPC | • Sensitization meeting/ dialogues<br>• IPC by volunteers and IPs<br>• Capacity building (HIV, HCT/PMTCT, referral) | • Photo cards<br>• Training manual |

*Secondary Audience: HCWs*

| SECONDARY AUDIENCE 3 | HCWs (CHEWs AND NURSES/MIDWIVES) |
|---|---|
| **Desired changes** | • Friendly attitude towards clients<br>• Improved relationships between HCWs and TBAs |
| **Barriers** | • Lack of IPC skills<br>• Competition between TBAs and HCWs over clients<br>• Pregnant women's preference for home-delivery and TBAs<br>• Stigma and discrimination |
| **Behavioral objective** | By the end of 2015, increase by 90 percent the number of HCWs who provide:<br>• friendly services to clients<br>• developed cordial relationships with TBAs |
| **Communication objectives** | By the end of the 2015, there will be a 90 percent increase in the number of HCWs who:<br>• are skilled in effective IPC skills and utilize them with ANC/PMTCT clients<br>• are motivated to establish linkages with TBAs<br>• have comprehensive knowledge of HIV and AIDS and are favorably disposed to providing services to HIV-positive women |

| | CHANNELS | ACTIVITIES | TOOLS and MATERIALS |
|---|---|---|---|
| **Intervention mix** | • IPC | • Trainings<br>• IPC by IPs, SACAS and other partners<br>• Seminars and meetings | • Posters<br>• Training manuals<br>• Job aid |

*Tertiary Audience: Community Leaders*

| TERTIARY AUDIENCE 1 | COMMUNITY LEADERS |
|---|---|
| **Desired changes** | • Support ANC/PMTCT services and encourage women to attend |
| **Barriers** | • Low knowledge of ANC/PMTCT services and benefits<br>• Strong attachments to negative socio-cultural norms that discourage use of ANC/PMTCT services |
| **Behavioral objective** | By the end of 2015, increase by 90 percent the number of community leaders who support ANC/PMTCT service uptake |
| **Communication objectives** | By the end of 2015 there will be an increase in the number of community leaders who:<br>• know the benefits of ANC/PMTCT services<br>• are motivated to engage in dialogue to address negative socio-cultural norms |

| | CHANNELS | ACTIVITIES | TOOLS and MATERIALS |
|---|---|---|---|
| **Intervention mix** | • IPC | • Advocacy meetings<br>• IPC by IPs, SACAs and volunteers<br>• Community dialogues | • Leaflets<br>• Community conversation toolkits<br>• Talking points |

*Tertiary Audience: Policy Makers*

| TERTIARY AUDIENCE 2 | POLICY MAKERS |
|---|---|
| **Desired changes** | • Establish more facilities providing ANC/PMTCT services closer to communities in need<br>• Provide adequate human resources for facilities providing ANC/PMTCT services<br>• Ensure availability of adequate commodities and equipment at the facilities |
| **Barriers** | • Low knowledge of the benefits of ANC/PMTCT service<br>• Low knowledge of ANC/PMTCT service coverage and gaps<br>• Other competing needs |
| **Behavioral objective** | By the end of 2015, increase by 90 percent the number of policy makers who make adequate budgetary provisions to support ANC/PMTCT services |
| **Communication objective/s** | By the end of 2015, there will be a 90 percent increase in the number of policy makers who:<br>• know the benefits of ANC/PMTCT services<br>• know the ANC/PMTCT service coverage and gaps in the region<br>• are motivated to give ANC/PMTCT issues priority in the budgetary allocations |

| | CHANNELS | ACTIVITIES | TOOLS and MATERIALS |
|---|---|---|---|
| **Intervention mix** | • IPC | • Advocacy meetings<br>• IPC by IPs, SACAs and other partners | • Talking points<br>• PowerPoint slides<br>• Advocacy kits |

### Positioning Statement

A pregnant woman can only deliver a healthy baby if we all support her in accessing and completing ANC/PMTCT services.

## KEY CONTENT, SOUTH-EAST ZONE

### Primary Audience: Pregnant Women

- Understand benefits of ANC/PMTCT services
- Know what ANC/PMTCT entails (e.g., four visits, ARV adherence)
- Negotiate accessing services with Husband/Partner, Mother-in-Law and family
- Attend and complete ANC/PMTCT services
- Demand for services at the clinic

### Secondary Audience 1: Husbands/Partners

- Provide resources and urge your wife to enrolll in ANC/PMTCT services
- Follow up on your wife's ANC/PMTCT schedule
- Remind your wife to attend every ANC/PMTCT appointment scheduled
- Visit the health center to ask questions whenever you are confused about your wife's care
- Discuss the benefits of ANC/PMTCT with health care team, your wife and your peers
- Ensure she completes her ANC/PMTCT visits and delivers at the clinic

### Secondary Audience 2: TBAs

- Know the benefits of HCT/PMTCT
- Know when to refer pregnant women to health facilities for HCT/PMTCT services
- Work positively with HCWs
- Refer pregnant women for HCT
- Ensure they get to the facility
- Hand her over to a health worker at the facility
- Work positively with health care workers

### Secondary Audience 3: HCWs

- Know where ANC/PMTCT services can be accessed
- Know the benefits of the services
- Understand what optimum ANC/PMTCT entails (e.g., at least four visits, ARV adherence)
- Understand and practice IPC skills to improve client relations
- Understand the benefits of linking with TBAs
- Work positively with TBAs
- Be friendly, respectful, helpful and empathetic
- Be professional in delivering services
- Ensure all pregnant women at your clinic obtain correct and consistent information about PMTCT

### Tertiary Audience 1: Community Leaders

- Know the benefits that pregnant women in your communities can receive through ANC/PMTCT services
- Ensure acceptance and normalization of ANC/PMTCT as pathway to reduce stigma for PLHIV in communities and congregations
- Encourage pregnant women to attend and complete ANC/PMTCT
- Constantly talk about the benefits of ANC/PMTCT to community members
- Pay visit to clinics on ANC days to express your support and encourage women to constantly attend ANC clinics

### Tertiary Audience 2: Policy Makers

- Knowledge of basic facts about HIV/AIDS transmission (including mother-to-child)
- Knowledge of sero-prevalence of HIV among women and youth in Nigeria
- Knowledge of contribution of Nigeria to the global burden of HIV and MTCT
- Knowledge of socio-economic impact of HIV for Nigeria
- Knowledge of effects at community level of HIV
- Knowledge of benefits of ANC/PMTCT services for mother and baby
- Knowledge of optimum practices related to ANC/PMTCT (e.g., number and timing of visits, adherence to ARV)
- Knowledge of availability/accessibility of ANC/PMTCT services at the community level
- Knowledge of effects of negative socio-cultural norms on utilization of ANC/PMTCT services
- Knowledge of other barriers (e.g., financial charges, lack of adequate human resources and positive IPC)
- Motivation to give ANC/PMTCT issues priority in the budgetary allocation
- Ensure that the health of women, unborn and born infants are priority for policy and funding
- Ensure all health facilities are well staffed, equipped and supplied with essentials like drugs.
- Be concerned about reducing the rate of maternal and infant mortality in Nigeria.

## E. COMMUNICATION STRATEGY FOR SOUTH-SOUTH ZONE PMTCT DEMAND CREATION IN NIGERIA

### Problem statement: Low uptake of ANC/PMTCT

PMTCT utilization in the South-South Zone of Nigeria is low, with 48 percent of pregnant women delivering at a health facility in 2008. Factors include low ANC attendance, poor and inadequate knowledge of ANC/PMTCT benefits, poor awareness of PMTCT sites and lack of knowledge about the HIV status of pregnant women. Even though spouses/partners generally support their women, they do not accompany their women for ANC due to gender-based misconceptions. (This is perceived as a "woman's role" and to accompany them would imply "weakness" or that they are "jobless.")

Preference for delivery in the home or faith home and patronage of TBAs fuels low uptake of services. Other factors include: fear of HIV status disclosure, fear of abandonment by spouse, stigma/discrimination, low economic empowerment and failure to return following an initial visit due to a negative experience (e.g., rude treatment by HCWs). All of these factors, together with inadequate funding and poorly trained personnel in IPC and ANC/PMTCT skills, are contributing to an increase in HIV-exposed babies as well as an increase in infant morbidity and mortality.

### Contextual Analysis

In the South-South Zone, married peers are first in the order of priority for pregnant women. Women of reproductive age prefer to confide in others like themselves. Women in the South-South part of the country are more empowered and tend to take on greater responsibility to access health care for themselves and their families. In general, the men in this region of the country support their women to make family planning decisions. Traditional birth attendants and faith houses are also held in high esteem in the South-South due to strong cultural and religious beliefs.

### COMMUNICATION STRATEGY: SOUTH-SOUTH ZONE

***Final audience selection and segmentation***

| AUDIENCES | |
|---|---|
| **Primary Audience** | • Pregnant Women |
| **Secondary Audience 1** | • Married Peers |
| **Secondary Audience 2** | • TBAs |
| **Secondary Audience 3** | • HCWs |
| **Secondary Audience 4** | • Husbands/Partners |
| **Tertiary Audience 1** | • Community and Religious Leaders |
| **Tertiary Audience 2** | • Policy Makers |

## Desired Changes, Barriers, Behavioral and Communication Objectives and Channel Mix by Audience Segment

### *Primary Audience: Pregnant Women*

| PRIMARY AUDIENCE | PREGNANT WOMEN | | |
|---|---|---|---|
| **Desired changes** | • Pregnant Women | | |
| **Barriers** | • Low knowledge of the benefits of ANC/PMTCT services<br>• Long distance of clinics from potential users<br>• Self-stigma as well as stigma and discrimination by family, community and HCWs against HIV-positive pregnant women<br>• Unfriendly attitudes of HCWs | | |
| **Behavioral objective** | By the end of 2015, increase by 90 percent the number of pregnant women who access ANC/PMTCT services | | |
| **Communication objectives** | By the end of 2015, there will be 90 percent increase in the number of pregnant women who:<br>• know the benefits of ANC/PMTCT services<br>• perceive HCWs as being friendly and trustworthy<br>• confirm existence of a nearby ANC/PMTCT clinic | | |
| | **CHANNELS** | **ACTIVITIES** | **TOOLS and MATERIALS** |
| **Intervention mix** | • IPC<br>• Mass media | • Facility health talk<br>• IPC by married peers, HCWs and volunteers<br>• SGDs at support group level<br>• Use mentor mothers | • Radio and TV jingles/spots<br>• Discussion guides<br>• Posters |

### *Secondary Audience 1: Married Peers*

| SECONDARY AUDIENCE 1 | MARRIED PEERS |
|---|---|
| **Desired changes** | • Support pregnant women to access and uptake regular ANC attendance for ANC/PMTCT services |
| **Barriers** | • Low knowledge of the benefits of ANC/PMTCT services |
| **Behavioral objective** | By the end of 2015, increase by 90 percent the number of peers of pregnant women who support their use of ANC/PMTCT services |
| **Communication objectives** | By the end of 2015, there will be a 90 percent increase in the number of peers of HIV positive women of reproductive age who:<br>• know the benefits of ANC/PMTCT and<br>• support their peers to attend ANC for PMTCT services |

| SECONDARY AUDIENCE 1 | MARRIED PEERS | | |
|---|---|---|---|
| | **CHANNELS** | **ACTIVITIES** | **TOOLS and MATERIALS** |
| **Intervention mix** | • IPC<br>• Mass media | • Facility health talk<br>• IPC by married peers, HCWs and volunteers<br>• SGDs at support group level<br>• Use mentor mothers | • Radio and TV jingles/spots<br>• Discussion guides<br>• Posters |

### *Secondary Audience 2: TBAs*

| SECONDARY AUDIENCE 2 | TBAs |
|---|---|
| **Desired changes** | • Refer pregnant women for HCT/PMTCT services<br>• Understand the usefulness as well as the limitations of the services they provide and how collaborations with HCWs can improve their work |
| **Barriers** | • Low knowledge of HCT/PMTCT services and its benefits for their clients/patients<br>• Fear of losing clients to HCWs |
| **Behavioral objective** | By 2015, there will be a 90 percent increase in the number of TBAs who refer and link pregnant women to facilities |
| **Communication objectives** | By the end of 2015 there will be a 90 percent increase in the number of TBAs who:<br>• know about the benefits of HCT/PMTCT services<br>• are motivated to refer women for HCT/PMTCT services |

| | **CHANNELS** | **ACTIVITIES** | **TOOLS and MATERIALS** |
|---|---|---|---|
| **Intervention mix** | • IPC | • Sensitization meeting/ dialogues<br>• IPC by volunteers and IPs<br>• Capacity building (HIV, HCT/PMTCT, referral) | • Photo cards<br>• Training manual |

### *Secondary Audience 3: HCWs*

| SECONDARY AUDIENCE 3 | HCWs (CHEWs AND NURSES/MIDWIVES) |
|---|---|
| **Desired changes** | • Friendly attitude towards clients<br>• Improved relationships between HCWs and TBAs |
| **Barriers** | • Lack of IPC skills<br>• Competition between TBAs and HCWs over clients<br>• Pregnant women's preference for home-delivery and TBAs<br>• Stigma and discrimination |
| **Behavioral objective** | By the end of 2015, increase by 90 percent the number of HCWs who provide:<br>• provide friendly services to clients<br>• developed cordial relationships with TBAs by 2015 |

| SECONDARY AUDIENCE 3 | HCWs (CHEWs AND NURSES/MIDWIVES) | | |
|---|---|---|---|
| **Communication objectives** | By the end of 2015, there will be a 90 percent increase in the number of HCWs who:<br>• are skilled in effective and utilize them with ANC clients<br>• are motivated to establish linkages with TBAs<br>• have comprehensive knowledge of HIV and AIDS and are favorably disposed to providing friendly services to HIV-positive pregnant women | | |
| | **CHANNELS** | **ACTIVITIES** | **TOOLS and MATERIALS** |
| **Intervention mix** | • IPC | • Trainings<br>• IPC by IPs, SACAS and other partners<br>• Seminars and meetings | • Posters<br>• Job aid |

### *Secondary Audience 4: Husbands and Partners*

| SECONDARY AUDIENCE 4 | HUSBANDS/PARTNERS | | |
|---|---|---|---|
| **Desired changes** | • Support and encourage wives/partners to access and complete ANC/PMTCT visits | | |
| **Barriers** | • Low knowledge of benefits of ANC/PMTCT services<br>• Peer pressure | | |
| **Behavioral objective** | By the end of 2015, increase by 90 percent the number of husbands/partners who support their wives/partners to access ANC/PMTCT services | | |
| **Communication objectives** | By the end of 2015, there will be a 90 percent increase in the number of husbands of pregnant women who:<br>• know the benefits of ANC/PMTCT services<br>• are motivated to discuss the benefits of ANC/PMTCT services with their peers<br>• are motivated to discuss the benefits of seeking ANC/PMTCT services with their wives/partners | | |
| | **CHANNELS** | **ACTIVITIES** | **TOOLS and MATERIALS** |
| **Intervention mix** | • IPC<br>• Mass media | • *Men.Care* forum<br>• IPC by HCWs/volunteers | • Discussion guide<br>• Radio and TV spots/jingles |

*Tertiary Audience 1: Community and Religious Leaders*

| TERTIARY AUDIENCE 1 | COMMUNITY LEADERS | | |
|---|---|---|---|
| **Desired changes** | • Support ANC/PMTCT services and encourage women to attend | | |
| **Barriers** | • Low knowledge of ANC/PMTCT services and benefits<br>• Strong attachments to negative socio-cultural norms that discourage use of ANC/PMTCT services | | |
| **Behavioral objective** | By the end of 2015, increase by 90 percent the number of community leaders who support use of ANC/PMTCT services | | |
| **Communication objectives** | By the end of 2015 there will be an increase in the number of community leaders who:<br>• know the benefits of ANC/PMTCT services<br>• are motivated to engage in dialogue to address negative socio-cultural | | |
| | **CHANNELS** | **ACTIVITIES** | **TOOLS and MATERIALS** |
| **Intervention mix** | • IPC | • Advocacy meetings<br>• IPC by HCWs and volunteers<br>• Community dialogues | • Leaflets<br>• Community conversation toolkits<br>• Talking points |

*Tertiary Audience 1: Religious Leaders*

| TERTIARY AUDIENCE 1 | RELIGIOUS LEADERS | | |
|---|---|---|---|
| **Desired changes** | • Encourage pregnant women to access ANC/PMTCT services | | |
| **Barriers** | • Low knowledge about the benefits of ANC/PMTCT services<br>• Myths and misconceptions, such as the belief that HIV is a punishment from God | | |
| **Behavioral objective** | By the end of 2015, increase by 90 percent the number of religious leaders who support use of ANC/PMTCT services | | |
| **Communication objectives** | By the end of 2015, there will be a 90 percent increase in the number of religious leaders who have increased knowledge on the benefits of ANC/PMTCT services | | |
| | **CHANNELS** | **ACTIVITIES** | **TOOLS and MATERIALS** |
| **Intervention mix** | • IPC | • Advocacy meetings<br>• IPC by HCWs and volunteers<br>• Community dialogue | • Talking points<br>• Leaflets<br>• Community conversation toolkit |

*Tertiary Audience 2: Policy Makers*

| TERTIARY AUDIENCE 2 | POLICY MAKERS | | |
|---|---|---|---|
| **Desired changes** | • Establish more facilities providing ANC/PMTCT services closer to communities in need<br>• Provide adequate human resources for facilities providing ANC/PMTCT services<br>• Ensure availability of adequate commodities and equipment at the facilities | | |
| **Barriers** | • Low knowledge of the benefits of ANC/PMTCT services<br>• Low knowledge of ANC/PMTCT service coverage and gaps<br>• Other competing needs | | |
| **Behavioral objective** | By the end of 2015, increase by 90 percent the number of policy makers who make adequate budgetary provisions to support ANC/PMTCT services | | |
| **Communication objectives** | By the end of 2015, there will be a 90 percent increase in the number of policy makers who:<br>• know the benefits of ANC/PMTCT services<br>• know the ANC/PMTCT service coverage and gaps in the region<br>• are motivated to give ANC/PMTCT issues priority in the budgetary allocations | | |
| | **CHANNELS** | **ACTIVITIES** | **TOOLS and MATERIALS** |
| **Intervention mix** | • IPC | • Advocacy meetings<br>• IPC by IPs, SACAs and other partners | • Talking points<br>• PowerPoint slides<br>• Advocacy kits |

### Positioning Statement

A pregnant woman can only deliver a healthy baby if we all support her to access and complete ANC/PMTCT services.

## KEY CONTENT, SOUTH-SOUTH ZONE

### Primary Audience: Pregnant Women

- Understand benefits of ANC/PMTCT services
- Know what ANC/PMTCT entails (e.g., four visits, ARV adherence)
- Negotiate accessing services with Husband/Partner, Mother-in-Law and family
- Attend and complete ANC/PMTCT services
- Demand for services at the clinic

### Secondary Audience 1: Peers (Married) of Women in need of PMTCT

- Support your pregnant friend to access ANC/PMTCT services

### Secondary Audience 2: TBAs

- Know the benefits of HCT/PMTCT
- Know when to refer pregnant women to health facilities for HCT/PMTCT services
- Work positively with HCWs
- Refer pregnant women for HCT
- Ensure they get to the facility
- Hand her over to a health worker at the facility
- Work positively with health care workers

### Secondary Audience 3: HCWs

- Know where ANC/PMTCT services can be accessed
- Know the benefits of the services
- Understand what optimum ANC/PMTCT entails (e.g., at least four visits, ARV adherence)
- Understand and practice IPC skills to improve client relations
- Understand the benefits of linking with TBAs
- Work positively with TBAs
- Be friendly, respectful, helpful and empathetic
- Be professional in delivering services
- Ensure all pregnant women at your clinic obtain correct and consistent information about PMTCT

### Secondary Audience 4: Husband/Partner

- Provide resources and urge your wife to enrolll in ANC/PMTCT services
- Follow up on your wife's ANC/PMTCT schedule
- Remind your wife to attend every ANC/PMTCT appointment scheduled
- Visit the health center to ask questions whenever you are confused about your wife's care
- Discuss the benefits of ANC/PMTCT with health care team, your wife and your peers
- Ensure she completes her ANC/PMTCT visits and delivers at the clinic

### Tertiary Audience 1: Community and Religious Leaders

- Know the benefits that pregnant women in your communities and congregations can receive through ANC/PMTCT services
- Ensure acceptance and normalization of ANC/PMTCT as pathway to reduce stigma for PLHIV in communities and congregations
- Encourage pregnant women to attend ANC/PMTCT clinics and complete at least four visits
- Constantly talk about the benefits of ANC/PMTCT to community and religious group members
- Pay visit to clinics on ANC days to express your support and encourage women to constantly attend ANC clinics

### Tertiary Audience 2: Policy Makers

- Knowledge of basic facts about HIV/AIDS transmission (including mother-to-child)
- Knowledge of sero-prevalence of HIV among women and youth in Nigeria
- Knowledge of contribution of Nigeria to the global burden of HIV and MTCT
- Knowledge of socio-economic impact of HIV for Nigeria
- Knowledge of effects at community level of HIV
- Knowledge of benefits of ANC/PMTCT services for mother and baby
- Knowledge of optimum practices related to ANC/PMTCT (e.g., number and timing of visits, adherence to ARV)
- Knowledge of availability/accessibility of ANC/PMTCT services at the community level
- Knowledge of effects of negative socio-cultural norms on utilization of ANC/PMTCT services
- Knowledge of other barriers (e.g., financial charges, lack of adequate human resources and positive IPC)
- Motivation to give ANC/PMTCT issues priority in the budgetary allocation
- Ensure that the health of women, unborn and born infants are priority for policy and funding
- Ensure all health facilities are well staffed, equipped and supplied with essentials like drugs.
- Be concerned about reducing the rate of maternal and infant mortality in Nigeria.

## F. COMMUNICATION STRATEGY FOR SOUTH-WEST ZONE PMTCT DEMAND CREATION IN NIGERIA

### Problem Statement

In 2008, in South-Western Nigeria, 70 percent[19] of pregnant women gave birth in health facilities; the other 30 percent gave birth at home with the assistance of a TBA or their mother-in-law. This situation is contributing to an increase in HIV-exposed babies as well as an increase in infant morbidity and mortality. There is a lack of IPC skills among HCWs and widespread stigmatization/discrimination of PLHIV by them. Unavailability of ANC/PMTCT services in most health facilities (public and private) contribute greatly to the low uptake of services. There are also deep cultural/religious beliefs resulting in preference for delivery at faith houses and with TBAs. Women often lack support from partners, community and religious leaders on ANC.

### Contextual Analysis

TBAs and family members stand out as high influencers of pregnant women. TBAs combine religion and culture to attend to these women. When complications develop, HCWs are mostly consulted. Family members, especially mothers and mothers-in-law of pregnant women, play a pivotal role in the reproductive health of pregnant women.

### Communication Strategy: South-West Zone

***Audience selection and segmentation***

| AUDIENCES | |
|---|---|
| **Primary Audience** | • Pregnant Women |
| **Secondary Audience 1** | • TBAs |
| **Secondary Audience 2** | • HCWs |
| **Secondary Audience 3** | • Husbands/Partners |
| **Secondary Audience 4** | • Family Members |
| **Tertiary Audience 1** | • Religious Leaders |
| **Tertiary Audience 2** | • Community Leaders |
| **Tertiary Audience 3** | • Policy Makers |

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## Desired Changes, Barriers, Behavioral and Communication Objectives and Channel Mix by Audience Segment

### *Primary Audience: Pregnant Women*

| PRIMARY AUDIENCE | PREGNANT WOMEN | | |
|---|---|---|---|
| **Desired changes** | • Pregnant Women | | |
| **Barriers** | • Low knowledge of the benefits of ANC/PMTCT<br>• Long distance of clinics from potential users<br>• Self-stigma as well as stigma and discrimination by family, community and HCWs against HIV-positive pregnant women<br>• Unfriendly attitudes of HCWs | | |
| **Behavioral objective** | By the end of 2015, increase by 90 percent the number of pregnant women who access ANC/PMTCT services | | |
| **Communication objectives** | By the end of 2015, there will be 90 percent increase in the number of pregnant women who:<br>• know the benefits of ANC/PMTCT services<br>• perceive HCWs as being friendly and trustworthy<br>• confirm existence of a nearby ANC/PMTCT clinic | | |
| | **CHANNELS** | **ACTIVITIES** | **TOOLS and MATERIALS** |
| **Intervention mix** | • IPC<br>• Mass media | • Facility health talk<br>• IPC by married peers, HCWs and volunteers<br>• SGDs at support group level<br>• Use mentor mothers | • Radio and TV jingles/spots<br>• Discussion guides<br>• Posters |

### *Secondary Audience 1: TBAs*

| SECONDARY AUDIENCE 1 | TBAs |
|---|---|
| **Desired changes** | • Refer pregnant women for HCT/PMTCT services<br>• Understand the usefulness as well as the limitations of the services they provide and how collaborations with HCWs can improve their work |
| **Barriers** | • Low knowledge of HCT/PMTCT services and its benefits for their clients/patients<br>• Fear of losing clients to HCWs |
| **Behavioral objective** | By 2015, there will be a 90 percent increase in the number of TBAs who refer and link pregnant women to facilities |
| **Communication objectives** | By the end of 2015 there will be a 90 percent increase in the number of TBAs who:<br>• know about the benefits of HCT/PMTCT<br>• are motivated to refer women for HCT/PMTCT services |

| SECONDARY AUDIENCE 1 | TBAs | | |
|---|---|---|---|
| | **CHANNELS** | **ACTIVITIES** | **TOOLS and MATERIALS** |
| **Intervention mix** | • IPC | • Sensitization meeting/ dialogues<br>• IPC by volunteers and IPs<br>• Capacity building (HIV, HCT/PMTCT, referral) | • Photo cards<br>• Training manual |

*Secondary Audience 2: HCWs*

| SECONDARY AUDIENCE 2 | HCWs (CHEWs AND NURSES/MIDWIVES) | | |
|---|---|---|---|
| **Desired changes** | • Friendly attitude towards clients<br>• Improved relationships between HCWs and TBAs | | |
| **Barriers** | • Lack of IPC skills<br>• Competition between TBAs and HCWs over clients<br>• Pregnant women's preference for home-delivery and TBAs<br>• Stigma and discrimination | | |
| **Behavioral objective** | By the end of 2015, increase by 90 percent the number of HCWs who provide:<br>• provide friendly services to clients<br>• developed cordial relationships with TBAs by 2015 | | |
| **Communication objectives** | By the end of 2015, there will be a 90 percent increase in the number of HCWs who:<br>• are skilled in effective and utilize them with ANC clients<br>• are motivated to establish linkages with TBA<br>• have comprehensive knowledge of HIV and AIDS and are favorably disposed to providing friendly services to HIV-positive pregnant women | | |
| | **CHANNELS** | **ACTIVITIES** | **TOOLS and MATERIALS** |
| **Intervention mix** | • IPC | • Trainings<br>• IPC by IPs, SACAS and other partners<br>• Seminars and meetings | • Posters<br>• Job aid |

### *Secondary Audience 3: Husbands/Partners*

| SECONDARY AUDIENCE 3 | HUSBANDS/PARTNERS | | |
|---|---|---|---|
| **Desired changes** | • Support and encourage wives/partners to access and complete ANC/PMTCT visits | | |
| **Barriers** | • Low/lack of knowledge of benefits of ANC/PMTCT services<br>• Peer pressure | | |
| **Behavioral objective** | By the end of 2015, increase by 90 percent the number of husbands/partners who support their wives/partners to access ANC/PMTCT services | | |
| **Communication objectives** | By the end of 2015, there will be a 90 percent increase in the number of family members, especially mothers-in-law of pregnant women, who:<br>• know the benefits of ANC/PMTCT services<br>• are motivated to discuss the benefits of ANC/PMTCT services with their peers<br>• are motivated to discuss the benefits of seeking ANC/PMTCT services with their wives/partners | | |
| | **CHANNELS** | **ACTIVITIES** | **TOOLS and MATERIALS** |
| **Intervention mix** | • IPC<br>• Mass media | • *Men.Care* forum<br>• IPC by HCWs/volunteers | • Discussion guide<br>• Radio and TV spots/jingles |

### *Secondary Audience 4: Family Members*

| SECONDARY AUDIENCE 4 | FAMILY MEMBERS | | |
|---|---|---|---|
| **Desired changes** | • Provide financial and psychosocial support to pregnant women to access ANC/PMTCT services | | |
| **Barriers** | • Low literacy<br>• Poor access to information on ANC/PMTCT<br>• HIV-related stigma | | |
| **Behavioral objective** | By 2015, increase by 90 percent the number of family members who support pregnant women to access ANC/PMTCT | | |
| **Communication objectives** | By the end of 2015 there will be an increase in the number of community leaders who:<br>• know where ANC/PMTCT services can be accessed<br>• know what ANC/PMTCT is and its benefits<br>• are motivated to initiate dialogue about ANC/PMTCT among family members<br>• are motivated to support pregnant women in the family to access and complete ANC/PMTCT visits | | |
| | **CHANNELS** | **ACTIVITIES** | **TOOLS and MATERIALS** |
| **Intervention mix** | • IPC<br>• Mass media | • IPC by HCWs and volunteers | • Radio and TV spots/jingles |

*Tertiary Audience 1: Religious Leaders*

| TERTIARY AUDIENCE 1 | RELIGIOUS LEADERS | | |
|---|---|---|---|
| **Desired changes** | • Encourage pregnant women to access ANC/PMTCT services | | |
| **Barriers** | • Low knowledge about the benefits of ANC/PMTCT services<br>• Myths and misconceptions, such as the belief that HIV is a punishment from God | | |
| **Behavioral objective** | By the end of 2015, increase by 90 percent the number of religious leaders who support use of ANC/PMTCT services | | |
| **Communication objectives** | By the end of 2015, there will be a 90 percent increase in the number of religious leaders who have increased knowledge on the benefits of ANC/PMTCT services | | |
| | **CHANNELS** | **ACTIVITIES** | **TOOLS and MATERIALS** |
| **Intervention mix** | • IPC | • Advocacy meetings<br>• IPC by HCWs and volunteers<br>• Community dialogue | • Talking points<br>• Leaflets<br>• Community conversation toolkit |

*Tertiary Audience 2: Community Leaders*

| TERTIARY AUDIENCE 2 | COMMUNITY LEADERS | | |
|---|---|---|---|
| **Desired changes** | • Support ANC/PMTCT services and encourage women to attend | | |
| **Barriers** | • Low knowledge of ANC/PMTCT services and benefits<br>• Strong attachments to negative socio-cultural norms that discourage use of ANC/PMTCT services | | |
| **Behavioral objective** | By the end of 2015, increase by 90 percent the number of community leaders who support use of ANC/PMTCT services | | |
| **Communication objectives** | By the end of 2015 there will be an increase in the number of community leaders who:<br>• know the benefits of ANC/PMTCT services<br>• are motivated to engage in dialogue to address negative socio-cultural | | |
| | **CHANNELS** | **ACTIVITIES** | **TOOLS and MATERIALS** |
| **Intervention mix** | • IPC | • Advocacy meetings<br>• IPC by HCWs and volunteers<br>• Community dialogues | • Leaflets<br>• Community conversation toolkits<br>• Talking points |

*Tertiary Audience 3: Policy Makers*

| TERTIARY AUDIENCE 3 | POLICY MAKERS | | |
|---|---|---|---|
| **Desired changes** | • Establish more facilities providing ANC/PMTCT services closer to communities in need<br>• Provide adequate human resources for facilities providing ANC/PMTCT services<br>• Ensure availability of adequate commodities and equipment at the facilities | | |
| **Barriers** | • Low knowledge of the benefits of ANC/PMTCT service<br>• Low knowledge of ANC/PMTCT service coverage and gaps<br>• Other competing needs | | |
| **Behavioral objective** | By the end of 2015, increase by 90 percent the number of policy makers who make adequate budgetary provisions to support ANC/PMTCT services | | |
| **Communication objectives** | By the end of 2015, there will be a 90 percent increase in the number of policy makers who:<br>• know the benefits of ANC/PMTCT services<br>• know the ANC/PMTCT service coverage and gaps in the region<br>• are motivated to give ANC/PMTCT issues priority in the budgetary allocations | | |
| | **CHANNELS** | **ACTIVITIES** | **TOOLS and MATERIALS** |
| **Intervention mix** | • IPC | • Advocacy meetings<br>• IPC by IPs, SACAs and other partners | • Talking points<br>• PowerPoint slides<br>• Advocacy kits |

### Positioning Statement

A pregnant woman can only deliver a healthy baby if we all support her to access and complete ANC/PMTCT services.

## KEY CONTENT, SOUTH-WEST ZONE

### Primary Audience: Pregnant Women

- Understand benefits of ANC/PMTCT services
- Know what ANC/PMTCT entails (e.g., four visits, ARV adherence)
- Negotiate accessing services with Husband/Partner, Mother-in-Law and family
- Attend and complete ANC/PMTCT services
- Demand for services at the clinic

### Secondary Audience 1: TBAs

- Know the benefits of HCT/PMTCT services
- Know when to refer pregnant women to health facilities for HCT/PMTCT services
- Work positively with HCWs
- Refer pregnant women for HCT
- Ensure they get to the facility
- Hand her over to a health worker at the facility
- Work positively with health care workers

### Secondary Audience 2: HCWs

- Know where ANC/PMTCT services can be accessed
- Know the benefits of the services
- Understand what optimum ANC/PMTCT entails (e.g., at least four visits, ARV adherence)
- Understand and practice IPC skills to improve client relations
- Understand the benefits of linking with TBAs
- Work positively with TBAs
- Be friendly, respectful, helpful and empathetic
- Be professional in delivering services
- Ensure all pregnant women at your clinic obtain correct and consistent information about PMTCT

### Secondary Audience 3: Husbands/Partners

- Provide resources and urge your wife to enrolll in ANC/PMTCT services
- Follow up on your wife's ANC/PMTCT schedule
- Remind your wife to attend every ANC/PMTCT appointment scheduled
- Visit the health center to ask questions whenever you are confused about your wife's care
- Discuss the benefits of ANC/PMTCT with health care team, your wife and your peers
- Ensure she completes her ANC/PMTCT visits and delivers at the clinic

### Secondary Audience 4: Family Members

- Encourage pregnant women to seek ANC/PMTCT services and complete at least four visits at the nearest health facility.

### Tertiary Audience 1: Religious and Community Leaders

- Know the benefits that pregnant women in your communities and congregations can receive through ANC/PMTCT services
- Ensure acceptance and normalization of ANC/PMTCT as pathway to reduce stigma for PLHIV in communities and congregations
- Encourage pregnant women to attend ANC/PMTCT clinics and complete at least four visits
- Constantly talk about the benefits of ANC/PMTCT to community and religious group members
- Pay visit to clinics on ANC days to express your support and encourage women to constantly attend ANC clinics

### Tertiary Audience 2: Policy Makers

- Knowledge of basic facts about HIV/AIDS transmission (including mother-to-child)
- Knowledge of sero-prevalence of HIV among women and youth in Nigeria
- Knowledge of contribution of Nigeria to the global burden of HIV and MTCT
- Knowledge of socio-economic impact of HIV for Nigeria
- Knowledge of effects at community level of HIV
- Knowledge of benefits of ANC/PMTCT services for mother and baby
- Knowledge of optimum practices related to ANC/PMTCT (e.g., number and timing of visits, adherence to ARV)
- Knowledge of availability/accessibility of ANC/PMTCT services at the community level
- Knowledge of effects of negative socio-cultural norms on utilization of ANC/PMTCT services
- Knowledge of other barriers (e.g., financial charges, lack of adequate human resources and positive IPC)
- Motivation to give ANC/PMTCT issues priority in the budgetary allocation
- Ensure that the health of women, unborn and born infants are priority for policy and funding
- Ensure all health facilities are well staffed, equipped and supplied with essentials like drugs.
- Be concerned about reducing the rate of maternal and infant mortality in Nigeria.

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## APPENDIX

# PRIORITY TOPICS FOR DEVELOPMENT OF TALKING POINTS (TERTIARY AUDIENCE)

- Basic facts about HIV transmission (including mother-to-child)
- Sero-prevalence of HIV among women and youth in Nigeria
- Contribution of Nigeria to the global burden of HIV and MTCT
- Socio-economic impact of HIV for Nigeria
- Effects at community level of HIV
- Benefits of ANC/PMTCT services for mother and baby
- Optimum practices related to ANC/PMTCT services (e.g., number and timing of visits, adherence to ARV)
- Availability/accessibility of ANC/PMTCT services at the community level
- Effects of negative socio-cultural norms on utilization of ANC/PMTCT services
- Other barriers (e.g., financial charges, lack of adequate human resources and positive IPC)

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## APPENDIX

# GEOGRAPHICAL AUDIENCE SEGMENTATION

| Audiences | NC | NE | NW | SE | SS | SW |
|---|---|---|---|---|---|---|
| Primary Audience I | Pregnant Women | Pregnant Women | Pregnant Women | Pregnant Women | Pregnant Women | Pregnant Women |
| Secondary Audience I | Husbands/ Partners | HCWs | TBAs | Husbands/ Partners | Married Peers | TBAs |
| Secondary Audience II | HCWs | Religious Leaders | HCWs | TBAs | TBAs | HCWs |
| Secondary Audience III | TBAs | Husbands/ Partners | Husbands/ Partners | HCWs | HCWs | Husbands/ Partners |
| Secondary Audience IV | | | Family Members | | Husbands/ Partners | Family Members |
| Tertiary Audience I | Community & Religious Leaders | Community Leaders | Community Leaders | Community Leaders | Community/ Religious Leaders | Religious Leaders |
| Tertiary Audience II | Policy Makers | Policy Makers | Religious Leaders | Policy Makers | Policy Makers | Community Leaders |
| Tertiary Audience III | | | Policy Makers | | | Policy Makers |

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