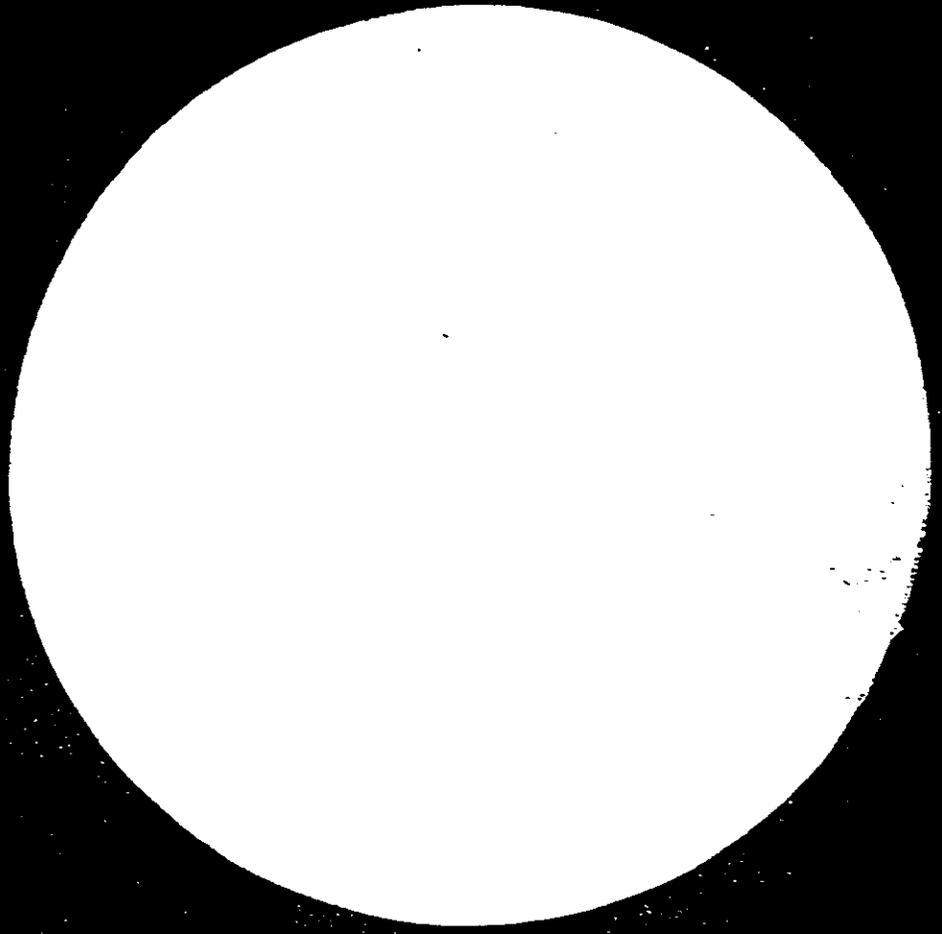


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# FAMILY HEALTH INTERNATIONAL NIGERIA



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Family Health International implements the USAID IMPACT Project in partnership with the Institute of Tropical Medicine, Management Sciences for Health, Population Services International, Program for Appropriate Technology in Health, and the University of North at Chapel Hill

**REPORT OF RAPID ASSESSMENT  
IN  
SELECTED LGAs,  
KANO STATE  
NIGERIA  
DECEMBER 2009**

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# Rapid Assessment Report Selected LGAs, Kano State

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# Rapid Assessment Report Selected LGAs, Kano State

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## List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
AIDSCAP	AIDS Control and Prevention Project
CBO	Community Based organization
CMD	Chief Medical Director
COPOP	Council of Positive People
CSOs	Civil Society Organizations
CSWs	Commercial Sex Workers
DC	Disease Control
DFID	Department of Foreign International Development
ECWA	Evangelical Church of West Africa
FHI	Family Health International
FSWs	Female Sex Workers
GS	General Services
HIV	Human Immunodeficiency Virus
IDH	Infectious Diseases Hospital
IMPACT	Implementing Prevention and Care Project
ISMA	Islamic Medical Workers Association
LACA	Local government Action Committee on HIV/AIDS
LGA	Local Government Area
M&E	Monitoring and Evaluation
MSO	Muslim Sisters Organization
NACA	National Action Committee on HIV/AIDS
NGO	Non-governmental organization
NLC	Nigeria Labour Congress
PLWH	Persons Living with HIV
PLWHA	Persons Living with HIV/AIDS
PMDs	Patent Medicine Dealers
PRO	Public Relations Officer
SACA	State Action Committee on HIV/AIDS
SAPC	State AIDS Program Coordinator
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
SWAAN	Society for Women and AIDS in Nigeria
VVF	Vesico Vagina Fistulae
Yospis	Youth Society for the prevention of infectious diseases and social vices

## EXECUTIVE SUMMARY

Family Health International (FHI), Nigeria, as part of its effort to redesign its ongoing IMPACT (Implementing Prevention and Care project) being funded by the United States Agency for International Development (USAID), conducted two waves of rapid assessments in identified states. In the first wave, FHI assessed Anambra and Nassarawa States while the second wave focused on Lagos, Kano and Taraba States. In the initial phase of the IMPACT Project, FHI has been working with a variety of NGOs and national organizations to develop pilot initiatives targeting high-risk groups. Under the next phase of the IMPACT, FHI working closely with the National Action Committee on AIDS, state and local government, plans to concentrate lessons learned in key high-risk areas in Nigeria. The goal of the second phase of the project is to develop comprehensive programming in key risk areas for both prevention and care. This will entail working with pilot Local Government Authorities to develop strategic plans of action and working with high risk and vulnerable populations through local organizations and structures in selected key risk areas.

A five-member team from Family Health International (FHI) visited Kano from November 28 – December 5, 2000 to conduct a rapid assessment of the HIV/AIDS situation and the opportunities for programming. The team set out to achieve the following specific objectives:

- Identification of risk settings and behaviours
- Identification of risk groups
- Identification of potential implementing partners, networks and structures for prevention and care and support of People Living with HIV/AIDS (PLWHA)
- Identification of health and social welfare systems and structures
- Assessment of the political environment for programming

The team visited government officials at the state level, government officials in three local governments – Nassarawa, Tarauni and Fagge; non governmental organizations (NGOs); religious institutions; people living with HIV/AIDS and key health workers in major health facilities. A key informant interview guide developed from a consultative process with

stakeholders was used for the assessment (see Appendix 3). In all a total of 85 key informants were interviewed (individually or in groups).

### Major Findings

The following are major findings from the assessment:

- Kano is one of the major high-risk areas in Nigeria. It is a cosmopolitan town with numerous risk factors, risk settings and risk groups. The risk factors include large population size; diverse ethnic populations; poverty; low literacy; youth unemployment; trading culture; AIDS denial amongst the population; high divorce rates and frequent remarriages by divorcees; drug abuse; use of unsterilized skin piercing objects; existence of deviant male youth gangs and de-boarding of secondary school students – an act associated with high rate of truancy and itinerant youth. The following risk settings were identified: Mobile markets where a lot of sexual networking occur, transport parks, brothels, military and police barracks. The team also identified the following high-risk groups in Kano – Transport workers, vulnerable women (married and unmarried), itinerant sex workers, traders, youth and low-income women.
- HIV/AIDS is a major concern to policy makers and key influentials against a background of rising profile of HIV infection and AIDS cases in the State. It is believed that about 250,000 persons now live with HIV in the state.
- About half of those interviewed knew someone who had died of AIDS
- A recent study showed that over 2,000 AIDS orphans were found in 6 metropolitan LGAs
- STIs and TB are major health problems with 3 to 5 new cases being diagnosed per week in a particular secondary health facility
- Although well recognized as co-factor in the transmission of HIV, quality STI services are not available and accessible to a large number of people in need of such services.
- Health workers recognized the need for capacity building in the areas of HIV/AIDS/STIs counseling and skills acquisition for syndromic management of STIs
- Government's expressed willingness at the state and LGA levels to fight the epidemic is not matched with corresponding financial support. HIV/AIDS budget at the state level is paltry and hardly

ever released while none of the LGAs visited had ever had a separate budget for HIV/AIDS

- Most government officials interviewed see HIV/AIDS as 'health issue'
- Policy makers in the local government need to be sensitized to enable them respond appropriately to the epidemic.
- National policy on AIDS had not been seen in the LGAs visited and none of the key informants in the LGAs knew about the National Action Committee on AIDS (NACA)
- The introduction of the Sharia legal code has driven Female Sex Workers (FSWs) underground
- Condom is widely available in the market but opinion leaders still frown at open condom promotion
- PLWHA met lack requisite capacities to actively provide psychosocial support to their peers
- There are ongoing NGO-driven interventions targeting in-school youth, women in adult literacy schools and PLWHA and PABA through community home-based care
- HIV antibody testing available in major health facilities but counseling services available in very few of the facilities where testing takes place
- No ongoing intervention with orphans and vulnerable children
- While most informants agreed that collaboration was imperative as AIDS was real, they pointed out that all interventions must conform with the culture, religion and practices of the people of Kano State
- The support/endorsement of traditional and religious institutions are critical to the success of any HIV/AIDS intervention in Kano
- State functionaries and NGOs were mutually suspicious of each other when programming for HIV/AIDS
- Generally, Civil Society Organizations (CSOs) programmed in the area of HIV/AIDS alongside other areas such as reproductive health, adolescent sexuality education, micro credits and VVF
- Policy makers and religious influentialists continue to view donor funds for development projects with deep-seated suspicion. Some key informants distinguished between 'political AIDS' and 'development AIDS,' the former being euphemistic reference to donor support projects planned and implemented using the top-bottom approach while the latter refers to donor supported projects

that empowers the people to plan and implement taking into account their community realities

## RECOMMENDATIONS

The assessment team came up with the following recommendations:

- The Kano environment is suitable for a comprehensive program which should focus on work with transport workers, vulnerable women, youth and men in the workplace
- There is a need to develop and strengthen care and support structures, STI and clinical services
- Orphans and vulnerable children should form a major component of any care and support initiative
- Care and support interventions should link projects with sources of anti-TB drugs
- There is a need to integrate HIV/AIDS into key state wide programs of unions and associations

## 1.0 Introduction/background

Family Health International (FHI) is a private voluntary organization based in the United States. FHI has over 25 years experience in reproductive health, particularly in the areas of family planning and HIV/AIDS. With funding from USAID, FHI has, for over a decade, been working in HIV/AIDS programming in Nigeria – AIDSTECH 1988 – 1991; The AIDS Prevention and Control Program (AIDSCAP) 1992 – 1997 which had projects, first in three states and later expanded to cover 14 states; a Bilateral Grant Agreement – 1997 – 1998 which focused on HIV/AIDS prevention and care in nine states and now Implementing Prevention and Care Project (IMPACT) that began in 1998. IMPACT focuses on prevention and care in 13 states. FHI has developed excellent collaborative relationships with public and private sector organizations in Nigeria including non-governmental organizations and community based organizations.

In the initial phase of the IMPACT Project, FHI has been working with a variety of NGOs and national organizations to develop pilot initiatives targeting high-risk groups. Under the next phase of the IMPACT, FHI working closely with the National Action Committee on AIDS, state and local government, plans to concentrate lessons learned in key high-risk areas in Nigeria. The goal of the second phase of the project is to develop comprehensive programming in key risk areas for both prevention and care. This will entail working with pilot Local Government Authorities to develop strategic plans of action and working with high risk and vulnerable populations through local organizations and structures in selected key risk areas. In each selected risk areas, FHI will work with a variety of partners to reach the identified high risk and vulnerable groups and ensure that their care and support needs are met. Where possible this work will be linked to work with national organizations and structures, such as the FHI collaboration with the Military, Policy, Unions and Schools.

To initiate the second phase, FHI conducted a Desk Assessment of High-Risk areas in Nigeria. Based on the prevalence rates and existence of high-risk setting, FHI identified a number of key states. Among these states, FHI identified four for initial rapid assessments. They are Anambra, Nassarawa, Kano and Lagos states. The rapid assessment in these four states will enable FHI to determine whether or not to proceed with comprehensive programs in them.

FHI proposes a participatory process as follows:

- Rapid Assessment in selected states and LGAs
- Selection and orientation of partners
- In-depth Assessments
- Project Design
- Project implementation and evaluation

This overall comprehensive approach is aimed towards establishing a synergy of efforts for a greater impact to ensure the link between prevention and care and the link between related high risk and vulnerable populations.

In Kano state, FHI is already working with two NGOs – the Muslim Sisters Organization (MSO) and the Society for Women and AIDS in Nigeria (SWAAN) and engages a wide range of NGOs yearly during the World AIDS Campaign. With the goal of scaling up these activities for comprehensive programme, FHI identified three LGAs for rapid assessment: Nassarawa, Fagge and Tarauni. All three are identified as key high-risk areas in Kano State.

## 2.0 Methodology and Objectives

The Rapid Assessment methodology comprised an initial desk assessment and interviews with key informants. The key informants were identified as –

- government officials at state and local government levels
- non-governmental organizations
- key institutions
- people living with HIV/AIDS
- key health care workers in major health facilities

A draft Key Informant Interview Guide (see Appendix 3) was developed from a consultative process with stakeholders supported by technical inputs.

The five objectives of the rapid assessment were –

1. Identification of risk settings and behaviors
2. Identification of risk groups
3. Identification of potential implementing partners, networks and structures for prevention and care and support for PLWHA
4. Identification of health and social welfare systems and structures
5. Assessment of the political environment for programming

The five objectives were explored at the level of the state and in three selected local government areas. The three selected local government areas were – Fagge, Nassarawa and Tarauni.

Based on the information gathered during the rapid assessment, FHI will decide whether or not to proceed with a comprehensive programme in those identified states and LGAs.

The assessment in Kano was constrained by two key limitations. First, the study team was not able to interview all stakeholders identified. In particular, no interview was held with the Ministry of Education, the Directorate for Local Government Affairs in the Deputy Governor's Office and the officials of the Tarauni LGA. This was primarily because the field work took place during the Ramadan (fasting) period in which most offices opened late in the morning and

closed early. The second limitation was that LGA boundaries were largely artificial as the population accessed services and contributed to the spread of AIDS from within and outside designated LGAs. This means that it was difficult to get an accurate picture of risk settings and government response strictly by LGA. This also had implications for LGA specific Monitoring and Evaluation (M&E) indicators of intervention in this area.

### 3.0 Introduction: Kano State

Kano state is one of Nigeria's oldest, largest and perhaps most traditional States in the Federation. Commerce and agricultural production have been the backbone of the Kano economy. Islam is the dominant religion though there are significant groups of Christians and others belonging to tradition and African faiths. Urban drift from rural areas within Kano, from other states in Nigeria as well as from Northern West Africa, has provided a steady stream of migrants adding to Kano's growing population. Kano is therefore a cosmopolitan melting pot of people and Kano city is characterized by over-crowding, high youth unemployment, over-burdened infrastructure which result in occasional outbreak of unrests. This is the context in which the AIDS virus is spreading in Kano. Kano State estimates that 250,000 of the State's over 9,000,000 population live with HIV with one health facility, the L.H.F., recording a minimum of referred cases weekly. STIs and TB are also major health problems with 3 to 5 new cases being diagnosed per week in one Secondary Health Facilities. As in other Nigerian States, current statistics for programming and planning are largely unavailable. It is in this context that the Rapid Assessment took place.

Section I  
Rapid Assessment Findings at the level of Kano State

4.0 Identification of Risk Setting and Behaviors at State level

The team found that risk factors in Kano state which contribute towards the spread of the AIDS epidemic are large population size, cosmopolitan urban centers, poverty, illiteracy especially in rural settings, youth unemployment and a thriving trading culture characterized by free movement of people and goods within Nigeria and to neighboring countries such as Benin Republic, Chad, Niger and Mali. The assessment team was told that the illiterate and uninformed population in the rural setting was especially at risk because they doubted whether the virus even existed. Indeed, one informant said to the team 'you people have an uphill task, especially among rural people'. Risk behaviors such as high divorce rates, frequent remarriages by divorcees, drug abuse and use of unsterilised objects in health facilities, by local barbers and traditional birth attendants and the existence of deviant male youth gangs were identified. In addition, the de-boarding of secondary schools in Kano State in 1998 was identified as an important risk factor for contributing to the spread of the virus. De-boarding was found to be associated with a high incidence of itinerant youth and with truancy in the youth population. In the sites visited, the following risk settings were identified: Mobile markets where a lot of sexual networking take place, transport parks, brothels, military and police barracks.

4.1 Identification of risk groups at State level

Key informants identified a broad spectrum of vulnerable and at risk groups. High risk groups were identified as the entire urban population of Kano state, the illiterate and uninformed rural population, the youth – both male and female, the unemployed, workers, and itinerant commercial sex workers who are known to move between rural, peri-urban and urban markets on market days. Importantly, married women in the home, and children were also identified as vulnerable groups. About half of those interviewed knew someone who had died of AIDS. In one case, the assessment team was told of a married secluded woman who was found to be HIV positive when attending antenatal clinic. Her husband was thought to be the source of the virus. The informant who told this story

concluded that married women are especially vulnerable in cases where husbands were not faithful. It was also suggested that the entire population of Kano State was at risk.

#### 4.2 Identification of potential implementing partners, networks and structures for prevention and care and support for PLWHA at State level

A narrow group of potential implementing partners within civil society exists in Kano State for prevention, care and support of PLWHA. With the exception of the Kano Branch of the Society for Women and AIDS in Nigeria (SWAAN), none of the associations visited or interviewed focused on HIV/AIDS exclusively. The pattern that was found was one in which civil society organizations in Kano State, programmed in the area of HIV/AIDS together with other areas such as VVF, reproductive health, adolescent sexuality education, micro credit and primary health care. These civil society organizations include associations of medical personnel in the public and private sector, women's revolving micro finance associations, youth groups and social clubs. The assessment team interviewed 7 potential civil society partners for prevention, care and support. These groups were the Society for Women and AIDS in Nigeria (SWAAN) Kano branch; Council of Positive People (COPOP); the Muslim Sisters Organisation (MSO); Youth Society for the Prevention of Infectious Diseases and Social Vices (YOSPIS); Islamic Medical Association (ISMA) Kano; the Nigeria Labour Congress (NLC), Kano branch and the Ansarudeen Medical Women's Association. SWAAN, COPOP, ISMA and Ansarudeen are involved in care and support interventions together with prevention programmes. YOSPIS and MSO were involved in prevention interventions. The Nigerian Labour Congress, Kano branch had only participated in AIDS enlightenment interventions organized by other agencies where it had to distribute literature to its members.

With the exception of YOSPIS, all other six civil society organizations are branches of or have representatives on national bodies. Ansarudeen, the NLC and SWAAN headquarters are in Lagos; MSO headquarters is Kano State. All NGOs were engaged in networking with wider groups of civil society organizations both within and outside Kano State.

Community support and outreach services were provided to varying extents by facilities such as the Infectious Disease Hospital (IDH); Aminu Kano Teaching Hospital; Murtala Mohammed Specialist Hospital; and Mohammed Abdullah Wase Specialist Hospital. A range of private hospitals in Kano state are also involved in providing facility based treatment and in some cases home visits for paying clients in Kano state.

#### 4.3 Identification of health and social welfare systems and structures at State level

The current state government's response to HIV/AIDS in Kano State can best be described as a health sector response. The State Action Committee on AIDS (SACA) was not yet in place and several health sector functionaries were not fully aware of the activities of NACA. The team found that most government officials interviewed clearly stated HIV/AIDS is a 'health issue' and quickly called for the relevant Primary Health care Officer to contribute to the discussion. The team was informed of the services offered in health facilities in the area of HIV/AIDS prevention, care and support and of the activities of the health sector response in working with the Local Government's Primary Health Care Officers to develop an HIV/AIDS LGA Plan. AIDS Action Managers were expected to be appointed in all 44 LGAs but the Action Plans have not been implemented due to lack of funds. There was no budget line item for HIV/AIDS programming.

In Kano State some health facilities and social welfare systems structures were identified. The major health facilities visited were secondary and tertiary hospitals. The facilities visited included Mohammed Abdullah Wase Specialist Hospital located in Nassarawa LGA, Murtala Mohammed Specialist Hospital in Municipal LGA, and the Infectious Disease Hospital (IDH) at Fagge LGA. Others of significance in Kano but not visited included Aminu Kano Teaching Hospital, Evangelical Church of West Africa (ECWA) Hospital, Ahmadya Hospital, Alnoury Hospital and numerous private hospitals.

The three hospitals visited are referral centers which have the entire Kano State as geographic catchment area. They also serve communities from other states in Northern Nigeria and neighboring countries such as Chad, Niger, Mali and Cameroon. The hospitals receive referrals from primary and secondary health facilities in the

state. HIV/AIDS/STIs cases are seen and attended to in these hospitals. These facilities are affiliated with SWAAN Kano. TB cases are also managed in these hospitals. Complicated cases are referred to other health centers of excellence outside the state.

Virtually all the health facilities visited lacked capacity in the area of syndromic management of STDs and requested for assistance in the area. They also will need help in the area of provision of affordable STI and TB drugs.

It was found that the epidemic had put a strain on traditional social welfare. The special social welfare feature observed in Kano State was the activities of individual health personnel and associations of medical personnel such as ISMA and Ansarudeen.

#### 4.4 Assessment of the political environment for programming at State level

The political environment was generally found to be receptive to collaboration with FHI on programming for HIV/AIDS interventions. At the state level, receptivity to programming was apparent from the commitment given by functionaries in the State Ministries of Health, Information and Women's Affairs to collaborate with FHI. Officials interviewed said that the state government's policy was very hospitable to international donors and that a forum had recently been convened to bring all development Ministries in Kano State into direct contact with foreign development agencies. It was also said that the Kano State government had a policy on collaboration with foreign development agencies, which was open and receptive.

While most informants agreed that collaboration was imperative, as AIDS was real, they were however quick to point out that all interventions must be in conformity with the culture, religion and practices of Kano State. Stakeholders interviewed also shared their fears and skepticism over foreign support for HIV/AIDS interventions in Nigeria. They expressed concern over a possible hidden agenda behind Western interest in working in the area of AIDS in Kano State. Concerns were expressed over the introduction of family planning and the fear that community leaders would be asked to promote condom use. In particular, the religious stakeholders interviewed

explicitly expressed their concern with Western foreign influence and intentions when programming in this area. The phrase 'political AIDS' was used by some groups interviewed. Indeed, a distinction was made between 'Political AIDS' and HIV/AIDS programs that are development oriented. 'Political AIDS' was seen as donor supported programs designed by 'outsiders' and implemented by 'outsiders' while 'Development AIDS' refers to donor supported projects that empower the people to plan and implement projects taking into account their community realities.

When making the point that programming in HIV/AIDS must be in conformity with religious and cultural practices, informants spoke specifically about Sharia. The team was told that interventions should be respectful of Sharia and strategies were discussed for programming with Commercial Sex Workers in the context of Sharia. Strategies such as working with Social Clubs and 'free women' in general rather than with CSWs as a distinct sub-category were put forward. This was based on the assumption that with Sharia, CSWs would remain underground.

The meeting with Council of Ulama which is reported below is indicative of the level of concern over culturally sensitive programming. The Council of Ulama is a major and credible constituency in Kano State. As important gatekeepers, this is a group of Islamic scholars and clerics who wield preponderant influence in religious and political lives of the people. Under the sharia dispensation, the council holds the ace in helping to shape public opinions, interpreting actions and issues from the Islamic prism.

The council's attitude towards HIV/AIDS is informed, on one hand, by a sense of concern about the rising profile of HIV infection in Kano State, and on the other hand by skepticism about the actual intentions of foreign donors who provide aid to fight the epidemic. "Not all help or assistance that come from the West to Africa is in good faith. We need to think through the assistance being offered," a council member told the assessment team. The council's primary concern about donor support is in the methodology adopted for the implementation of projects supported with donor funds. The council considers inappropriate top-bottom approaches to donor-supported projects that tend to keep the very people to whom such efforts are

targeted on the fringes of decision-making and participation. The Council prefers and would support a situation where people in the communities are allowed to do the work while the donors provide support and take the back seat. "Remove the ugly foreign faces," one of the key informants said.

In addition, the Ulama wishes solution is found to AIDS in a manner that does not contradict the religious beliefs of the people and that whatever initiatives are proposed for HIV/AIDS prevention and care fit into the broad government program and response to HIV/AIDS in the state.

It was also observed that State functionaries and NGOs were mutually suspicious of each other when programming for HIV/AIDS. State functionaries were concerned with issues of ethics and compliance with state operating procedures by all actors in the HIV/AIDS field operating in the state. The state also sees itself as being responsible for protecting the interest of the vulnerable population as well as the sustainability of interventions. NGOs on the other hand, were concerned with high impact and quick action. This seemed to lead to a conflict of interest where NGOs requests for permission to program were often delayed by a careful bureaucracy. The Ministries of Health and Education were especially bureaucratic in giving permission for NGO interventions.

Finally, at the state level it was also observed that while stakeholders were supportive of the prevention, care and support focus of FHI, they were equally interested in knowing about the cure for AIDS.

## Section II Rapid Assessment at the LGA level

### 5.0 Fagge Local Government Authority

Fagge LGA with a population of over one million, was created in 1997 and was carved out of the Metropolitan LGAs. There are 11 wards in this local government with the Sabon Gari market area being divided into 2 wards, Sabon Gari North and Sabon Gari South. This is the most economically active local government in Kano State with monthly revenue in excess of one million Naira from market activities alone. Other economic activities in Fagge include currency exchange, tailoring and embroidery, food processing, and artisan trades. With one of the smallest land sizes for a local government and one of the largest populations, population density is high in Fagge.

Fagge is largely a settler's town with its population coming from other parts of Northern Nigeria as well as from neighboring Niger, Ghana, Benin Republic and Mali. Workers in Fagge are generally employed in the informal sector.

The three main markets in the Fagge local government include Sabon Gari market- the largest market in Kano State, the Singer whole-sale dry goods market and the Kantin Kwari textile market.

### 5.1 Identification of risk settings and behaviors

Risk settings in this local government are the motor parks, brothels, and clusters of migrant settler populations. In addition to these, the risk factors that drive the epidemic in the LGA remain the large population, population density, urban poverty, poor urban sanitation and waste management, migrant populations with inadequate social support networks and economic insecurity caused by the dominance of informal sector activities.

### 5.2 Identification of risk groups

Risk groups identified are the male cross-border traders, male currency traders, long distance drivers, petrol sellers, commercial sex workers, and vulnerable women whose spouses are temporary migrants.

5.3 Identification of potential implementing partners, networks and structures for prevention and care and support for PLWAHs

In this LGA, trade based associations, guilds, social clubs, micro finance associations, Muslim and Christian religious organizations and migrant associations are the main civil society groups that can be identified. The Ansarudeen Women’s association was the main civil society organization interviewed in this LGA.

This organization was established about five years ago. It is a membership based organization which aimed to address the health problems of migrant Yoruba women. Currently this organization has no office but meets in mosque located in Sabon Gari in Fagge local government. The group has not undertaken any programs in this LGA but have offered outreach services to its members and have talked with commercial sex workers living and working in the Sabon Gari area around its mosque.

5.5 Identification of health and social welfare svstems and structures for care and support

In Fagge local government there are several and different types of primary and secondary health facilities. These are presented below:

Primary Health Care Fagge  
Facilities Chart

District Unit	Health Facilities	Referral Facilities
Sabon Gari	Mud Jidda Hospital Jaba Health Post IDH Hospital FSP Clinic, Rimi Market	IDH
Fagge	Sabo Garba M/Hospital Ofishin Galadama Health Clinic Pilgrim Camp Health Facility	Sabo Garba Hospital
Kwachiri	Kwachiri HC Bukavu Barrack Health Clinic	IDH Muhd Jiddah Hospital

	Naa Clinic Nafa Clinic Tudun Bojuwa health Clinic Dan Rimi Community Health Post Kurna Makarnta Health Post Darerawa Health Post	
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*(A reproduction of the PHC chart displayed at Fagge LGA)*

In the area of HIV/AIDS one of the most significant health facilities in this LGA is the Infectious Diseases Hospital. IDH is a 220 bed facility, with 3 medical doctors and several nurses in its employ .The facility serves as a reference center for the other hospitals in the state. Difficult cases from this hospital are usually referred to the teaching hospitals.

The IDH started seeing AIDS cases in 1991. Since, then, there has been a steady increase in the number of HIV/AIDS patients attended to in the hospital. On the average, 30 cases are seen weekly and two ward s fully occupied by AIDS cases. The hospital does not have an AIDS policy and have not seen a copy of the National HIV policy guidelines.

In this facility, HIV testing takes place and those that test positive are counseled and on discharge referred to Home Based Care facility. Reagents are bought locally and/or supplied by the federal ministry of health/DFID. Majority of patients seen in this hospital are TB cases, mainly referred from health facilities within and outside the state. There has been a steady increase in the number of TB cases seen in the hospital. Drugs are available at the hospital pharmacy and usually sold to the patients, who in most cases, cannot afford the costs.

#### 5.6 Assessment of the political environment for programming

The local government was found to be concerned with the problem of AIDS in the locality. However, the absence of commitment from the politicians was identified as a problem by the primary health care officials interviewed. Health issues were seen to rank lower than political and infrastructural policy areas. The local government has neither HIV/AIDS budget nor policy. There has been one public

enlightenment for the general population earlier in the year 2000. The budget for this intervention N26, 000.00 and it consisted of mounting loud speakers on 4 vehicles to spread the message of HIV/AIDS prevention to the general public.

Cholera was identified as the major health problem over which the LGA had developed interventions to address. There is no AIDS Action Manager at this Local government, however, the Epidemic Control Committee is charged with the responsibility for AIDS prevention in the LGA. While there is no LACA in this local government, the primary health care staff were aware of the existence of NACA and were looking forward to the establishment of SACA.

It was explained that one of the difficulties of carrying out AIDS interventions in this local government is that the Directorate for Local Government Affairs which is responsible for conveying Federal Allocations to the Local governments, does not recognize a separate budget line for this area of activities. It was felt that support from international development agencies such as FHI would contribute towards redressing the constraints of the local government. With a staff of 305, the local government primary health staff is the largest amongst departments in the LGA. Significantly, there are many female members of staff as well as several persons from various ethnic groups at both the political and bureaucratic levels in the LGA.

## 6.0 Nassarawa LGA

Nassarawa Local Government was carved out of Kano municipal. It has the following wards - Brigade, Badawa, Kawo, Gwagwarwa, Tudun Wada, Tudun Murtala, Dakata, Kawaji, Kaura Goje, Gama, Giginyu, Hotoro, North and South. This LGA has the second highest population density after Kano Municipal with a population size estimated at a little over a million inhabitants.

The LGA has neither HIV/AIDS budget nor policy and its officials had not seen the national policy on HIV/AIDS. No data was found on HIV prevalence. Although the assessment team learnt that the LGA was deeply concerned about HIV/AIDS, there are no structures in place for responding to the epidemic, hence, HIV/AIDS activities are hardly

implemented by this LGA. A key informant in the LGA could only recall a one-off HIV/AIDS lecture by the PHC Coordinator for staff enlightenment. Save for this one-off lecture by the PHC Coordinator, HIV activities initiated by the LGA are virtually non-existent. Cholera was identified as the health problem over which the LGA had done some investigations to determine its prevalence.

Apart from the government officials, traditional and religious leaders were identified as key gatekeepers in the LGA strategy for the success of HIV/AIDS interventions. The response of the key informants suggested to the assessment team that the local government had not received any previous direct donor support but that it was willing to collaborate with Family Health International or other agencies to implement HIV/AIDS programs.

#### 6.1 identification of risk settings and behaviors

Nassarawa is a cosmopolitan LGA with many risks settings. It is a commercial center with about six active markets and several motor parks. The major markets are Dakata grain market, Gwagwarwa market and Yan Kaba vegetable market. After Fagge LGA, Nassarawa generates the second highest revenue to the Kano State government. It also has multi-ethnic populations such as Hausas, Fulanis, Ibos, Yorubas, Arabs, Nigeriens, Malians, Ghanaians etc. Nassarawa LGA has several primary and secondary schools.

This is in addition to a large pool of for-profit private sector establishments in the formal economic sector, which account for a sizeable proportion of the workforce in the metropolis. Most workers in Nassarawa work in industries as this LGA has the highest concentration of industrial enterprises including construction companies. Other industries include tanneries, textile manufacturing companies, edible oil and flour processing companies and plastics manufacturing companies. The Bompai Industrial Estate in the LGA is one of the original industrial sites in Kano State predating the now famous Sharada Industrial Estate. The Government Reserve Area, GRA, is estimated to occupy a relative small section of the Kawo and Hotoro wards of the LGA, with areas such as Brigade and Gama being core working class areas with a non-conformist sub-culture. The Badawa area which is close to the Government Reservation

Area (GRA) in Kawo ward is known as a notorious hide-out for criminals and 'free women'.

The plural ethnic groups and settler populations alongside ongoing social interactions amongst the diverse populations were factors identified as being capable of making people inculcate behaviors that predispose them to HIV infection.

### 6.2 Identification of risk groups

Key informants also identified risk groups in the LGA. These include in-school and out-of-school youth, especially the unemployed youth. In addition, vulnerable women (married and unmarried) were identified as at-risk population.

### 6.3 Identification of potential implementing partners, networks and structures for prevention and care and support

There are three dominant types of Civil Society Organizations (CSOs) in Nassarawa LGA – the Community Based Organizations (CBOs), youth clubs and social clubs. The CBOs are mainly cultural organizations found in the settler communities in the LGA. The Tiv Association, Yoruba Association, Ibo Union, Auchi Association, Badawa Youth Association are examples of CBOs in the LGA. Most of these CBOs have restricted memberships having been formed by settler ethnic groups that found the need to bond together in the area. The social clubs and trade associations on the other hand have relatively open memberships. The Gama Youth Association and Gama United (a football club) fall in this category. There are also other associations established along occupational lines. Examples include Traditional Birth Attendants, Traditional Barbers, Traders Associations and trade unions.

Although the CBOs are active in the communities, they are not involved in HIV/AIDS. They however possess appropriate structures that can be enhanced through capacity building and effectively deployed for HIV/AIDS interventions in the communities. Key informants believe that these CBOs can be used to effectively penetrate the communities with relevant and appropriate HIV/AIDS information.

#### 6.4 Identification of health and social welfare systems and structure

In Nassarawa LGA, there are four hospitals, one of which is a tertiary health facility. These hospitals are Mohamed Abdulahi Wase Specialist Hospital, Sir Mohammed Sanusi Hospital, ECWA Hospital and Ahmadiya Hospital. The last two are mission hospitals. Apart from these, there are 16 other health facilities. These include three health clinics, two dispensaries, one maternal and child health clinic, and ten health posts. There are also numerous private health facilities within the Nassarawa LGA. The assessment team visited the Mohammed Abdulahi Wase Specialist Hospital. This hospital doubles as both tertiary and secondary health care facility. The hospital is a 218-bed facility with 17 doctors and 143 nurses. It serves the entire state and neighboring states such as Niger and Chad. The catchment area of this facility in terms of population is 15 Million. It receives referrals from private, primary and secondary health care facilities within and outside the state. This hospital in turn refers cases to the University Teaching Hospital in Kano.

The Wase Specialist Hospital started seeing suspected AIDS cases in the early 1990s. Ever since, there has been consistent increase in the number of cases seen in the hospital. On the average, ten AIDS cases are seen on a monthly bases. The hospital does not have the national HIV policy guidelines. They do have an unwritten policy guideline for handling patients who attend the hospital. HIV testing services are rendered in the hospital with test reagents supplied by government and purchased-locally. Pre and post – test counseling services are offered to patients. Diagnosed TB patients are treated in the hospital.

STD services are rendered with etiological approach to management. An increasing number of STI cases are seen on the average monthly. For obvious reason of religion, condom was not discussed. The main constraints with STI management in the hospital are:

- Inadequate drugs
- Test equipment
- Capacity building

There are no care and support structures in the LGA. Cases seen are often referred to the Infectious Diseases Hospital which is seen

as the only hospital where such cases should be treated. There are no NGOs in the LGA providing community home-based care. The Society for Women for Women and AIDS in Nigeria (SWAAN) is the only group providing community home-based care in area. Apart from SWAAN, the only other group providing some form of home based care is the network of PLWHA which is known as COPOP. Both organizations currently receive support from Family Health International/IMPACT.

#### 6.5 Assessment of the political environment for programming

There was a high level of receptiveness to the prospects of working with international development organizations. No other international development organization had visited this LGA prior to the FHI visit and there was a great appreciation of the FHI discussions. Despite this level of acceptance, however, there is an apparent low level of awareness of HIV/AIDS programs and issues among policy makers in the LGA. Policy makers in the LGA continue to see HIV/AIDS as a health problem and believe that the prerogative to develop health initiatives remains that of the health unit. Because the health unit too has not fully come to terms with the need to articulate broad based HIV/AIDS programs to serve the diverse populations in the LGA, budgetary allocation and support for HIV/AIDS is often buried under the omnibus health budget.

#### 6.6 Observations

It is apparent that the LGA requires help in developing a strategic plan to articulate an effective response to the epidemic. The first step is to sensitize policy makers in the LGA to appreciate the issues and challenges involved in HIV/AIDS programming. The CBOs have very important roles to play in HIV prevention and care in the LGA and they need to be sensitized in this direction. The CBOs also require capacity building to enable them take on the challenges of intervening appropriately for HIV/AIDS prevention and care in their communities.

Access to quality STI services is still a problem in the LGA. Syndromic management is not popular as a method for providing quality STI services and health workers will require training to acquire syndromic management techniques.

## 7.0 Tarauni LGA

Tarauni LGA was created in 1997 at the same time as the Fagge local government. There are 10 wards in this local government. Relative to the other local governments in Kano State, this local government is small in population and size. Most of the population of this area have relocated from other local governments in the Kumbotso, Dala, Gwale, Municipal areas due to population pressures and relocation for road construction in the 1980s. There are only 3 key original settlements in this area. There is only one main market in this LGA, the Tarauni market. Similarly, there is only one major motor park in Unguwa Uku where passengers go to and arrive from several different cities in Nigeria.

With no major industries and with most workers who reside in this area working in other local government areas, Tarauni is amongst the lowest income generating LGAs in Kano State. Youth unemployment, drug abuse, a thriving industry of black market petrol sellers and resident commercial sex workers characterize this LGA.

### 7.1 Identification of risk factors and behaviors

The risk factors in this LGA are urban poverty, unemployment, and lack of economic opportunities in the community.

### 7.2 Identification of risk groups

Risk groups include youth, commercial sex workers, the unemployed, and drug abusers.

### 7.3 Identification of potential implementing partners, networks and structures for prevention and care and support for PLWAHs

In this LGA there are trade based associations, Islamic associations, women's micro credit associations and a few NGOs. None of these associations are involved in the care and support. However, one NGO – AHIP is involved in prevention interventions targeting adolescents in particular.

### 7.4 Identification of health and social welfare systems and structures

Most of the health facilities in this LGA are either privately owned or are public primary health posts.

### 7.5 Assessment of the political environment for programming

It is difficult to determine the political environment for programming in this LGA as the Assessment Team was not able to secure an interview.

#### GENERAL OBSERVATIONS

The following are general observations from the rapid assessment:

- Kano is a cosmopolitan town with numerous risk settings for HIV/AIDS programming. These include huge and diverse ethnic populations, cosmopolitan urban centers, active center of commerce, transport workers, large army of unemployed youth, large number of local barbers (local surgeons) and traditional birth attendants who use unsterilized skin piercing instruments and deviant male youth gangs who engage actively in commerce. It is a university town with a large presence of adolescents. In addition, the presence of uniformed services (Police, Military, Immigration etc) and mobile markets where a lot of sexual networking occur also add to the risk settings.
- HIV/AIDS is a major concern to policy makers and key influentials against a background of rising profile of HIV infection and AIDS cases in the State. It is believed that about 250,000 persons now live with HIV in the state. About half of those interviewed knew someone who had died of AIDS
- STIs and TB are major health problems with 3 to 5 new cases being diagnosed per week in secondary health facilities
- Although STIs are well recognized as co-factors in the transmission of HIV, quality STI services are not available and accessible to a large number of people in need of such services. Health workers recognized the need for capacity building in the areas of HIV/AIDS/STIs counseling and skills acquisition for syndromic management of STIs
- Patent Medicine Dealers (PMDs) who remain the first point of contact for most people seeking medical care, need to be targeted with adequate and relevant information on HIV/AIDS

- The absence of anti TB drugs and dilemma about how to access anti TB drugs were seen as major problems
- Patients often die due to the reluctance of people to donate blood. This reluctance on the part of potential blood donors is fuelled by the fear of knowing their HIV sero status
- Government's expressed willingness at the state and LGA levels to fight the epidemic is not matched with corresponding financial support. HIV/AIDS budget at the state level is paltry and hardly ever released while non of the LGAs visited had ever had a separate budget or programmed HIV/AIDS activities
- Policy makers in the local government need to be sensitized to enable them respond appropriately to the epidemic. National policy on AIDS had not been seen in the LGAs visited and non of the key informants in the LGAs knew about NACA
- While most informants agreed that collaboration was imperative as AIDS was real, they pointed out that all interventions must conform with the culture, religion and practices of the people of Kano State
- The support/endorsement of traditional and religious institutions are critical to the success of any HIV/AIDS intervention in Kano
- State functionaries and NGOs were mutually suspicious of each other with regards programming for HIV/AIDS
- Policy makers and religious influentials continue to view donor funds for development projects with deep-seated suspicion. Some key informants distinguished between 'political AIDS' and 'development AIDS,' the former being euphemistic reference to donor support projects planned and implemented using the top-bottom approach while the latter refers to donor supported projects that empowers the people to plan and implement taking into account their community realities

## RECOMMENDATIONS

The assessment team came up with the following recommendations:

- It is the consensus of the assessment team, based on the findings from the field, that Kano should be targeted with a comprehensive program package. The Kano environment was found suitable for a comprehensive program which should focus on work with transport workers, vulnerable women, youth and men in the workplace, religious groups, STIs and care and support
- The traditional and religious institutions were found to be indispensable constituencies that must be carried along to fashion out effective and acceptable program strategies
- Members of the Council of Ulama should be sponsored to Senegal, an Islamic environment that shares a lot in common with Kano, to understudy the role of the Ulama there in HIV/AIDS prevention and care. The trip should be undertaken before project planning and proposal development
- Similar visit could be arranged for ISMA group to Uganda to understudy the very successful IMAU project with a view to adapting it in Kano
- There is a need to develop and strengthen care and support structures, STI and clinical services
- Orphans and vulnerable children should form a major component of any care and support initiative
- Care and support interventions should link projects with sources of anti-TB drugs which are not easily available in Kano
- Strong consideration should be given to the idea of setting up VCT sites and especially provide marriage counseling in relation to HIV and AIDS
- There is a need to integrate HIV/AIDS into key state wide programs of unions and associations

- Health practitioners from the key health facilities in Kano – tertiary, secondary and primary should be trained in syndromic management of STDs
- The Nigeria Medical Association should be carried along in plans for the training of healthworkers in syndromic management of STDs

The chart below provides an overview of potential partners for both prevention and care in the three LGAs

Target Groups	Nassarawa LGA	Fagge LGA	Tarauni LGA
	<i>Potential Partners</i>	<i>Potential Partners</i>	<i>Potential Partners</i>
Vulnerable Women	Ansarudeen	Ansarudeen	Ansarudeen
Youth In-School	NUT; MOE	NUT; MOE	NUT; MOE
Youth Out-of-School	YOSPIS	YOSPIS	YOSPIS
STIs	NMA; Government Structures; Private Health Facilities	NMA; Government Structures; Private Health Facilities	NMA; Government Structures; Private Health Facilities
Faith based	MSO; ISMA	MSO; ISMA	MSO; ISMA
Care and Support	SWAAN; COPOP; ISMA; Govt. Structures; NMA; Private Health Facilities	SWAAN; COPOP; ISMA; Govt. Structures; NMA; Private Health Facilities	SWAAN; COPOP; ISMA; Govt. Structures; NMA; Private Health Facilities
Workplace	NLC	NLC	NLC
Uniformed Services	AFPAC; PACC	AFPAC; PACC	AFPAC; PACC
Transport Workers	NURTW	NURTW	NURTW

## APPENDIX: LIST OF PERSONS INTERVIEWED

ORGANIZATIONS VISITED	PERSONS CONTACTED	DESIGNATIONS
<b>GOVERNMENT STRUCTURES</b>		
<b>Ministry of Health</b>	Dr Mansur Kabir	Hon. Commissioner
	Alh. Umar Faruk Usman	Perm. Secretary
	Dr Dayyabu Mohamed	Director PHC&DC
	Dr M. S. Ado	MD Zone One
	Dr Sulaiman Abdulahi	Coord. SACP
	Sani Tanko	PRO
<b>Ministry of Education</b>	Alh. Ahmed Idris	Director sch. Mangd.
<b>Ministry of Women Aff. &amp; Social Dev.</b>	Alh. Idi Usman Dan Fulani	Permanent Secretary
	Ibrahim Abdulhamid	Director Adm & GS
	Maryam Mohamed	Press Secretary
<b>Ministry of Information</b>	Alh. Sule	Director Information
<b>LOCAL GOVERNMENT</b>		
<b>Nassarawa LGA</b>	Tijani Ibrahim Kura	Secretary
	Dauda Garba Abbas	Coordinator PHC
	M. T. Nadabo	M & E Officer
<b>Fagge LGA</b>	Alh. Wada Hassan	Deputy Secretary
	Ado Musa	PHC Coordinator
	Mairo Abdullahi	MCH Coordinator
<b>HEALTH FACILITIES</b>		
<b>M. A. WASE SPECIALIST HOSP.</b>	Dr Suleman Sani Wali	CMD
	Dr Mohamed Shehu	Deputy CMD
	Alh. Wali Usman	Chief Lab Scientist
	Alh. Awulu Abdulahi	Chief Pharmacist
	Mrs Alambas	ACNO
<b>INFECTIOUS DISEASES HOSPITAL</b>	Dr Sani Ado Jibril	CMD
	Dr Abdullahi Suleiman	Coord. SACP

M. M. Sp. HOSPITAL	Dr Yanusa Adamu Dangwani	CMD
Council of Ulama	Alhaji Muzzammil Sani Hanga	Member
	Alj. Babangida Ahmed	Member
	Sheik Umar Kabo	Chairman
	Dr Sulman Sani Wali	Member
	Sheik Alkali Idris Kuliya	Chief Imam of Kano
NGOs/CBOs		
Ansarudeen Nurses & Midwives Association.	Aduke Fatimah Olabode	Vice Chairman
	Maryam Rilwan	Member
	Hadiza Haliru	Member
ISMA	Dr Sagir Saleh	Member
	Dr Muhd Muktar Hamza	Member
YOPSIS	Aminu G. Magashi	Exc. Chairman
	Yahaya Ibrahim El-Yakub	Member
MSO	Kilishi Sanusi	Program Officer
	Rukayya Ibrahim	Propagation Officer
	Hafsatu Isma	..
	Asman Yahaya	PRO
	Sadiya Adamu	Amirah (President)
	Hasiya Musa	Assist Da'awa
	Amina Ahmed	..
NLC	Amin Tafida	State Chairman
	A. A. Getso	Ag Secretary
	A. M. Matawalle	Vice Chairman
	Myop Ibrahim	Ass Secretary
	Garba Ayo	Member
	Amina Sami	..
	Salamatu Mohammed Sarki	
	Emmanuel Richard	Ass. Secretary
	Mohd Idris Usman	Member
	Samuel S. Sani	Organizing Secretary
COPOP	Bashir Lawan	
	S. Bada	
	Hussani Garba	
	Danjuma Adamu	

	Abdul Fatahi Mohamed	
	Abdul Fatahi Rukayat	
	Halima Abdullahu	
	Yayaha Allamdu	
	Simon Ogbole	
	Grace Ogbole	
	Juliana Emaikwa	
	Christiana Emaikwu	
	Niama Yahaya	
	Sadiq Abdulahi	
	Aminu Bagaya	
	Joseph Neya	
	Paul Nze	
	Junior Nze	
	Aishat Yahaya	
	Hajara Bashir	
	Mohamed Sabiu	
	Aishat Yau	
<b>SWAAN KANO</b>	Hadiza Babayaro	Member
	Hafsat Kolo	..
	Jamila Hahaya	Chairperson
	Aishatu Mustafa	Member
	Fatima Aluned	Member
	Fatima Sanigwazo	Member
	Aishatu Lawal	..

FHI/NIGERIA  
 RAPID ASSESSMENT TOOLS  
 Key Informant Interview Guide

### Government Response

- Ongoing efforts
- Ongoing collaboration-
  - With donors/international agencies
  - With NGOs/CBOs
    - Acceptability of donor support*
- Ongoing Program with women, youth, poverty alleviation, microenterprise and child welfare
- Presence of structures
  - Are there any community health workers here – TBA, CHOs etc.
  - AIDS Committee at state level
  - State AIDS Coordinator
  - AIDS Action Manager
  - Integration of AIDS into PHC
  - Number of schools – secondary, tertiary etc.
  - Economic activities (any major employers)
- Awareness of NACA and other state multi-sectoral structures (is there a state HIV/AIDS policy or do they have access to policy papers)
- Perceived effectiveness of existing structures (regular meetings, activities etc)
- Budgetary allocations, released and actual expenditure related to HIV/AIDS
- Felt need for HIV/AIDS programs
  - Other areas of priority
- Socio-cultural/religious issues and concerns

### HIV/AIDS/STI RISK SETTINGS

- Risk behavior – what kind of behaviors/activities that you have seen that make people vulnerable/susceptible to HIV?
- What in your own opinion constitute the greatest risk behavior that facilitates HIV/STI transmission in this state/LGA/community?
- What do you feel is the risk for HIV in this community OR what is the perception to be the risk in this state/LGA/community?
- What are the geographic areas where risk behaviors take place?
- Community mobilization around the issue of HIV/AIDS

- What are the opportunities for HIV/AIDS prevention and care programming in this community?
- What do you think is an effective way to handle the HIV/AIDS situation in this community?

#### ASSESSMENT OF CIVIL SOCIETY ORGANIZATIONS' POTENTIAL FOR BEHAVIOR CHANGE INTERVENTIONS.

1. Experience in community development and HIV/AIDS activities
2. HIV related programming experience
3. Relevant local/state/regional experience
4. Collaboration
  - Are there other organizations working in HIV prevention & care
  - Is there any networks of local NGOs in community development & HIV
  - Any linkages/referral systems with other service providers in the area (health service, spiritual service, micro-enterprise, education etc)
  - Perception of work with other NGOs
  - Perception of work with government
5. Do you use any communications materials
  - What materials are you using
  - What is the most effective channel of communications of communicating to your target group
6. Where are you currently getting your funding for programs
7. Where do you refer people for services
8. Relevant administrative/managerial resources and expertise
  - What is the organizational structure - is there an org. chart?
  - Do you have a bank account
9. Access to personnel and other resources
  - What is your membership - how many voluntary and how many full-time paid staff
  - Access to communications - telephone, fax, email

## CARE AND SUPPORT

### Overarching Impression Discussion Points

To be discussed by each site team before deployment and at debriefing meeting

State HIV prevalence rates                      MC name        ..... OMC name  
.....

1. High risk groups Locations and size: FSW, Truckers, Migrant men. At risk youth, Informal settlements
2. Who are partners in HIV broad comprehensive Care and Support, public, voluntary and private and what are they doing?
3. Patient load/demand for Care and Support? Change over time? In each level of care from state to primary.
4. Potential for learning site to be established. E.g., nursing training college, care partners, etc. within a site (LGA).
5. Home based care (professional support for illnesses) demand for terminally/chronically ill.
6. Get a sense of what the burden of HIV/AIDS epidemic is (through mortality estimates in general and TB patients).

### Health Care Structure

How many of the following are in the LGA?

- Government Hospitals.....
- Teaching Hospitals (qualify Gov.)....
- Mission Hospitals.....
- Private Hospitals.....
- Public Health Centres.....
- Public Health Clinics.....
- Church and religious clinics.....
- Private Sector providers .....
- NGO clinics.....
- CBO clinics.....
- Traditional medicine practitioners.....

- Are there community health workers in the area?

## Health Facility

What is your position designation.....  
What are your primary duties.....  
What kind of Health facility is this .....  
How many in-patient beds are there .....

What is the geographical catchment area of this facility.....  
What is the catchment area of this facility in population.....  
How many doctors in this facility .....  
How many nurses in this facility .....  
How many CHO/CHEWs in this facility.....

Who refers patients to you:

Who do you refer patients to (name if possible):

Teaching hospital.....  
Federal Medical Centre.....  
Specialist Hospital.....  
General Hospitals .....  
Primary health care Centres.....  
Primary health care Clinics.....  
Village health workers .....  
Church and religious clinics.....  
Private Sector providers .....  
NGO/CBO clinics.....  
Traditional medicine practitioners.....

Are there community health care workers attached to health facilities

When did you start seeing suspected AIDS cases.....  
Has there been a gradual increase of suspected AIDS cases.....  
Have there been periods of rapid change (more or less).....  
How many suspected AIDS cases do you see each week .....

Do you have a copy of the National HIV policy guidelines?.....  
Can we see which version you are using.....  
Do you have your own HIV policy .....  
Can we see it?.....

## Specific technical areas

### VCT

Do you do HIV testing in this facility – where do you get your supplies

Do you send patients for testing – where.....

What happens to those who test positive.....

Are they told their results.....

Do you have HIV counseling services.....

Who trained your HIV counselors - what curriculum was used,  
when.....

- not active but planned – where , when will they open, who will be in charge.....
- Do you have linkages with other Care and Support activities and services.....

### Home based care (professional support for illnesses)

- Describe HBC activities
- Describe the structure of home based care staff/teams....
- demand for terminally/chronically ill care .....
- Describe composition and types of services provided and length of time have been active (e.g. terminally ill vs. HIV only, TB incorporated, linkages to clinical care.)
- Linkages with other Care and Support activities and services.....
- Linkages with prevention activities.....

### PLWA groups/networks

- Are there any PLWA groups - name, location, who is in charge.....
- not active but planned.....
- Describe composition and types of services provided and length of time have been active (e.g., advocacy, support, peer education etc.) .....

### MTCT

- Any MTCT interventions – what? .....

### OVC

- When children do not have their immediate parents who takes care of them?
- Do you suspect any changes in extended families ability to take care of their relatives children? Briefly describe.
- What type of impact has HIV/AIDS had on children.....



How many STDs in adult males			
Male urethral discharge			
Male genital ulcer			
How many STDs in adult females			
Female urethral discharge			
Female genital ulcer			

Who refers patients to you:

- Teaching Hospital
- Federal medical centre
- General hospital
- Health Centre
- Private clinic
- NGO clinic
- Self-referral
- Other

Specify .....

Where do you refer difficult STD cases to .....

What type of diagnosis do you base your treatment on?

- An etiologic diagnosis such as gonorrhoea or syphilis?
- A syndromic diagnosis such as urethral discharge or genital ulcer disease?

Etiologic =1

Syndromic =2

Both =3

Do you have a microscope in this clinic? Y  N

Do you perform HIV testing in this clinic? Y  N

What is the name of the test .....

Do you tell the patients the results Y  N

Do you counsel patients on the meaning of the results Y

N

Do you send your STD patients (or specimens) to another facility for laboratory investigations? Y

N

Where .....

DO you keep a supply of condoms in this clinic? Y  N

ASK TO HAVE ONE Y

Do you provide condoms to your STD patients? Always   
Sometime   
Never

Do you provide instructions to your patients on how to use condoms? Always   
Sometimes   
Never

Do you follow any specific treatment guidelines in your management of STD patients? Y  N

IF YES, which? .....

Have you received a copy of the STD treatment schedules recommended by the National AIDS and STD Control Programme?

Y  N

Verified Y  N

What are the main constraints on your work with STD?

.....  
.....  
.....

Health Care Facility Data

We would be very grateful for the following information, if it is available:

Hospital admissions and clinic attendance			
	1997	1998	1999
Medical admissions			
Surgical admissions			
Paediatric admissions			
Adult male outpatient attendance			
Adult female outpatient attendance			
Paediatric outpatient attendance (under 5)			
How many TB cases (all forms) were recorded			
How many smear positive pulmonary TB cases were recorded			
How many smear negative pulmonary TB cases were recorded			
How many extra pulmonary TB cases were recorded			
How many smear positive pulmonary TB cases completed their TB treatment			
How many smear positive pulmonary TB cases died before completing their TB Rx			
How many smear positive pulmonary TB cases were lost to follow up			

If this intervention is not available until later, please leave a copy of this form with the Health Care Facility. It should be returned to:

Family Health International  
 18a Temple Road  
 Ikoyi  
 Lagos.