

**UNDP Global INNOVATION FACILITY FOR
RESULTS COMMUNICATION FOR KEY
AFFECTION POPULATION**

**Project title: Scaling up key population
access to Treatment, Care and Support
Services using social communication
system.**

By:

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Final Narrative Report

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Project background

In Nigeria, HIV disproportionately affects a number of high risk populations. A modes of transmission (MoT) study conducted by the Government of Nigeria in 2009 found that high risk populations, namely, female sex workers (FSWs), men who have sex with men (MSM), and injecting drug users (IDUs) account for 23% of new infections, though they comprise only 1% of the population. Moreover, these high risk populations and their partners will account for 40% of new infections, and new research indicates that this figure may actually be well above 50%. These estimates are not surprising, given that HIV prevalence among brothel-based FSWs is 37.4%, and 30.2% among non-brothel-based FSWs, 13.5% among MSM, and 5.6% among IDUs (Integrated Biological and Behavioral Surveillance Survey, IBBSS, 2010).

This national HIV prevalence for key populations makes provision of HIV prevention, treatment, care and support services to the community a top priority. This priority is further heightened by the fact that key populations also engage in sexual relationship with the general population thereby serving as a bridge between their community and the general populations. Given the current unfavourable legal environment that has criminalized association with MSM simply implies that ongoing work within the community may be ground to a halt if innovative strategies are not adopted to engage the community in HIV prevention, treatment and care programme.

A recent publication of the Population Council on the public health impact of anti-LGBT Laws in Africa did show evidence that number of MSM reached with HIV prevention information and educational sessions in Nigeria by Population Council dropped from 1100MSM in 2013 to zero after the passage of the law in January 2014; as the peer educators began to resign and participants became harder to reach. This further supports the need for innovative communication strategies to provide HIV prevention information and educational sessions to the key population and also link them to friendly centers to access reproductive health services.

This project therefore plan to adopt an innovative approach to communicate information to key populations (MSM and FSW) in the two municipalities where the Lagos Municipal Action Projects are currently being piloted. This will significantly bridge the current gaps created by the unfriendly legal environment with its negative impact on access to HIV information and care services. The Lagos Municipal Action project inaugurated a technical working group that comprises of CSOs working with key populations, and representatives of the municipal authority and they have the mandate to deliver the set goals of the municipal action plan. This project will therefore provide a platform for the Technical working group to adopt the innovative communication strategies to reach out to the MSM and FSW communities within their constituencies.

Description of Project

The purpose of this project is to create awareness on HIV and existing prevention, treatment and care services for key populations (MSM and FSW) and youths in Ikeja and Shomolu LGs of Lagos State, contributing to the Lagos Municipal Action Project strategic objective 2. Scale up Treatment, Care and Support Services for MARPs by (Strategy 2.2) Strengthening capacity of peer led organisations to scale up existing services targeted at key populations most at risk of HIV exposure.

Specific objectives:

- To equip at least 250 key populations (MSM, FSW and youths) with basic HIV information and education including education on existing and new biomedical HIV prevention tools - condoms and lubricants, post exposure prophylaxis – using social communication systems (WhatsApp, text messages and black berry messages)
- To link up key populations, their networks and Groups with existing reproductive health services clinics that provides access to condoms and lubricants, post exposure prophylaxis and HCT in the target local governments (LGs) (MARPS friendly clinics in Shomolu and Ikeja LGs) and HIV treatment clinics at the state level using social communication systems (WhatsApp, text messages and BBM)
- To document and assess the impact of the project on key population HIV knowledge and access to prevention, treatment and care services.

Description of the target population involved in the project

Target Population Involved in the Project include

Female sex workers (FSW): For the purposes of this project, a FSW, both brothel and non-brothel-based is defined as any female 15 years and above who receives money or other valuable gifts/incentives in exchange for sexual acts in areas such as brothels, bars, restaurants, night clubs, hotels, or on the street. For this project, 5 FSW peer educators were engaged in the dissemination of low literacy HIV information materials to the peers. Inclusive among the peer educators for this project include PLHIV that is living open with the status and a youth. Each of the peer educators build a cohort of minimum 10 peers to reach out with HIV information.

Men who have sex with men (MSM): For the purposes of this project, an MSM is defined as any male 18 years and above who has engaged in sexual activities with other men. This target group is considered to be at a higher risk of contracting and transmitting HIV because of the elevated biological risk of HIV transmission through unprotected anal sex, multiple partnerships, and the potential for riskier sexual behaviour due to the stigma and discrimination attached to male-to-male sex and the recent criminalization of the same sex marriage further heighten their HIV risk. For this project, 5 MSM peer educators were engaged in the project and each peer educators build a cohort, minimum of 10 MSM to reach out with HIV information using social media.

Description of the project partners

The Project partners include:

New HIV Vaccine and Microbicides Advocacy Society (NHVMAS): Is the lead partner for this project. NHVMAS is a non-governmental organisation established in 2003 and incorporated in 2008 with the National Cooperate Affairs Commission. It is a coalition of stakeholders invested in HIV prevention research and development. These include community advocates, community members, researchers, policy makers, ethicists, medical doctors, nurses, students. Its activities are all tied together specifically to promote and support research, development and future access of Nigerians to New HIV Prevention technologies in a cost effective and timely fashion. It is in an attempt to achieve this goal that NHVMAS identified MARPS as a critical stakeholder as New HIV prevention technology researches would often engage populations with high HIV incidences for HIV prevention trials. Also, because of the communities' high HIV incidence, the chances of their engagement in HIV treatment trials as PLHIV are equally high. As a community watchdog, NHVMAS feels it as an ethical imperative to therefore address the need to build the capacity of these communities to engage with research in ways to ensure they benefit from the planned trials so it addresses their HIV prevention and treatment needs. It has therefore engaged in multiple activities over the years to address this goal. New HIV Vaccine and Microbicides Advocacy Society is one the key members of the Lagos Municipal Action Project TWG.

The Ikeja and Shomolu Municipality- These are the two local governments in Lagos State that worked in partnership with UNDP, UNFPA and other partners to develop the Lagos Municipal Action Plan on HIV for the key populations and currently, the Lagos Municipal Action Project are currently being piloted. The provided the needed municipal authority leadership and support for the implementation of the activities of the UNDP innovative facility grant.

The Lagos Municipal Action Project Technical Working Group and other participating CSOs: The Lagos Municipal Action Project on HIV and Key population Technical Working Group is a group of stakeholders comprising of the seven CSOs working with key populations (MSM and FSW), the Medical Officer of Health of the Ikeja and Shomolu municipal authorities, the representatives from the Lagos State Ministry of Justice and Ministry of Women Affairs. The group has the mandate to improve the quality of HIV prevention and treatment services for the MSM and FSW in Shomolu and Ikeja LGs through advocacy, resource mobilization and support for the implementation of the Municipal Action Plan on HIV and the key population.

DESCRIPTION OF THE PROJECT DELIVERABLES

Technical Working Group/project planning meeting: The planning meeting was held on the 11th of November, 2014 at the Ikeja LG secretariat. It helped the TWG members to familiarise on the project objectives and draw up an action plan for the implementation of this project. At the meeting, the dates and process for the conduct of the project activities was defined. The method for mobilization of the key population for the project was also defined. There were several other deliberations on the Lagos Municipal Action Project and how strategies to address the HIV needs of the key populations were explored. (For the full report of the meeting, copy the link: <http://www.nhvmas-ng.org/website/reportcontent.php?pubid=85>)

Community consultation on result communication: The community consultative meeting was held on the 14th of November, 2014 at the Ikeja LG secretariat. It helped to familiarize the community of the project objectives, facilitate open dialogues on community HIV issues and concerns that must be integrated into the project. One key outcome of the consultation was the identification of the peer educators that would be engaged in the project and familiarize of the community the friendly health facilities in Ikeja and Shomolu LGs. (For the full report of the meeting, follow the link: <http://www.nhvmas-ng.org/website/reportcontent.php?pubid=>)

One day Training workshop for LGBT and FSW Peer Educator: The one day training took place in Ikeja LG secretariat on the 18th of November, 2014; and had 11 peers educators in attendance and four members of the TWG that facilitated the training. The training sites for this project help to bring the key populations closer to the municipal authority and also help in advocacy for the municipal response to HIV needs of key population.

NHVMAS adopted the training tools it developed in 2010 and 2011 to implement the training. In 2010/11, NHVMAS worked with ICAD, Canada and SAT, South Africa to develop a training toolkit that will enable CSOs and key population gatekeepers to understand HIV and new prevention technology. Resource materials from other partners were also used to deliver the training. The training contents include: Basic facts on HIV and AIDS, Existing HIV prevention tools, Condoms and lubricants safety and New Biomedical HIV prevention tools. The workshop was delivered using participatory approach, including PowerPoint presentations, plenary discussions, brainstorming, demonstrations and experience sharing. The training also allowed for multiple questions and answer sessions to help clarify myths and misconceptions.

The pre- and post-test assessments showed that participants' knowledge and skills improved significantly after the training ($p < 0.0006$). (For the full report of the meeting, follow the link: <http://www.nhvmas-ng.org/website/reportcontent.php?pubid=84>)

Development and dissemination of simple HIV information and education series: NHVMAS through consultation with the community and the TWG, developed simple (low literacy) HIV information and education material. The content covered include: Basic facts on HIV and AIDS, HIV and STI, Human sexuality- Anal, vaginal, oral sex and associated HIV risk, Existing HIV prevention tools, Condoms and lubricants access and safety, HCT, New biomedical HIV prevention tools, HIV treatment where to access services, HIV treatment literacy and adherence. The information was shared daily using innovative communication approach- What asp, text messages and face book among the peer educators and their peers. (See appendix 1 for the tool).

Social media communication: The social communication was led by the Project Coordinator and the trained peer educators. The peer educators received HIV information extracted from the developed HIV information and education series daily using sms, whatsApp and the same information was disseminated to the peers on the network of each of the peer educator using facebook, sms, and whats App. The sms sent included the contact phone numbers where HIV prevention and treatment services can be obtained. The peers continue to engage in communication with the peers and questions or clarifications that they could not provide answers to are referred to the group for discussion. Each of the peers has a minimum of 10peers on the network. A total of xxxx peers are directly reached on the project.

Equipment and infrastructural support: The project supported the procurement of three telephone handset that was deployed for the dissemination of the HIV information. The handset was handed over to the peers with the anchor organisations providing supportive supervision to ensure the tools are used for the purpose it was procured.

Monitoring meeting: There is ongoing technical monitoring of the peer educators on the project, this includes follow up via telephone calls to ensure the messages sent out are received and disseminated to the peers. Challenges are addressed. However, the end of the project monitoring and evaluation meeting that will bring together the peers and selected project beneficiaries will be held on the 22nd of December 2014.

Below are some of the feedbacks:

Some of the peers on the network showed enthusiasm to share the information to other peers and they were encouraged to do so and refer back to the peer educator for any support.

MSM living with HIV are worried and asking what the Nigerian government is doing about the MSM that are HIV positive. They were reassured of the available support for MSM living with HIV and information on MARPs Friendly centres was shared.

Project outputs, lesson learned, next step and conclusion

Key project outputs

- 11 MSM and FSW peer educators knowledge and skills on HIV and AIDS built and empowered to share information among peers
- 11 Peer educators developed minimum of 10 peers whom they provide HIV prevention and treatment messages
- At least 200 MSM, FSW and youths have continued and sustained access to HIV prevention and treatment education, directly from the peer educators.
- Increased number of key populations (MSM, FSW and Youth) who have information on where to access HIV services and the MARPs friendly clinics in Shomolu and Ikeja LGs of the state reproductive health outlets.
- Simple low literacy HIV education and information materials developed for sustained dissemination of HIV information to the peer educators.

Lesson learned

- The peer educators are fascinated with the project initiative especially the empowerment that enables them to lead peer education in their community. This is also in line with the national MSM and FSW strategic plan of increasing peer owned responses to the HIV epidemic.
- The project provided a common platform and comfort zone for the key populations especially the MSM to communicate on HIV prevention and treatment needs.
- The community is still very apprehensive of the criminalization of key populations in Nigeria and are therefore fearful of possible litigation if identify is known. While this project focused on HIV prevention and treatment access, there is need to explore human rights education to be able to empower them to take up their rights by themselves.

Challenges:

- The gender disparity in skills and knowledge on social media posed challenge in getting the MSM and FSW on the same page of communication on the project. Most of the FSW and female PLHIV on the project are on the comfort zone of using sms rather than use the whats App or face book.
- The short life span of the project did not provide enough time and space for the delivery of the project activities and learning on the field.
- The 20% funds released for the project activities was grossly inadequate to deliver the project activities and NHVMAS has to mobilize funds internally to drive the project.

Next step:

The Technical Working Group will continue to engage with the trained peer educators well after the project life span. We will work towards integrating the initiative into the organizations programme.

Conclusion: The project is really making a lot of impact in facilitating HIV communication among the key populations especially for the MSM who are facing heated legal environment because of the same sex bill in our country. There is need to sustain this progress and expand service to other members of the community.

Appendix 1: HIV Information and Education series- Facilitating HIV prevention and treatment education using social media.

Project goal (purpose): The purpose of this project is to create awareness on HIV and existing prevention, treatment and care services for key populations (MSM and FSW) and youths in Ikeja and Shomolu LGs of Lagos State, contributing to the Lagos Municipal Action Project strategic objective 2. Scale up Treatment, Care and Support Services for MARPs by (Strategy 2.2) Strengthening capacity of peer led organisations

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to scale up existing services targeted at key populations most at risk of HIV exposure.

Expected results:

- Key populations (MSM, FSW, Youth) would have continued and sustained access to HIV prevention information to enable them change high HIV sexual risk behavior.
- Increased number of key populations (MSM, FSW and Youth) who access HIV services from the MARPs friendly clinics in Shomolu and Ikeja LGs and the state reproductive health outlets.
- Increased percentage of MARPs assessing condoms and lubricants in targeted outlets.
- The project shall contribute to the National MSM and FSW strategic plan of increasing peer owned responses to the HIV epidemic.

Participant criteria (specific audience): Key populations most at risk of HIV and AIDS (MSM, FSW, Youth)

Session outline (content, objectives, methods, materials for each session):

- Basic facts on HIV and AIDS
- HIV and STI
- Human sexuality- Anal, vaginal, oral sex and associated HIV risk
- Existing HIV prevention tools:
- Condoms and lubricants access and safety
- HCT-
- New biomedical HIV prevention tools- PrEP, T4P
- HIV treatment- where to access services
- HIV treatment literacy and adherence

Methods of evaluation

During sessions: Monitor data generated from the peer educators which would include (i)

number of new contacts enlisted for messages (ii) number of phone contacts received and information shared (iii) number of referrals made to MARPS friendly clinics (iv) number of condoms and lubricants distributed to social contacts.

End of the project: focus group discussions with the project beneficiaries.

Session name	Main content and objectives	Training methods and activities	Materials needed
Basic facts on HIV and AIDS	Increase knowledge on HIV and correct misconception.	Social media simple (low literacy) HIV information	Smart phone Internet Developed simple low literacy HIV information
HIV and STI	Build knowledge on association between HIV and STI	Social media simple (low literacy) HIV information	Same as above
Human sexual behaviour and HIV risk Anal, vaginal, oral sex and associated HIV risk	Build knowledge on HIV risk associated with vaginal, oral and anal sex. Explain the anatomical and physiological factors that makes anal sex with the highest risk of HIV	Social media simple (low literacy) HIV information including pictorials	Same as above
Existing HIV prevention tools: Condoms and lubricants use	Increase knowledge on HIV prevention tools Sensitize them on condom and lubricant use	Same as above	Same as above
Existing HIV prevention tools: HCT	Build knowledge on the benefit of HCT and create demand for the services	Same as above	Same as above
New biomedical HIV prevention tools- PrEP, T4P	Build knowledge on PrEP and national plan for prep. Sensitize the need for community to demand for prep	Same as above	Same as above
HIV treatment- where to access services	Create awareness on HIV prevention and treatment sites in Ikeja and Shomolu LGs	Same as above	Same as above

Sessions contents

1. Basic facts on HIV and AIDS

HIV stands for human immunodeficiency virus, which is the virus that causes HIV infection.

Like all viruses, [HIV](#) cannot reproduce itself except when inside human cells.

AIDS stands for acquired immunodeficiency syndrome and is the most advanced stage of HIV infection.

HIV attacks and destroys the infection-fighting CD4 cells of the immune system. Loss of CD4 cells makes it difficult for the body to fight infections. Without treatment, HIV gradually destroys the immune system and advances to AIDS.

HIV is spread through contact with the following body fluids of a HIV infected person.

- Blood
- Semen
- Pre-seminal, vaginal and rectal fluids
- Breast milk

Ways in which one can get infected with HIV:

- Unprotected sexual intercourse with an infected person
- Contact with an infected persons blood or use of infected blood products
- From HIV positive mother to her baby during pregnancy, delivery and breastfeeding
- Injecting drugs through sharing injecting needles and syringes

It is NOT possible to become infected with HIV through:

- Sharing cutlery and crockery
- Insect/animal bites
- Touching, hugging or shaking hands
- Using toilet seats
- Eating food prepared by someone with HIV

Anybody can get HIV, but the following steps can prevent from HIV infection.

- Getting tested and knowing partner's HIV status.
- Having less risky sex.
- Correct and consistent condom use
- Limit number of sexual partners
- Don't inject drugs/use only sterile drug injection equipment and never share equipment
- Use of pre-exposure prophylaxis (PrEP)

NOTE: HIV transmission is possible at any stage of HIV infection—even if an HIV-infected person has no symptoms of HIV.

2. HIV and STI

STI stands for sexually transmitted infection, and are infections that can be passed from person to person when having sex. You can get an STI by having vaginal, anal, or oral sex. STIs can infect many areas of the body and are caused by microscopic organisms such as bacteria,

viruses or parasites and they do not always cause signs or symptoms. There are several different types of STI such as Chlamydia, Genital Warts, Gonorrhoea, Hepatitis B, Hepatitis C, Herpes, Syphilis, and Trichomoniasis.

Symptoms of Sexually Transmissible Infections (STIs)?

Symptoms of each STI can vary, from local symptoms affecting the genitals, to symptoms that affect various other parts of the body. The following common symptoms of STI to look out for:

- A vaginal discharge
- Abnormal vaginal bleeding
- A discharge from the penis
- A sore, ulcer, rash, or lump that appears on the penis or around the vagina, vulva or back passage (anus)
- Pain when you have sex
- Pain when you pass urine (although the common reason for this is a urine infection and not an STI)
- Swelling of the glands in your groin

LINK BETWEEN STI AND HIV INFECTION

Individuals who are infected with STIs are at least two to five times more likely than uninfected individuals to acquire HIV infection if they are exposed to the virus through sexual contact. If an HIV-infected individual is also infected with another STI, that person is more likely to transmit HIV through sexual contact than other HIV-infected persons.

Testing and treatment of sexually transmitted infections (STIs) can be an effective tool in preventing the spread of HIV.

3. Sexual behaviors and HIV risk – Oral, Vaginal and Anal sex

Sexual behaviour is the way in which individuals experience their sexual pleasure. It has to do with what sex we have and what we do sexually (e.g. vaginal, anal sex, oral sex,)

Oral sex: Contact between the mouth and tongue and genitals (penis, testicles, anus, vagina), which includes licking, sucking, kissing.

Anal sex: Sex which usually involves the insertion of the penis into the anus (penile-anal penetrative sex). Penetrative penile-anal sex: Sex act describing the positioning or role of the 'active' partner or 'top' whose penis is being inserted into the anus of his sexual partner. Receptive anal sex: Sex act describing the positioning or role of the 'passive', 'receptive', 'bottom' whose anus is being entered. This is a common sexual behaviour among MSM but it is also practiced between men and women.

Vaginal sex: Sex which usually involves the insertion of the penis into the vagina (penile-vaginal penetrative sex)

HIV risk: Risk is defined as the chance that a person may acquire HIV infection. High risk behaviours are those that offer more opportunities for the HIV virus to be transmitted from one person to another. Examples of high-risk behaviours include unprotected sex with a partner whose HIV status is unknown or positive; multiple unprotected sexual partnerships;

and using contaminated needles and syringes to inject drugs.

Oral sex, carry a much lower risk of HIV transmission. Unprotected anal sex carries a high risk of HIV and STIs transmission, as opposed to vaginal sex. In men, unprotected receptive anal sex is 10 times more risky than engaging in unprotected vaginal sex. For a woman, engaging in unprotected (receptive) anal sex is five times more risky than engaging in unprotected vaginal sex .

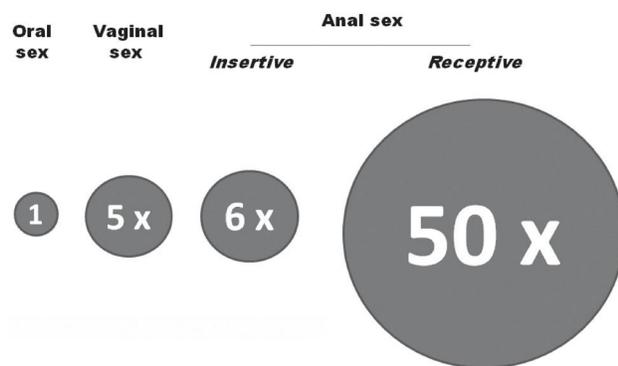


Figure 1: Male risk for HIV during different sex acts
Source: Smith et al. (2005)

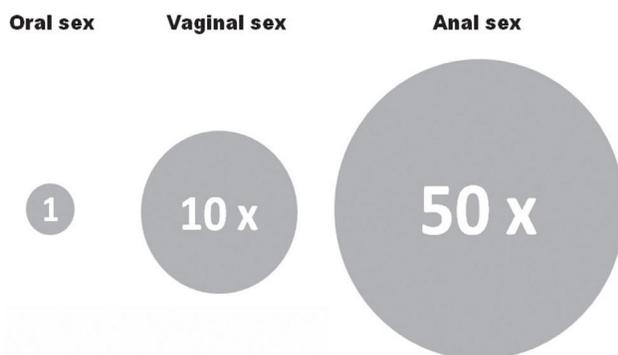


Figure 2: Female risk for HIV during different sex acts
Source: Smith et al. (2005)

The difference in risk of HIV infection has to do with differences between the anus and the vagina.

Table 1: Differences between penile-anal and penile-vaginal sex

Penile-anal sex	Penile-vaginal sex
No natural lubrication in anus	Vagina produces natural lubrication when sexually aroused.
Anus has limited elasticity	Vagina has elasticity and stretches
Colon and rectum only a single layer of epithelial cells (one cell thick)	Vagina much thicker epithelial layer (approximately 40 cells thick)
Tears easily with no lubrication	Vagina doesn't tear as easily, and is more robust
Presence of faecal matter possible (containing bacteria)	No faecal matter present
Many inflammatory cells (CD4 receptors) under surface in rectum	Fewer CD4 receptor cells in vagina than rectum

4. Existing HIV prevention tools:

HIV prevention involves using a number of methods to reduce or eliminate the risk of HIV being passed from one person to another (transmission).

HIV can be transmitted in three main ways:

- Sexual transmission
- Transmission through blood
- Mother-to-child transmission

Universal HIV prevention methods try to address the three main routes of transmission listed above. [HIV testing and counseling](#) as well as [HIV awareness education](#) are central to preventing HIV transmission as well.

Prevention methods for [sexual transmission of HIV](#) include but are not limited to the following: [Abstinence](#), including the delay of sexual debut and abstinence until marriage
Being tested for HIV and being faithful in marriage and monogamous relationships
Correct and consistent use of male and female condoms for those who practice high-risk behaviours



Mother to child transmission can be prevented through the PMTCT (Preventing Mother to child transmission). This means all pregnant women must know their HIV status, and those who are positive must access P MTCT services



Transmission through blood occurs when contact is made with HIV infected blood. Preventing transmission through blood includes [screening blood products and reducing needle sharing and accidents](#).

Other prevention methods include:

- Medical Male Circumcision
- Treatment of STI
- Post-exposure prophylaxis (PEP)- Taking ARV drugs for 4weeks if exposed to HIV infection like case of rape or accidental needle prick from infected partner.



5. Condoms and lubricants use:

A condom is a protective sheath used during anal, vaginal or oral sexual intercourse. It creates a physical ‘barrier’ between the genitals and sexual fluids of two partners engaging in intercourse. It can be used for contraception, and/or HIV and STI prevention. There are two main types of condoms – ‘male’condoms and ‘female’ condoms.



Male condoms are usually made out of latex (rubber). Female condoms are usually made out of polyurethane (a thin strong plastic). Male condoms made out of polyurethane also exist (but are not widely available) – these are useful for avoiding latex allergies. Currently, the female condom is approved for vaginal use only – that is why it is called the ‘female condom’. However, ‘female condoms’ can also be used for anal sex, and research shows that some MSM use the female condom for HIV/STI protection.

Lubricants are substance which reduces friction during sexual intercourse. Lubricants can be water based (e.g. K-Y Jelly, Assegal, Lubrica) or oil-based (e.g. Vaseline, body cream, cooking oil). Latex male condoms should only be used with water-based lubricants, as oil-based ones weaken latex. Most female and male condoms already have water-based lubricant on them; however, adding lubricant is especially important for anal sex as the lining of the anus does not produce its own natural lubrication and is sensitive to tearing. Oil-based lubricants must NOT be used with the male condom as they damage the latex and may *increase* the risk of condom breakage .

Using male or female condoms is still considered the best way to prevent acquiring HIV and STIs during vaginal or anal sex. When used correctly and for all sex acts, condoms are 80–95% effective at preventing HIV and STIs. In addition, the use of condom-compatible lubes has been associated with a decreased risk of condoms breaking or slipping.

Need instruction on use of male or female condom, contact me.

Instructions for correct female condom use

Method 1: Use by receptive partner

1. Check the expiry date.
2. Find the arrow on the packaging and tear downwards.
3. Insert the female condom into the vagina or anus.
4. Either keep or remove the inner ring, depending on preference. The inner ring can be used to insert the female condom, and then be removed thereafter.
5. Leave the outer ring on the outside of the body.
6. Add lubricant to the inside of the female condom or on the penis if needed.
7. Guide the penis inside the outer ring into the female condom. If the penis enters to the side of the female condom or pushes one of the sides of the outer ring inside the vagina or anus, STOP, adjust the outer ring, and start again.
8. To take out the female condom, twist the outer ring and gently remove.
9. Tie a knot and dispose of it in the trash.

Instructions for correct male condom use

1. Store condoms in a place away from heat and humidity. Check the expiration date on the package. Check that the package is not damaged and has no holes by feeling the air in it.
2. Do not rip or puncture the condom when opening the package. Open it with the fingers, NOT with teeth, scissors, a knife or anything sharp.
3. Check that the condom is not dry.
4. Make sure the tip of the condom is the right way round – the lubricated side should be on the outside, and the condom should roll down easily.
5. Pinch the tip (teat) of the condom with one hand. This removes the air and makes space to hold the semen.
6. Place the condom on the erect penis and unroll it to the base of the penis with the other hand, while still pinching the tip of the condom. If uncircumcised, pull back the foreskin before putting on the condom. After it has been put on, push the foreskin forward again (towards the tip) to let the foreskin move without breaking the condom.
7. Smooth out any air bubbles.
8. Add a water-based lubricant (e.g. K-Y Jelly®) to the outside of the condom if necessary. Do NOT use oil-based lubricants.
9. After ejaculation, hold the condom at the base of the penis and pull it off before the penis softens.
10. Remove the condom, taking care not to spill any semen.
11. Wipe any ejaculate off the penis.
12. Make a knot in the condom and dispose of it appropriately out of the reach of children.
13. Use a new condom for each new act of intercourse.

If the condom breaks or slips during intercourse, STOP, remove it and put on a new condom.

6. HIV COUNSELING AND TESTING



HIV counseling and testing is an important part of HIV prevention and treatment services.

What does HIV Counseling & Testing involve?

HIV C&T has three distinct components: (i) risk assessment and counseling before the blood or oral sample is taken, (ii) testing of the sample, and counseling and (iii) referral with the test results.

C&T can be confidential—a person's name is recorded with the test results—or anonymous—no name is recorded with the test.

Benefits of having an HIV test

- HIV testing is very important for your health. The sooner you are tested, the sooner you can take steps to remain healthy.
- If your result is negative, your counselor or doctor will talk to you about how to protect yourself from being infected in the future
- If your test result is positive, you can take steps to prevent passing the HIV to others. Your counselor or doctor will talk to you about ways to prevent passing HIV to others. You will also receive a referral for treatment for HIV and learn about other ways to stay healthy

HIV testing is especially important for pregnant women

- HIV can be passed from a pregnant mother to her baby during pregnancy, birthing process or through breast milk.
- It is important to know your HIV status before or early in pregnancy so that you can make important decisions about your own health and the health of the baby.
- If you are pregnant and have HIV, treatment is available for your own health and to reduce the risk of passing HIV to your baby

HIV C&T services can be accessed from Primary health centers, community-based organizations, outreach programs, mobile vans, family planning clinics and general hospitals. For key population friendly services, you can visit Primary Health Center Ojodu, Primary Health Center Ikeja , Contact phone no: 08038268566 (Ms. Bola), Wright Memorial Primary Health Center, Shomolu, Contact phone no: 08023434659 (Kazeem) or Population Council Community Health Center Yaba.

Knowing your HIV status whether HIV negative or HIV positive, is key to preventing the spread of HIV and accessing counseling and medical care.

7. New biomedical HIV prevention tools:

Why new biomedical HIV prevention when we have the A,B, C, D?

A stands for Abstinence

B stands for be faithful to one uninfected partner

C stands for correct and consistency use of condom

D stands for desist from sharing unsterilized sharp object and unscreened blood.

Despite these existing information, yet we still have new infections and increased in number of those that are infected with HIV and other sexually transmitted infection hence the need for new HIV prevention tools. In view of this New biomedical HIV prevention is being introduced such as PrEP, Treatment for Prevention, Vaccine and Microbicide.

PrEP means Pre- exposure- Prophylaxis and it involves taking oral Anti Retro Viral drug (ARV) by HIV negative people to prevent HIV infection. PrEP also means taking drugs before HIV exposure to prevent rather than to treat a disease. PrEP is also introduced to sero-discordant couples to prevent the second partner for being infected with the virus.

Treatment as prevention simply means treating people who are HIV positive using ARV drugs to prevent the transmitting of new infection to the negative partners. This can also work at population level by increasing HIV testing.

Microbicide can be defined/explained as substance that can reduce the risk of acquiring or transmitting sexually transmitted infections including HIV when it is inserted in the vagina or rectum. Microbicides is not yet in the market.

HIV Vaccine is a substance that teaches the body to recognise and defend itself against germs that causes disease. It is not a cure but prevents infection or slows down disease progression. No effective HIV vaccine yet.

8. HIV TREATMENT; ACCESSING SERVICES

HIV drugs or AIDS drugs are called ARV, or antiretroviral therapy. These drugs help the immune system to fight HIV, and they can boost the amount of antibody response, and drop the HIV viral load to minimal or even undetectable levels. Antiretroviral therapy is normally considered successful when it reduces the viral load of a person living with HIV to undetectable levels.

People who have an undetectable viral load in their blood are more likely to live a long and healthy life and are less likely to pass HIV to others.

Persons living with HIV need access to a continuum of services to achieve an undetectable viral load: HIV testing and diagnosis, linkage to appropriate medical care (and other health services), support while in care, access to antiretroviral treatment if and when they are ready, and support while on treatment.

HIV treatment is available in all the General Hospital in Lagos State, Lagos State University Teaching Hospital Ikeja and Lagos University Teaching Hospital Idiaraba.

For key population friendly services, you can visit Primary Health Center Ojodu, Primary Health

Center Ikeja , Contact phone no: 08038268566 (Ms. Bola), or Wright Memorial Primary Health Center, Shomolu, Contact phone no: 08023434659 (Ms. Kazeem) or Population Council Community Health Center Yaba.

HIV treatment adherence

All Persons living with HIV need to maintain adherence to treatment. Treatment adherence means taking drugs according to the prescribing instructions. That is:



- Never missing a dose
 - Keeping to specific times of administration
 - Taking it the right way
 - Lifelong treatment even when feeling well
- Underscore the difficulty of taking pills daily.

Non drug adherence could be in form of missed or delayed dose, failing to follow guidelines, experimenting with dosing

Why do I need to maintain adherence:

Poor adherence to ARV treatment leads to

- Incomplete viral suppression allowing the development of HIV resistant strain
- Lead to treatment failure
- Affect future treatment options

Need support with treatment, you can call 08038268566 (Ms. Bola), or 08023434659 (Ms. Kazeem) or 08056445676 (Ms. Florita)

