AC

MODULES 4 & 5 TABLE OF CONTENTS

MODULE 4: Community Response

MODULE 5: The Structure of National Response and How Civil Society Fits

MODULE 4
COMMUNITY RESPONSE

Objectives

At the end of the training, participants are expected to:

- ☞Explain what constitutes a community and how individuals and institutions in the community can be specifically involved in ATM activities;
- ☞Discuss the roles and significance of PHCs to community-based activities for ATM;
- ☞Identify factors affecting community ATM services;
- ☞Identify specific ATM community interventions;
- ☞Understand and apply ATM behaviour change strategies;
- ☞Develop locally relevant ATM messages for interventions;
- ☞Discuss how ownership and sustainability of integrated ATM activities could be achieved.

Training Contents

Nature of communities

✎Factors that affect community response to ATM

✎The PHC and the WHS

✎Community mobilisation strategies

✎Interventions

✎Ownership/ Sustainability

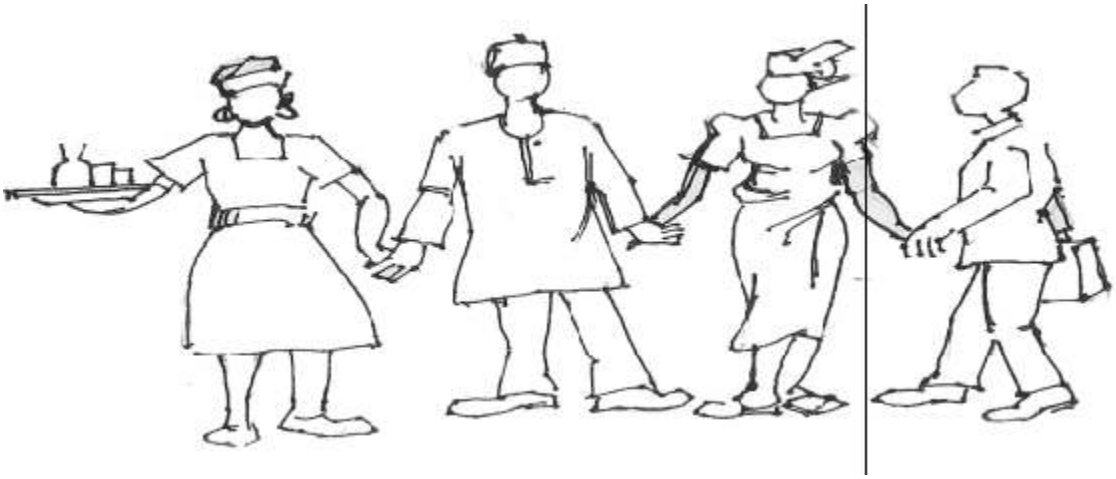
4.1. Nature of Communities

What to know in the community

Identify existing community structures and hierarchy of the political structure
Determine the community needs for services, including
Demographic data; size, population density, composition
Socio-economic data e.g. on the presence of welfare programmes
Existing service providers: public and private health facilities (functional and non-functional) and traditional healing homes
Number of existing ATM cases in each facility/community
Existing ATM interventions/community coping mechanism
TB/HIV co-infection rate
Analyse the strengths and weaknesses of existing care services in the community
Assess the knowledge of ATM; their causes, features, treatment among vulnerable groups in the community
Determine the barriers (social, physical, financial) of access to services and extent of stigma associated with diseases.

The Family/Household

The family is the nucleus of the community. The patient, treatment supporter, community volunteer and all other members of the community including those who are at a risk of being infected by the patient or suffer as a result of someone being sick, all come from a family. When a diagnosis is made, with the consent of patient/client, there is need to inform the family and properly educate them about



the disease. They should be encouraged to assist the patient to commence and complete treatment. This will lead to a reduction in stigma and discrimination as they are often a product of ignorance and poor knowledge of ATMs especially TB/HIV/AIDS and their treatment. It will also afford an opportunity for the screening of other members of the family. Other family/household level activities are counselling, folklore, songs or rhymes, peer group discussion, TBA/community volunteers-led discussion, mobile women traders and family meeting.

The Treatment Supporter

A Treatment Supporter (TS) is a motivated individual willing and capable to support a patient to commence and complete his/her treatment and follow up examination. The treatment supporter could be a relation or someone close to the patient's home who shall be trained on how to provide support to the patient while on treatment. S/he should:

- be acceptable to the patient;
- preferably live close to the patient;
- be polite and considerate of the patient's needs at every contact;
- be kind to the patient and interested in the patient's welfare;
- respect the patient's confidentiality;
- be trained by the health services to perform expected tasks;
- be a responsible and not a care-free person.

The treatment supporter will be required to perform the following tasks:

- Identification of people with symptoms of ATM e.g. coughing for three weeks or more and referral to the DOTS centre for sputum examination, diagnosis and follow up;
- Custody of patient's drugs and Direct Observation of Treatment;
- Ticking of patient's drug in-take in the treatment card;
- Recognition of danger signs/side effects and referral of patient to the DOTS centre and clinic/care facility;
- Tracking of patients when they interrupt treatment and tracing of contacts of TB patients;
- Provision of support and care to the patient.

The Community Volunteer

A community volunteer (CV) refers to a member of the community who:

- Is identified and recommended by the community;
- Expresses willingness and commitment to participate in ATM interventions;
- Is resident in the community;
- Is able to speak the local language fluently;

May be a volunteer in other health programmes in the community.

The CV will be responsible for health promotion to the community with emphasis on signs and symptoms of the ATMs and inform community members where services are available and can be accessed. The CV should carry out the following roles in the community:

- Community health promotion and education
- Assist in the identification of a TS
- Advocates to the community for support to ATM control
- Assist in defaulter tracking

Community Health Worker

The community health worker is a health worker, preferably a health extension worker who serves as a link between the health facility and the community. The roles of CHW include:

- Drug supply at required intervals;
- Training of TS/CV;
- Assist the CV in the provision of health promotion to the community;
- Update records of drug intake using completed cards by the TS;
- Supervision of the TS.

Community

The role of the community will include:

Identification of community volunteer;
Support the patient and TS (logistics of transport where needed);
Provide support for interventions;
Should ensure that free services are indeed provided free;
Mobilise those with symptoms for diagnosis.

TBL Supervisor (TBLS)

The TBLS, though primarily responsible for TB, especially as it relates to the logistic support to the health facility, will also support malaria and HIV/AIDS interventions. Specifically, s/he will

Undertake activities for ATM programme;
Supervise the work of the DOT Provider(s) in each DOTS clinic;
Receive requisition for drug supply from DOTS provider;
Ensure adequate stock of TB drugs and other required materials in each

DOTS clinic at all times;

- Submit quarterly report (data) to the designated officer/STBL Control Officer;
- Provision of training support for the CHW, Community Volunteer and the Treatment Supporter;
- Collate case findings and treatment outcome (Disaggregate data for patients on CTBC);
- Support the CV in defaulter / contact tracing.

Community Based Organisation/Community Development Committee

The CBO and/or the CDC will:

Help to facilitate entrance into community;

- Be involved in community mobilisation;
- Facilitate the selection of volunteers;
- Help lobby for government commitment to ATM control;
- Ensure accountability of local health services to the community;
- Facilitate feedback to the communities.

Motivation for Community Volunteers

The work of volunteers is primarily voluntary. However, incentives are useful in order to retain them. These incentives should not necessarily be monetary but should be agreed upon and provided by the community, NGOs and/or the government. Such incentives should encourage sustainability.

Effective communication among the volunteers, the CBOs, health workers and the ATM Control should be encouraged. Supervisions, review meetings and refresher trainings are opportunities for interactions and communication. They give volunteers a sense of fulfilment and effective health care delivery.

Criteria for Selecting Participating Communities

A community consists of people living together in some form of social organisation in a particular locality. Such groups of people usually act together in the pursuit of common interest. It may vary in size and socio-economic profile and its members usually share social, cultural, economic characteristics as well as common interests including health. A community may not be rural.

Participating communities should:

- Express willingness and political commitment to be part of the ATMs framework;
- Have a linkage to preventive, diagnostic and treatment services;
- Identify willing and acceptable community volunteers and leaders for support activities;
- Support the functioning of volunteers in line with agreed guidelines;
- Be given priority where such communities have poor treatment outcome and/or high defaulter rate;
- Be given priority where such communities have high prevalence of TB and HIV/AIDS or malaria cases;
- Be given priority where such communities have difficult geographical access;
- Be given priority where such communities have existing CBOs and CDC.

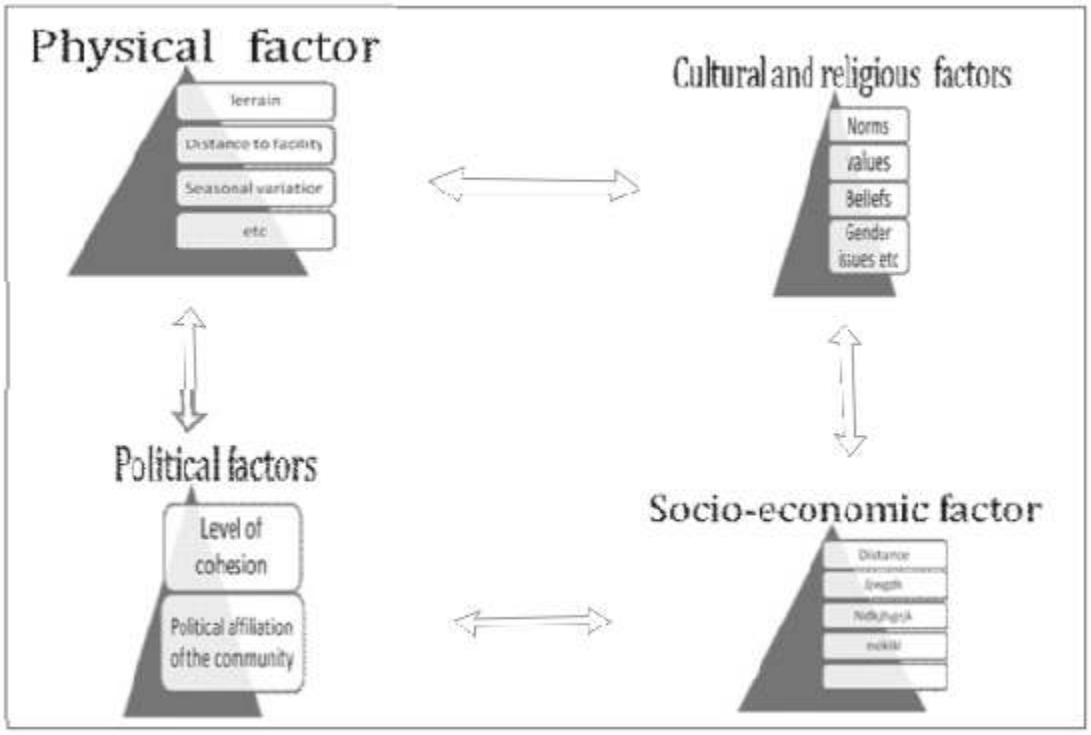
4.2. Factors that Affect Community Response to ATM

Community response to ATM intervention can be affected by many factors. These factors can be categorised into:

- Physical;
- Socio-economic;
- Political; and
- Cultural &religious factors.

The foregoing factors, norms, values, knowledge of the issues and expectations regarding the three diseases will affect the response of the community to ATM. This is why a situation analysis seeking to diagnose the community is important as baseline before any intervention is contemplated. The structures, institutions and individuals who drive the political process and economy should be mapped in order to prioritise the interventions, after determining the targets for various levels and phases of intervention. It is important to know the profile of the community in relation to trends and outcomes of previous efforts and lessons learned.

4.3. The PHC and the WHS



Primary Healthcare (PHC)

Primary healthcare is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self- determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process. (Alma-Ata Declaration of 1978)

Development of PHC in Nigeria

- Basic Health Services Scheme (1975-1984) marked the beginning of reorientation of national healthcare to PHC approach;
- Period of renaissance (1985-1992) was the second attempt to implement PHC in the country;
- Nigeria's maiden Health Policy was launched in 1988;
- PHC was identified as the cornerstone of the national health policy;
- PHC unit was then upgraded to a department in FMOH;

- SMOH responsible for providing PHC planning, programming, financial and operational support;
- Framework for managerial capability to be developed at the LGA level for effective supervision; setting up of Village Health System (VDC & WDC); training of volunteer health workers; strengthening of monitoring and evaluation;
- Step by step planning and implementation of PHC started in Nigeria with 52 LGAs. By 1990, all LGAs were covered;
- NPHCDA established in 1992 to provide support to National Health Policy, particularly relating to PHC; mobilise resources both locally and internationally for PHC; support the monitoring and evaluation of PHC systems, guidelines, programmes and activities; support community health i.e. village health services; promote and support health systems research; provide technical collaboration at all levels; promote PHC through advocacy, organisation of training and seminars;
- Restructuring of NPHCDA into six zonal offices and the headquarters;
- NPHCDA was mandated to pioneer the revitalisation process of PHC in the country in 2000;
- The Ward Health System was introduced as a strategy to revitalise PHC.

Eight essential and interrelated components of the primary healthcare model include:

Public education and participation regarding prevention and control of health problems;
Promotion of food supply and proper nutrition for everyone;
An adequate supply of safe water and basic sanitation for everyone;
Comprehensive maternal and child health care, including family planning;
Global immunisation against major infectious diseases;
Prevention and control of locally endemic diseases;
Appropriate and accessible treatment of common diseases and injuries;
Provision of essential drugs to all.

The Key Principles

- PHC is based on the community as the nucleus of healthcare activities;
- Care should be aimed at the most needy and vulnerable groups;
- PHC should include a range of essential, integrated and appropriate activities using appropriate technology;
- Care should be accessible and acceptable to everybody;
- PHC should be affordable;
- There should be full community participation, and PHC should contribute to the self-reliance and self-determination of communities;

- PHC should be integrated both with other parts of the health programme and with other development sectors(multi-sectoral approach).

The Practice of PHC

- Curative health care (treatment of common diseases and injuries, activities at the hospital level where laboratory facilities are used to diagnose, health centre level where nurses trained as diagnosticians work, and village level where village health workers function; provision of essential drugs at affordable costs;
- Immunisation services; ante-natal, peri-natal and post-natal; family planning services;
- Interventions to improve nutritional status;
- Health promotion;
- Prevention and control of common local diseases e.g. malaria, sexually transmitted diseases, including AIDS and TB;
- Water, sanitation and waste disposal;
- Palliative care for life-limiting illness at any stage of its development;
- Functional referral system.

Ward Health System

- Recognises the political ward as operational level for health activities;
- Seeks to develop capacities of communities to own their health system and relies on WDCs to develop the capabilities of the communities to own, plan, implement, monitor and evaluate health activities;
- Provides integrated PHC services;
- empowers the people to plan, manage, finance and monitor services, serve as social control process and ensure sustainability;
- Health worker coordinate and supervise clinic and community based services such as CHEWs, VHWs and TBAs, etc;
- Health information collected based on measurable indicators and used for managing the health system;
- Equitable distribution of facilities and resources.

Challenges of PHC in Nigeria

- Poor financial allocation to health at all levels
- Inadequate funding and instances of misapplication/misappropriation of allocated funds
- Weak/inconsistent political commitment and support
- Inequitable distribution of manpower/poor staffing
- Weak community participation and ownership
- Poor logistic support
- Poor staff commitment

" Poor record keeping/data management
" Low service Utilisation
" Ensuring effectiveness of the two way referral system
" Adequacy of supervision, monitoring and evaluation at all levels
" Maintenance of infrastructure at all levels especially the ward and LG levels

4.4. Community Mobilisation Strategies/Interventions

Community mobilisation is a dynamic process that involves planned actions to reach, influence, enable, and involve key segments of the community in order to collectively create an environment that will effect positive behaviour and bring about desired social change. Segments include influential groups or individuals as well as formal and informal leaders among those who will directly benefit from the desired social change. The process therefore is grounded in local concerns and energy, and both empower and ensure local ownership, leading to greater sustainability and impact.

Community mobilisation strategies are:

- Advocacy;
- Communication;
- Social mobilisation;
- Peer education;
- Social Marketing.

Advocacy is a planned, systematic, continuing and strategic effort to gain the resource and other support and specific commitment of decision makers in order to address specific needs in an identified area.

Advocacy / Policy Change

Advocacy and policy change include a range of strategies designed to involve people in influencing decision making at the organisational, local, national, and international levels, usually involving strategic planning, community mobilisation, capacity development, coalition building, and the promotion of changed policies and environments. Effective advocacy should create an environment for cumulative change beyond the level of the individual, and should have a community-defined objective.

Targets for advocacy for ATM activities and expected support will include:

- Government at all levels for political, financial and logistic commitment;

- Bilateral and multilateral donors for financial and technical assistance based on evidence-based needs;
- Organised private sector for financial and logistic assistance;
- Health authorities and other Ministries, Departments and Agencies (MDAs) for support, understanding and involvement in programme implementation;
- Traditional, religious, community, opinion leaders and other key stakeholders to gain their confidence, facilitate the mobilisation of the members of the community and tackle challenges;
- Media organisations and their key officials for effective dissemination of ATM information and coverage, assessment and evaluation of specific activities/interventions, issues and events.

Communication to develop context-specific behavioural communication change (BCC) tools, adapted to convey simple, clear and culturally appropriate messages to create awareness and stimulate participation among members of the community about ATM. These have to be based on a clear understanding of existing beliefs and practices and be complemented by high profile activities, endorsements, and other media and publicity activities.

Areas of focus are:

- the cause/risk factors of ATM;
- mode of transmission/infection;
- symptoms and signs;
- available facilities for diagnosis and treatment;
- importance of adherence to treatment;
- the need to support and motivate patients to complete their treatment.

The following may be utilised as means and channels of communication:

- Inter-personal communication: health workers, CBOs, CVs, TSs;
- Film shows and documentaries on ATM;
- Dramas and playlet;
- IEC materials (posters, picture codes, fliers, etc);
- Social clubs: age group, market women associations;
- Religious bodies e.g. churches and mosques;
- Town criers/announcers;
- Media: e.g. radio, television and newspapers;
- Other community-specific communication channels e.g. town hall meetings, festivals and rally.

Interpersonal Communication

Interpersonal communication (IPC) involves the face to face interaction between

two persons or within a group where there is contact between the interacting persons. It could be verbal or non-verbal.

Some principles of IPC which will help CSOs to more effectively engage targets include:

– IPC is inescapable. Communication is inevitable and we keep sharing meaning in the course of interactions. That this presupposes that care need to be taken in order not to send the wrong signals either by speech or by other cues;
– Non-verbally IPC is irreversible. When something is said or expressed non-verbally, it is virtually impossible to retract. Although people often try to do damage control, impressions are difficult to erase;
– IPC process is complicated. This is because many factors impact the communication process. Such variables include perceptions of yourself as well as the other person perceptions of you and themselves;
– IPC is contextual. It never happens in isolation but within a context. Such a context could be psychological as defined by the personality, values and needs of the interacting individuals. The Relational context refers to how a party reacts to the other person. The Situational context deals with the psycho-social 'where' of interaction (stadium, laboratory, and classroom) while the Environmental context deals with the physical 'where' of interaction (e.g. location, temperature). The Cultural context relates to the learned rules and behaviours which impact the interaction. It is important to understand these contexts in order to effectively engage targets for purposes of specific activities and interventions.

Interpersonal communication and counselling is defined as person-to-person or small group interaction and exchange is a critical skill for health care providers, hotline respondents and others who have direct contact with those we are trying to reach in order to influence their decisions and help improve their skills. It encompasses both verbal and non-verbal communication negotiation and classic counselling techniques.

Behaviour Change Communication

Behaviour change communication (BCC) is the strategic use of communication to promote positive health outcomes, based on proven theories and models of behaviour change. BCC employs a systematic process beginning with formative research and behaviour analysis, followed by communication planning,

implementation, and monitoring and evaluation. Audiences are carefully segmented, messages and materials are pre-tested, and both mass media and interpersonal channels are used to achieve defined behavioural objectives.

Social Mobilisation involves engaging individuals, groups, institutions, coalitions, networks, communities in order to identify needs, raise the consciousness for and awareness of the issues and what needs be done to address them and secure their sustained involvement to ensure ownership and the achievement of set objectives.

Targets for Social Mobilisation

- Support Groups of patients and those cured of similar ailments are useful in sharing their fears, beliefs, and experiences, to encourage patients support patients on treatment to adhere to treatment, help in the identification of those with signs and symptoms and defaulters. Communities and health facilities should encourage the formation of such support groups through which to educate patients on their right to treatment.
- Community Development Committee (CDCs)/Village Development Committee (VDCs) being integral to Ward Health System(WHS) where non-existent should be established and empowered to supervise community ATM activities.
- Existing community based organisations (CBOs) should be mobilised for integrated ATM activities.
- Other community targets are, Mothers' clubs, praise singers, peer group counselling, association meetings, dramas, mobile vendors, mobile theatre for development, social gatherings (naming, marriage, and burial ceremonies), religious sermons/activities, co-operative meetings, Age group associations, cultural groups, market women association meetings, trade associations, village square meetings.

Entry Points For Community Engagement in ATM activities

- Courtesy visit to opinion leaders in the community by local health team/CSOs/CBOs to gain their confidence and secure the full involvement of the community in ATM processes and activities;
- Meeting with the members of the community to select reliable community participants as volunteers and for treatment support. Such persons will be trained.

Community Engagement based on a situation analysis and noting the following:

- Avoid making promises that will not be fulfilled;
- Avoid flamboyance during the visits;
- Do not by-pass local authorities;
- Do not impose your ideas on the people;
- Note existing interventions in the community.

Peer Education

Peer education occurs in a variety of settings (street corner, social club, bar, school grounds, home, church, bus station, factory, farm or any other comfortable place) and involves non-professional teachers peer educators, talking to, and working with and motivating their peers.

Peer education may be:

- Factory workers giving ATMs prevention talks to their colleagues during lunch hour;
- Women from a women's group making house-to-house calls to distribute leaflets and talk with homemakers;
- Out-of-school youth organising video and information shows for other young people;
- Military personnel counselling new recruits;
- Students meeting in dormitories;
- Sex workers discussing TB/HIV/AIDS prevention and treatment.
- Trained people assisting others in their peer group to make decisions about ATM through activities undertaken in one-on-one or small group settings.

Peer education is:
- Culturally appropriate;
- Community-based and is a link to other community-based strategies;
- Accepted by their target audiences;
- Economical but effective.

Activities that can Increase Awareness of ATM:
- Conduct informal small group discussions;
- Organise and conduct formal group discussions;
- Teach peers about issues of prevention, detection and treatment;
- Organise meetings and educational sessions (to be taught by someone else);
- Participate in World AIDS Day, Africa Malaria Day, World TB Day and other public events;

- Hold regular meetings;
- Distribute educational materials;
- Display posters and other educational materials;
- Present video screenings;
- Design/develop educational materials;
- Perform dramas;
- Organise sports events.

Activities to Motivate and Support Behaviour Change

Important:
Trained peer educators should be involved in planning and carrying out these activities

Remember:
- Talk to peers one-on-one
- Teach peers how to do a personal risk assessment
- Teach peers how to negotiate ATMs prevention
- Provide individual counselling
- Recommend or refer peers for TB diagnoses/HIV testing

Qualities for Selecting Peer Educators

- Ability to communicate clearly and persuasively with their peers.
- Good interpersonal skills, including listening skills.
- Socio-cultural background similar to that of the target audience (this may include age, sex and social class).
- Accepted and respected by their peers.
- Non judgmental attitude.
- Strongly motivated to work toward minimum standard for disease prevention.
- Demonstrate care, compassion and respect for people affected by ATMs.
- Self-confident and show potential for leadership.
- Pass a practical, knowledge-based examination at the end of the training.
- Time and energy to devote to this work.
- Should have the potential to be a role model for their peers.
- Should be able to get to the location of the target audience.
- Should be able to work at irregular hours.

Social Marketing

Social marketing applies traditional commercial marketing tools and concepts such as the **4 P**'s - **p**roduct, **p**rice, **p**romotion, and **p**lace (distribution) - to achieve the objectives of public health and other social programmes. Social marketing programmes involve products such as condoms, contraceptives, zinc tablets, or bednets, or may focus only on health practices or on influencing health-seeking behaviours.

4.5. Ownership/Sustainability

Central to interventions is the logic that beneficiaries, communities and governments will continue with activities as a way of ensuring sustainability. At the heart of such sustenance is the concept of ownership which means the wholesale buy-in of communities and governments in such a way that they continue to provide the finance, logistics, personnel and other requirements on a consistent basis.

Ownership is a test of stated commitments by local stakeholders to a cause. It is the evidence of their belief in the benefits of programmes in the absence of or minimal donor or external support.

Since ATMs interventions straddle key areas of community health, social and economic concerns, ownership and sustainability are essential to consolidating on the gains currently being recorded. Such ownership assures that gaps are addressed.

That is why CSOs should actively contribute to the process of ensuring project ownership and sustainability of initiatives, while also being a part of the ferment of ideas to strengthen planning, strategy and implementation.

Methods

Plenary presentation, Interactive Discussion, Experience Sharing, Group session/Planning/exercise, Assignment, Group presentation, Demonstration, Role play, plenary discussion, Evaluation

Group work/exercises

Group 1:

a. Design a participatory community plan for an ATM intervention based on a report that two children die weekly from malaria in your community, while cases of drug-resistant TB is on the rise and that sexually exposed senior primary school children are being infected with HIV/AIDS.

Group 2:

a. Do a situation analysis of key targets for an advocacy plan to secure the commitment of key stakeholders in view of the underfunding of ATMs in any state in Nigeria. Also come up with key discussion points during the meetings and why you consider them key.

b. Develop three key messages each on HIV/AIDS, TB and malaria for four identified targets in Lagos, Kano and Anambra States.

Group 3:

a. You are sent to a transit town like Jebba in Kwara State and Shagamu in Ogun State where there is a high number of susceptible trailer/tanker drivers. Rumours have it that there are also many commercial sex workers in the two locations. Design an ATM community mobilisation intervention activity to address these issues.

MODULE 5

THE STRUCTURE OF NATIONAL RESPONSE AND HOW CIVIL SOCIETY FITS

Objectives

At the end of the training, participants are expected to:

- ☞Discuss and state the levels of ATM national response;
- ☞Identify ATM donors and partners;
- ☞State the roles of the private sector in ATM activities;
- ☞Ask and answer specific questions on how CSO coalitions/networks could collaborate better for integrated ATM outcomes.

Trainin

5.1. Tiers of Government

The role of government at national, state and local levels should be central to the ATM initiative. Despite gains recorded in the endorsement of various treaties, agreements to achieve prevention, control and treatment targets, there remain challenges of translating commitment/pronouncements to action at the respective tiers of government. There are challenges with meeting expectations, especially in the five elements of DOTS, for instance, in the areas of human resource capacity, laboratory infrastructure, and monitoring and reporting.

Each of the diseases has well enunciated Strategic Plans while ownership issues remain a challenge. A lot of activities still appear to be driven by donors and from the national level where the donors and development partners and government operate coordination mechanisms. Although such mechanisms exist at State and LGA levels there are variations to implementation of stated commitments.

There are also integration challenges at the various tiers, although collaboration has been more evident between the TB and HIV/AIDS programmes. The TB/HIV Working Group was officially inaugurated in July 2006. In the Integrated Vector Management (IVM) approach for malaria prevention ITN/LLIN is a major approach. Distribution is based on a mixed model that involves all form of deliveries: free public sector campaigns either integrated with other health activities such as immunisations or as 'stand alone' campaigns. Others are free public sector routine distributions through ANC and NPI (EPI) services are subsidised at cost sales through the commercial sector. There are however major plans for LLINs distribution nationally. There is also emphasis on the prompt diagnosis and treatment of clinical cases at all levels, prevention and treatment of malaria in pregnancy.

5.2. Donors/Development Partners

Partnership is central to the heart of the participation by stakeholders in ATM activities. This has been institutionalised in the context of Public-Private Partnership (PPP) which is the major thrust of health sector reform and a mechanism for optimising health services delivery.

The thrust of partnership revolves around the following key elements:

- Build and maintain relationships (networking) with relevant individuals and

groups at the appropriate levels.

- Share information with all relevant individuals and groups to encourage collaborative participation and confidence building.
- Strengthen collaboration between health related agencies with community groups to encourage participatory approach to immunisation and primary healthcare issues.
- Desire to achieve both immediate and long term solution with sustainable impact in PHC and immunisation services.
- Partners should encourage leadership across collaborating agencies especially in the government ministries.

These partners pool resources (human, financial and material) with the aim of addressing the challenges of ATMs. They include NACA, RBM, NTBLCP, CiSHAN, ACOMIN, TB Network, The Global Fund, USAID, DFID, ActionAid, UNAIDS, ILO, WHO and UNICEF.

5.3. The Private Sector

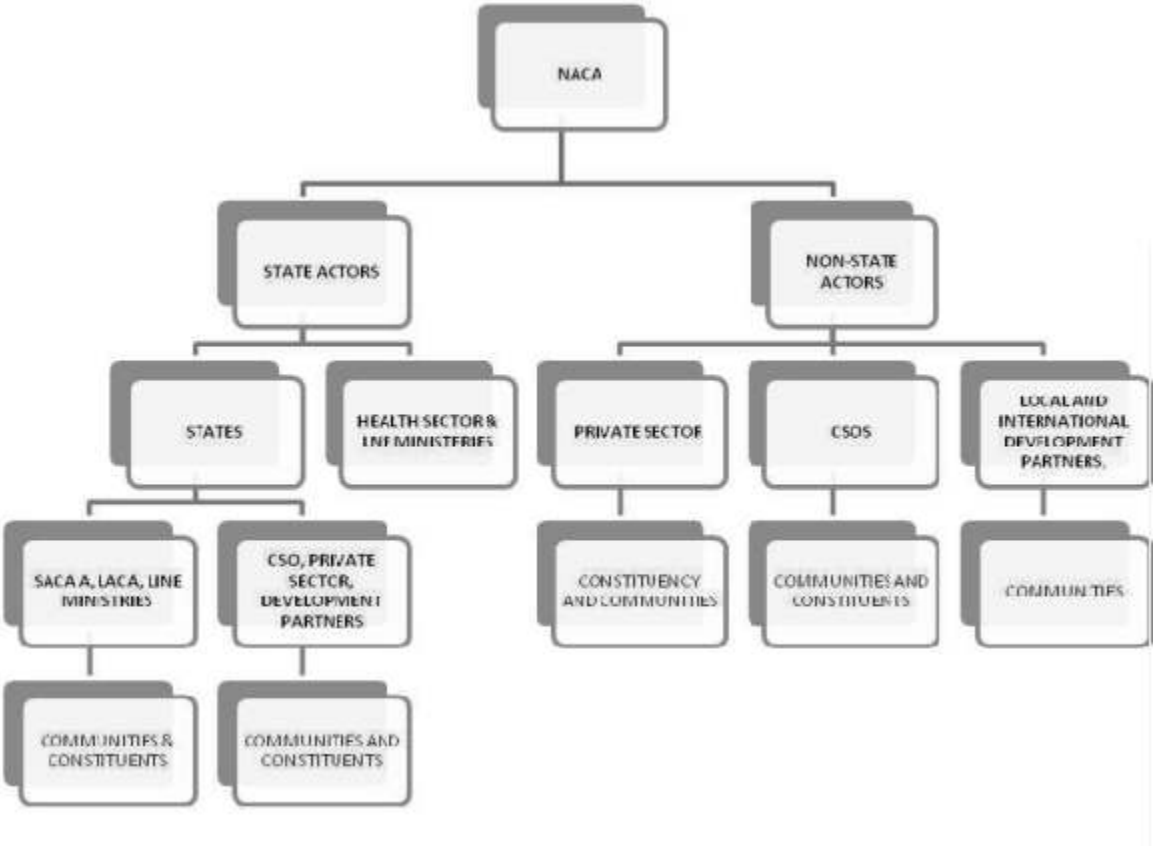
The private sector has a history of financial, logistics and other contributions to ATM interventions but the Public Private Partnerships (PPP) is yet to be optimised as a resource pool. The commitment of the private sector is seen as significant to securing the long-term sustainability of programmes for education, prevention, treatment and care in Nigeria. Private sector entities often partner with other institutions to implement and/or expand their programmes. Institutional relationships exist under the PPP for collaboration; for example, The Global Fund and local partners.

Five avenues through which private sector firms can be more involved in ATM activities include:

- Collaborating on proposal development for specific activities;
- Supporting the implementation of programme activities through logistics and finance;
- The private sector can also contribute by providing consulting services or staff for secondments;
- Technical assistance and services in the implementation of projects;
- By participating in Country Coordination Mechanism (CCM) - a national, multi-stakeholder decision-making body known as a CCM.

From research evidence, there are five areas in need of private sector strategic support:

- Developing an awareness in the private sector of its potential role;



- Developing an enabling environment for mutual trust and communication among private and public partners;
- Fine-tuning methodologies of interventions including the design and negotiation of public/private partnerships;
- Accelerating service delivery by increasing absorptive capacity, improving project design and contributing to implementation management;
- Setting targets for achieving universal access to ARVs, DOTS and ITNs/LLINs.

5.4. Coalitions/Networks

In order to achieve the objective of integration for multi-sectoral ATM interventions, it is important to answer the following questions, even while acknowledging the existence of some coalitions and networks:

- Is there an existing network or coalition established to deal with ATM problems? If not, are there other people or groups who are concerned with this issue and who should become part of the coalition?
- Have they had a meeting to discuss common concerns? Are they doing anything to overcome it? Who are those to join them but are not yet part?
- Can a strong coalition be established? Who will get it going? Who will keep it

going?

Methods

Plenary presentation, Interactive Discussion, Experience Sharing, Group session/Planning/exercise, Assignment, Group presentation, Demonstration, Role play, plenary discussion, Evaluation.

Group work/exercises

Group 1:

a. In Koko, there is a very popular civil society group which is widely respected in government circles, the private sector and the religious community. Its leader is a former politician. Although it is a democracy and good governance group, it has never been involved in public health issues. In the same town are other smaller CSOs which are working hard to promote ATM
i ssues but are led by enthusiastic young men with little influence. As an ATM CSO, discuss specific steps you will take to overcome the challenges posed by inadequate attention to ATM issues in the critical local communities you operate and how you will engage the influential CSO for ATM activities. Remember that the community you work in is deeply involved in the politics of your state but not paying enough attention to the ravages of the three diseases which you should also highlight.

Group 2:

a. Come up with five practical steps for coalition building for effective integration of ATM interventions in Abuja as a federal capital in Nigeria, and in any state and LGA of your choice.

Group 3:

a. List ten steps for the engagement of the executive, legislature and judiciary for specific activities they are in the best position to actualise for ATM integration in Nigeria. Provide the justification for each step of engagement.

SOURCES OF CONTENT/REFERENCE MATERIALS

2006 - 2010 National Strategic Framework for Implementing TB/HIV Collaborative Activities in Nigeria, Federal Ministry Of Health Department Of Public Health

2008 National HIV Sero-Prevalence Sentinel Survey Among the Ante Natal Clinic Attendees, Preliminary Findings

Adesegun O.F / Kayode I., Analysis of HIV/AIDS Treatment Access Policy in Nigeria and its Implementation.

Aishatu Abdullahi, Prevalence of HIV infection among TB patients in Kano state, 2007

AU, May 2006; Special summit of the African union on HIV/AIDS, Tuberculosis and malaria: Abuja 2-4 May 2006 - financial factors affecting slow progress in reacting agreed targets on HIV/AIDS, TB and malaria in Africa.

Behaviour Change Through Mass Communication: Using Mass Media for AIDS Prevention, The AIDS Control and Prevention (AIDSCAP) Project

Bruce Paruell and Kim Benton, Facilitating sustainable behaviour change: A guidebook for designing HIV programmes, 1999.

Collaboration Handbook: Creating, Sustaining, and Enjoying the Journey, Amherst H. Wilder Foundation (Order from the Publishing Center, 919 Lafond Ave., St. Paul, MN 55104, 800-274-6024, www.wilder.org.

Dr. Damaris O. Onwuka, Zonal Coordinator, NPHCDA South East Zone, Enugu, Overview of PHC in Nigeria, Presentation at the PHC Technical Review Meeting for Jan-June 2007 in Ebonyi State, July 18 -20 2007

E.Segura, Issues in Reform 2005 (Accessed online May 16 2010)
Federal Ministry of Health, National Malaria Control Programme, Abuja, Nigeria. Strategic Plan 2009-2013 A Road Map for Malaria Control in Nigeria

FMOH / NACA, Situation Analysis Report on STD / HIV/AIDS in Nigeria, March 2000.

Four Principles of Interpersonal Communication, http://www.pstcc.edu/facstaff/dking/interpr.htm

Guidelines For Community Tuberculosis Care, Federal Ministry of Health, Department of Public Health, National Tuberculosis and Leprosy Control Programme

HIVTB Global Leaders Forum, Key Messages, June 9, 2008 (available online).

How to Create an Effective Peer Education Project: Guidelines for AIDS Prevention Projects, The AIDS Control and Prevention (AIDSCAP) Project

Key Messages for the Launch of The Red Ribbon Month and World AIDS Day, 1 December 2008, The South African National Aids Council (SANAC)

Key messages for World AIDS Day 2009, http://www.info.gov.za/issues/hiv/aidsday2009.htm#messages Malaria.pdf (available online)

Mark Person, Improving the Health of the Nigerian People, May 2003.

Naomi R / Sam Kalibala / Charles M / Jem Rosen, Integrating HIV prevention and care settings: Lessons learned from Horizons studies, July 2001.

National HIV/AIDS Strategic Documents, March 2010.

National Integrated Communication and Social Mobilisation Strategy for Immunisation in Nigeria, Federal Government of Nigeria National Primary Health Care Development Agency, 2008

National TB and Leprosy Control Programme Annual Report - 2008

Nigeria. FMOH, HIV/AIDS in Nigeria: Overview of the Epidemic, 2002.

Nigeria. FMOH, HIV/AIDS: What it Means for Nigeria (Background, Projections, Impact, Interventions, and Policy), 1st edition, 2002.

Nigeria. FMOH, National Reproductive Health Strategic Framework and Plan 2002 2006, June 2002.

Nigeria (NACA), HIV/AIDS Emergency Action Plan: A 3 year Strategy to Deal with HIV/AIDS in Nigeria

Nigeria (NACA), Project Implementation Manual (PIM) for Nigeria HIV/AIDS Programme Development Project, 2002.

Nigeria (NACA), National HIV and AIDS Strategic Communication Framework for Nigeria, February 2003.

Nigeria, National Policy on HIV/AIDS, 2003

Oliende Amollo P.M, Human Rights Implications of the HIV/AIDS pandemic in Africa, October 1997

Partnership with the Media: Working with the Media for HIV/AIDS Prevention, The AIDS Control and Prevention (AIDSCAP) Project

PMI Communication and Social Mobilisation Guidelines

Policy and Advocacy in HIV/AIDS Prevention: Strategies for Enhancing Prevention Interventions, The AIDS Control and Prevention (AIDSCAP) Project.

Policy Project Nigeria, HIV/AIDS in Nigeria: Situation, Response and Prospects, November 2002.

Raymond W. Copson, AIDS in Africa, January 2003.

Scott C. Ratzan, Journal of Health Communication: International Perspectives.

Seidel, R. Behaviour Change Perspectives and Communication guidelines on six Child Survival Interventions (AED/CCP), Dec, 2005.

Strategic Plan 2009-2013: A Road Map for Malaria Control in Nigeria, Federal Ministry of Health, Malaria Control Programme, Abuja, Nigeria

Supporting Community Based Responses to Aids: A Guidance Tool for Including Community Systems Strengthening In Global Fund Proposals

TAC Messages for World AIDS Day, http://www.tac.org.za/community/node/2785, 27 November, 2009

TB Policy in Nigeria: A Civil Society Perspective, Open Society Institute, 2006

The Global Fund's Strategy for Ensuring Gender Equality in the Response to HIV/AIDS, Tuberculosis and Malaria ("The Gender Equality Strategy")

The Link between Malaria and HIV and AIDS, Roll Back Malaria and World Vision (available online)

The Principles & Practice of Primary Health Care, networklearning.org, (updated August 2006)

The Role of the Private Sector in the Global Fund to Fight AIDS, Malaria and Tuberculosis: Opportunities, Achievements, Challenges

UNAIDS, Accelerating Action against AIDS in Africa, 2003, unaids@unaids.org
UNAIDS, A joint action to HIV/AIDS, 2003, unaids@unaids.org

UNAIDS, HIV/AIDS: human resources and sustainable development; World Summit on Sustainable Development, Johannesburg, 2002.

UNAIDS, Meeting of Ministers of Health of the OAU on HIV/AIDS, June 2000, unaids@unaids.org

UNAIDS, Report on the global HIV/AIDS epidemic, July 2002, unaids@unaids.org

UNAIDS / WHO, AIDS epidemic update, December 2002.

UNICEF /UNAIDS / WHO, Young People and HIV/AIDS: Opportunity in Crisis, July 2002, pubdoc@unicef.org, unaids@unaids.org, info@who.int

USAID Nigeria Concept Paper, 2003

World Bank, Intensifying Action Against HIV/AIDS in Africa: Responding to a Development, 2000.

World Economic Forum, Key Messages on TB (available online)

Workplace Action on HIV/AIDS: Factsheet 4, ILO

World Health Organisation, Global Tuberculosis Control: Surveillance, Planning, Financing. Who Reports 2004, 2005 and 2006. Geneva, Switzerland.

www.wikipedia.org/gender mainstream

Additional Resources

For further information about male involvement approaches in Module 3, see the resources available through the IGWG Men and Reproductive Health Task Force at www.rho.org/html/menrh_igwg.html.

This checklist adapted in Module 3 was developed as a joint effort between the Bank's Gender and Development Group in PREM (PRMGE) and the Africa Region Health team (AFTH2) in a publication entitled, “HIV/AIDS Projects in the Africa Region: a Baseline Assessment.”
http://www.worldbank.org/afr/aids/gom/submanuals/12%20Gender%20HIV-AIDS.pdf

Appendices

Action Plan template

State goal of your plan

S/n	Objective	Methodology /Strategy	Activity	Target Beneficiaries	Persons responsible	Time line	Objectively Verifiable Indicators	Means of Verification	Resource requirement	Sources of funding

Sample Messages

Malaria Key Messages (including Action and Audiences)

Belief:

- Mosquitoes cause malaria
- Mosquitoes that bite at night are the only cause of malaria
- Malaria is serious, can be fatal
- Children under 5 and pregnant women are most vulnerable
- Malaria transmission can occur year-round

- You can prevent malaria in your home
- There is an effective treatment for malaria.
- Indoor Residual Spraying (IRS) is an effective means of malaria prevention and control
- Insecticides used in IRS are safe
- ITNs/LLINs are an effective means of malaria prevention and control
- ITNs/LLINs are safe for the general population and specifically children under 5 and/or pregnant women
- ITNs/LLINs must be used nightly
- It's important to take medicine to prevent malaria when pregnant
- Intermittent Preventive Treatment in Pregnancy (IPTp) is safe
- It's important to seek treatment for fever in children within 24 hours from a qualified provider

Action:

- Acquire ITN/LLIN
- Sleep under an ITN/LLIN every night
- Prepare buildings for spraying and allow sprayers inside structures
- Seek treatment from qualified health worker within 24 hours of onset of fever of child
- Take the complete dose of anti-malarial correctly
- Go to ANC before the fourth month of pregnancy
- Return to ANC as scheduled

Interventions, Mode of Delivery and Key Audiences:

ITNs/LLINS: Delivered free through mass campaigns, routine delivery through ANC/EPI visits, social marketing, voucher programmes

Policy makers

- Ensure adequate supplies are available at front line facilities and in the community
- Endorse the removal of taxes and major financial barriers
- Support a coordinated and harmonised ITN strategy

Families, decision makers, e.g. heads of households, mothers

- Acquire ITNs /LLINs
- Hang ITNs/LLINs correctly; use them consistently

Health service providers and community volunteers, distributors (vendors)

- Promote ITNs/LLINs at every opportunity (ANC visits, child visits, etc)
- Give information on how/when to use ITN/LLIN, including demonstrating

how to hang

- Distribute and explain vouchers as needed and provide information on where to get ITNs/LLINs

Community leaders, organisations

- Promote ITNs/LLINs at every opportunity (community meetings, child health days, etc) and special events
- Demonstrate use, hanging, etc.

IRS: Delivered through annual/semi-annual campaigns prior to rainy season

Policy makers

- Explain the rationale and implications of IRS

Families

- Prepare buildings before spraying
- Allow sprayers inside home
- Don't wash walls after spraying

Sprayers

- Carry out effective, quality operations
- Wear protective equipment (ensure that pregnant women are not unduly exposed)
- Facilitate spraying within communities (planning, discussing with community, etc.)

Community leaders, organisations

IPTp: Delivered through routine ANC visits, at least twice

Policy makers

- Understand the dangers of malaria during pregnancy
- Enforce the national IPTp policy

Women, mothers

- Attend ANC in first trimester and return regularly
- Take SP doses, as per country policy

Health service providers

- Provide correct SP dose to healthy pregnant women at correct times and explain its purpose and potential side-effects

- Encourage early and frequent ANC attendance; give appointments for next visit

Community leaders, organisations

Encourage early and frequent ANC visits, especially for IPTp

Treatment of Fever: Delivered through community/home-based channels, the private sector, at the health facility, and in some cases, through Private Patent Medicine Vendors (PPMVs) traditional healers

Policy makers

- Support the introduction of evidence-based practices for case management
- Endorse classification of first line ACT for over-the-counter sale and distribution
- Support the establishment of a quality control system for anti-malarials.

Families

- Recognise signs and symptoms of malaria and the high risk that malaria poses for children under 5 and pregnant women
- Seek treatment for children within 24 hours of on-set of fever
- Access and give the right ACT, in the right dose, for the right number of days
- Recognise signs of severity/complications/failure to respond to treatment and seek help from a qualified provider promptly

Health service providers (including community-based, where appropriate)

- Ask about previous treatments (to identify treatment failures) and symptom history
- Prescribe the right ACT in the right doses
- Explain clearly how to take medication and discuss side effects
- In areas of stable malaria transmission, treat all febrile children under 5 with the appropriate ACT
- Recognise signs of severe disease and treat or refer

Private Patent Medicine Vendors Medicine dispensers

- Ask about previous treatments (to identify treatment failures) and symptom history
- Dispense the right ACT in the right doses
- Explain clearly how to take medication and discuss side effects
- In areas of stable malaria transmission, treat all febrile children under 5 with the appropriate ACT

- Ask about signs of severity and refer to health Centre when necessary (see PMI Communication and Social Mobilisation Guidelines).

TB Key Messages

- TB is preventable and curable.
- TB is a chronic infectious disease caused by Mycobacterium tuberculosis. The disease is neither a curse nor hereditary; anyone can get it.
- Persisting cough for two weeks or more, coughing up blood or blood in the sputum are major TB symptoms. Chest pains, fever, night sweats and weight loss are also frequent symptoms.
- Prompt diagnosis and early initiation of standardised treatment is key to successful management of TB.
- TB is curable with regular and standard treatment under the supervision of doctors or healthcare staff.
- Most TB patients will not be infectious after a two-week treatment.
- TB patients can return to work once it is confirmed that they are no longer infectious.
- Both TB and HIV are infectious diseases that can seriously harm people's health and each speeds the other's progress.
- A person living with HIV, with a fever or swollen glands or with any of the symptoms mentioned above may have TB and should seek care as soon possible. TB is curable even in persons living with HIV with regular and standard treatment under the supervision of doctors or healthcare staff.
- Multidrug-resistant TB can develop with irregular treatment or by discontinuing treatment before completing the full course or by taking poor quality drugs.
- Stigma and discrimination of those with TB make TB detection difficult and should be eliminated.
- Adequate knowledge and awareness can minimise stigma and discrimination.
- TB prevention, care and control in the workplace is good for employers and employees.
- The government, private sector, local communities and the general public should make a joint effort for better TB prevention, care and control.

HIV/AIDS/TB Key Messages

- Every three minutes a person living with HIV dies of TB.
- Bold leadership is needed at all levels to cut the number of deaths from TB

among people living with HIV.

- HIV and TB are major constraints for socio-economic development.
- Joint TB and HIV/AIDS interventions will strengthen health systems and contribute to the achievement of the Millennium Development Goals on poverty reduction by keeping people healthy and productive.
- The emergence of drug resistant strains of TB has created additional challenges to individual patients and the health system.
- Available drugs, diagnostics and vaccines are not appropriate for people with HIV/TB co-infection. New tools are needed that work in the presence of co-infection.

Malaria and HIV/AIDS Key Messages

- Malaria and HIV/AIDS are preventable.
- HIV-positive individuals may be more susceptible to malaria illness because of their weakened immune systems.
- Malaria contributes to a temporary increase in viral load among HIV-infected people which can increase mother to child transmission and transmission in adults.
- Malaria and HIV/AIDS make the poor poorer.
- PLWHIV are at greater risk of clinical malaria and severe illness.
- Children and adults who have HIV/AIDS are more likely to experience severe malaria requiring hospitalisation and possible death.
- HIV infection can decrease the protection offered by anti-malarial treatment
- Malaria causes anaemia which often requires blood transfusions, a procedure that increases the risk factor for HIV infection.
- Both HIV/AIDS and malaria HIV worsens the effect of malaria during pregnancy, causing an increase in anaemia, clinical disease and low birth weight in babies.
- Malaria can be effectively treated, even in PLWHIV.

AIDS Key Messages

Prevention

African health services provide these services free of charge.

- Having more than one sexual partner increases the risk of HIV.
- Every time you start a new sexual relationship you should both be sure of your HIV status.
- Young people to delay having sex for the first time.
- Young people to make informed choices to prevent unwanted pregnancies and HIV infection.
- Sexually active people should be faithful to their partners and to use

condoms each time they have sex.

- Pregnant women to test for HIV early in their pregnancy .
- Having unprotected sex when drunk increases the risk of HIV infection.
- Having unprotected sex in exchange for money or other material things increases your risk of HIV infection.
- HIV & AIDS and TB continue to aggravate suffering, illness and death, orphan hood, while increasing pressures on health workers, teachers, the elderly, and loss of national productivity and profits.
- TB is preventable and curable, if patients complete and adhere to their treatment even if they are HIV positive.
- Always ask to be screened for TB if you are HIV positive and test for HIV if you have TB.
- TB can be cured even if you are HIV positive.
- TB can be cured if you take your medication consistently for not less than six months.
- Antiretroviral therapy (ART) and good nutrition can substantially prolong and improve the lives for those living with HIV.
- ARVs are a lifelong commitment.

Government/Partners

- We are unequivocally committed to treating and caring for people living with HIV & AIDS and TB, and reducing the impact on their families.
- We are taking responsibility to make sure that everyone tests for HIV receives counselling and education on available prevention methods and that all people have access to treatment for TB and HIV.
- We will strengthen our partnership with CSOs and stakeholders to ensure effective health systems response to ATMs.

Communities

- Go for HIV and Tb screening today.
- Support people living with HIV.
- Let everyone know and prevent mother to child transmission of HIV/AIDS
- Protect yourself from illicit sex and protect others.
- Couples should talk about their relationships and how they can protect each other from HIV infection.
- Couples can protect themselves by remaining faithful to each other, testing for HIV together and always using condoms.
- Men, women, families and healthcare workers should support pregnant women so that they can make decisions to protect their children from HIV.
- Communities should provide care and support to those living with and

affected by HIV, in particular orphans and vulnerable children.

- Speak out against violence against women.
- Stop stigma and discrimination against people living with HIV/AIDS and TB patients.
- All those with tuberculosis (TB) can access TB drugs
- All HIV positive people can access anti-retroviral (ARV) treatment.
- Go to the nearest health centre for information on ATM testing, care and treatment
- Use condoms each time you have sex.
- Having sex when you have been drinking or using drugs increases your chances of getting infected with HIV.
- Having sex in exchange for money or other material things increases your chances of getting infected with HIV.
- It is your right as a PLWHIV to get anti-retroviral (ARV) treatment.
- Successful treatment means being responsible for taking the medications every day. This is a lifelong commitment.
- Anti-retroviral (ARV) treatment and good nutrition can prolong and improve the lives of people living with HIV.
- Your health is your responsibility. If you are HIV positive then go for regular checkups at your nearest health facility so that you get the medications that you need.
- Every man and woman has the right to decide if and when they want to have a baby.
- Every man and women has the responsibility to prevent unwanted pregnancies and sexually transmitted infections.
- Every pregnant woman and her partner should visit a clinic as soon as she realises she is pregnant and they should test for HIV.
- Fathers, families, communities and healthcare workers should support women living with HIV so that they can make the best decisions for their baby during the pregnancy and after the birth.
- Every HIV positive pregnant woman should ask for and receive ARV treatment to stay healthy and to prevent infecting her child with HIV.
- Every HIV positive mother has the right to decide whether to only breastfeed or to only use infant formula feeding. To make a decision she must discuss these choices with her health care worker.
- Every baby born to a HIV positive mother should be tested for HIV after six weeks.
- Every baby born with HIV has the right to receive ARV treatment to improve its quality of life.
- Do your CD4 count so that you can access ARV treatment.
- Let's all change our sexual behaviours and act responsibly.
- Talk to your partner, friends, family and colleagues at work about how you

can prevent becoming infected with HIV.

- Pregnant women should test early in their pregnancy for HIV so that they can prevent their babies from getting infected with HIV.
- Organise a discussion in your office, community or organisation about what you can do to stop the spread of HIV.
- Organise a community march or activity to talk about HIV.

Pre and Post Test

NB: Every question after the first question to be answered in not more than two short sentences.

Time Allowed: 30 minutes

1) What do the following acronyms mean?
   a. HIV/AIDS
   b. ITN
   c. ARV
   d. IPT
   e. ABC
   f. IRS
   g. TB
   h. PLWHIV
   i. NTBLTC
   j. CTBC
   k. DOT
   l. RBM
2) What do you understand by integrated response to HIV/AIDS, TB and malaria epidemics?
3) What is multi-sectoral response to HIV/AIDS, TB and malaria epidemics?
4) What is Supply chain management in HIV/AIDS, TB and malaria epidemics management?
5) What is the importance of Information sharing in programme development & policy formulation for HIV/AIDS, TB and malaria epidemics interventions?
6) Why should Monitoring, evaluation and reporting be embarked upon by the CSOs in HIV/AIDS, TB and malaria epidemics interventions?
7) What are the resources required for HIV/AIDS, TB and malaria epidemics interventions?
8) What are the various ways for resource mobilisation in HIV/AIDS, TB and malaria epidemics interventions?
9) Why should the CSOs be involved in oversight functions in HIV/AIDS, TB and malaria epidemics interventions?
10) List five ways in policy influencing for HIV/AIDS, TB and malaria epidemics interventions?
11) State points of advocacy to other stakeholders in HIV/AIDS, TB and malaria epidemics control?
12) What are the capacity development needs of CSOs at the community level in HIV/AIDS, TB and malaria epidemics control?

13) What is the importance of strategic plan development for CSOs in HIV/AIDS, TB and malaria epidemics control?

14) What is the importance of mainstreaming gender in HIV/AIDS, TB and malaria epidemics interventions?

15) What is the importance of the media in HIV/AIDS, TB and malaria epidemics interventions?

16) What is the importance of partnerships and collaboration in HIV/AIDS, TB and malaria epidemics interventions?

……

……

... ...

……

.....

Pre and Post Test

NB: Every question after the first question to be answered in not more than two short sentences

Time Allowed: 30 minutes

1) What do the following acronyms mean?
   a. HIV/AIDS
   Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
   b. ITN
   Insecticide-Treated Nets
   c. ARV
   Anti Retroviral
   d. IPT
   INH (Isoniazid) Preventive Therapy
   e. ABC
   Abstinence, Being Faithful, Condom
   f. IRS
   Indoor Residual Spraying
   g. TB
   Tuberculosis
   h. PLWHIV
   People Living With HIV and AIDS
   i. NTBLTC
   National Tuberculosis and Leprosy Training Centre
   j. CTBC
   Community TB Care
   k. DOT
   Directly Observed Therapy
   l. RBM
   Roll Back Malaria

2) What do you understand by integrated response to HIV/AIDS, TB and malaria epidemics?
   Ensuring a combined and effective response to HIV/AIDS, TB and malaria epidemics for optimal utilisation of resources.

3) What is multi-sectoral response to HIV/AIDS, TB and malaria epidemics?
   Involving all the sectors such as the public sector, private sector, civil society organisations, faith-based organisations, professional bodies, the trade

unions and community associations, etc, in instituting interventions in ATM.

4) What is Supply chain management in HIV/AIDS, TB and malaria epidemics management?
A reliable and consistent supply of various commodities and test kits, laboratory reagents and medical consumables, etc, needed to support effective response to HIV/AIDS, TB and malaria epidemics.

5) What is the importance of Information sharing in programme development & policy formulation for HIV/AIDS, TB and malaria epidemics interventions?
Information sharing is a process of disseminating set of timely data that has been processed and verified among stakeholders to support effective response to HIV/AIDS, TB and malaria epidemics.

6) Why should Monitoring, evaluation and reporting be embarked upon by the CSOs in HIV/AIDS, TB and malaria epidemics interventions?
Monitoring ensures the provision to management and main stakeholders of an ongoing intervention with early indications of progress, or lack thereof, in the achievement of results while Evaluation as a selective exercise ensures the systematic and objective assessment of progress towards and the achievement of an outcome while Reporting ensures the documenting and disseminating of activities and results to relevant stakeholders.

7) What are the resources required for HIV/AIDS, TB and malaria epidemics interventions?
a. Financial
b. Technical
c. Human
d. Material

8) What are the various ways for resource mobilisation in HIV/AIDS, TB and malaria epidemics interventions?
- Submitting grant proposals
- Special events
- Running a small business
- Soliciting donations
- Unsolicited contributions

9) Why should the CSOs be involved in oversight functions in HIV/AIDS, TB and malaria epidemics interventions?
- Programme activities are carried out as planned;
- Programmes that are successful are scaled up further and those that are not are provided with capacity building or halted;

Funds are spent efficiently, effectively and transparently; Both beneficiaries and financing agencies are provided with timely and complete information on the appropriate disposition of funding.

10) List five ways in policy influencing for HIV/AIDS, TB and malaria epidemics interventions?
   a. Identifying issues requiring policy interventions.
   b. Reconstituting the issues requiring policy interventions.
   c. Issue-based advocacy for relevant stakeholders.
   d. Bill drafting and bill development for the lawmakers.
   e. Mobilising the right set of policy makers on the subject matter.

11) State points of Advocacy to other stakeholders in HIV/AIDS, TB and malaria epidemics control?
   a. The epidemiologic situation on ATM.
   b. Status of currently available health services and their performance on ATM.
   c. The situation and needs of the target groups.
   d. The expected benefits of community.

12) What are the capacity development needs of CSOs at the community level in HIV/AIDS, TB and malaria epidemics control?
   Capacity development may cover personnel and institutional development, depending on the needs assessment or the demands. Capacity building may be done in form of specific training/retraining, mentoring, partnership, funding, technical support, conferencing/meetings.

13) What is the importance of strategic plan development for CSOs in HIV/AIDS, TB and malaria epidemics control?
   The strategic plan development in HIV/AIDS, TB and malaria epidemics control enables organisation to where it is, how it is going and how to get there. It should outline the vision, the goal, the objectives and the activities of the organisation with respect to any aspect of ATM interventions.

14) What is the importance of mainstreaming gender in HIV/AIDS, TB and malaria epidemics interventions?
   -It allows the assessment of the implication of any action in all areas and all levels for men and women (legislation, policies and programmes)
   -It is a strategy for making men and women's concerns to be an integral part of the design, implementation and evaluation of policies and programmes
   -It ensures that the entire population fully participate in processes and outcomes for ATM interventions

15) What is the importance of the media in HIV/AIDS, TB and malaria epidemics interventions?

- Make people aware of ATM in their own community.
- Provide information on the three diseases.
- Educate people about how to prevent or protect themselves.
- Help shape ideas about acceptable and healthy behaviour and practices.
- Refer people to health centres for treatment.
- Help people change their behaviour by imitating role models.
- Help people understand the benefits of behaviour change.
- Help people understand how to change their behaviour

16) What is the importance of partnerships and collaboration in HIV/AIDS, TB and malaria epidemics interventions?

- Partnership allows access to more financial resources, tangible resources, people resources, licensed client services, and professional expertise.
- Donor agencies, such as foundations and government grants, will be more likely to consider programme proposals because more areas of need are addressed and there is less duplication of services.
- Collaboration allows and promotes cooperation and relationships, even though the parties are not necessarily bound contractually and the relationship is less formal and responsibilities may not be shared equally.
- Partnerships and collaborations make easier to identify stakeholders (persons or organisations) that are capable and motivated to support the successful implementation of the programme in the context of the national guidelines.

Community Systems Strengthening (CSS) Component of the Global Fund Round 8 Health System Strengthening (HSS) Project Brief

The mounting scale of the three epidemics of HIV/AIDS, Tuberculosis and Malaria (ATM), and the more recent availability of significant financial resources to respond to the diseases, has increased pressure on national systems to scale-up and improve the quality of implementation efforts. Scaling up the response to the three diseases will not be successful without strengthened community systems. In the context of health, community systems strengthening (CSS) is therefore an approach that promotes the development and sustainability of communities and community organisations and actors, and enables them to contribute to the long-term sustainability of health and other interventions at community level. The focus is to develop the role of key populations and communities, and community organisations, networks and other actors, in the design, delivery, monitoring and evaluation of services and activities aimed at improving health outcomes.

CSS is a way to improve access to and utilisation of formal health services but it is also, crucially, aimed at increased community engagement (meaningful and effective involvement as actors as well as recipients) in health and social care, advocacy, health promotion and health literacy, health monitoring, home-based and community based care and wider responses to ensure an enabling and supportive environment for such interventions. Besides, in order to have real impact on health outcomes, however, CSOs, CBOs, FBOs and their networks must have effective and sustainable systems in place to support their activities and services. This includes a strong focus on capacity building, human and financial resources to enable community actors to play a full and effective role alongside health and social welfare systems. CSS is a means to prioritise adequate and sustainable funds for specific operational activities and services and, crucially, core funding to ensure organisational stability as a platform for operations and for networking, partnership and coordination with others.

The Global Fund recognises that the presence of strong, sustainable community-based organisations is an important element of ensuring program impact, sustainability, and results for ATM prevention, treatment, and care and support efforts. CSS initiatives are encouraged by the Global Fund with the aim of achieving improved outcomes for ATM and related health challenges with emphasis on strengthening community based and community led systems for ATM response.

Nigeria, in recognition of the above, is being supported by the Global Fund under the Round 8 application for the Health Systems Strengthening (HSS) intervention which is aiming at developing the systems for health care delivery in the country. The Community Systems Strengthening project is one of the Service Delivery Areas of the HSS intervention. The CSS component of the Global Fund Round 8 is geared towards strengthening the capacity of core process of the civil society/community based networks and community level committees to ensure the provision of an increased range and quality of services in scaled up ATM interventions.

The CSS is focused on developing the Civil Society for HIV and AIDS in Nigeria (CiSHAN); Civil Society in Malaria Control, Immunisation and Nutrition (ACOMIN); and the Civil Society for the Eradication of Tuberculosis in Nigeria (The TB Network); integrating services for treatment and prevention of ATM at the Primary Health Care and strengthening Ward Health Development Committee level. This will be achieved through integrated training and development of civil society organisations, selected from the three networks, and activating the Ward Health Development Committees in the selected Local Government Areas. The Principal Recipient for the Health Systems Strengthening Project is National Agency for Control of HIV/AIDS (NACA), whilst the Sub-Recipient is ActionAid Nigeria. The three Networks on HIV/AIDS; Malaria and TB are the Sub-Sub Recipients to ActionAid Nigeria.