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<th>ACRONYMS AND ABBREVIATION</th>
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<td>ART</td>
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<tr>
<td>ARFH</td>
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<td>BBFSW</td>
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<td>CBO</td>
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<td>CDC</td>
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<td>DCOP</td>
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<td>DIC</td>
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<td>FMWASD</td>
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<td>FSW</td>
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<td>FY</td>
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<td>GBV</td>
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<td>IDP</td>
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<td>IEC</td>
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<td>IHVN</td>
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<td>NAFDAC</td>
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<td>NASCP</td>
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<tr>
<td>NBBFSW</td>
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<td>NEPWHAN</td>
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NGO  Non-governmental organization
NHLS  National Health Laboratories Service
OASYS  One World Accuracy System
OC  Outreach coordinator
OPD  Outpatient department
OSS  One-stop shop
OVC  Orphans and vulnerable children
PACA  Police Action Committee on AIDS
PEP  Post-Exposure Prophylaxis
PEPFAR  President’s Emergency Plan for AIDS Relief
PHDP  Positive Health, Dignity and Prevention
PITC  Provider Initiated Testing and Counseling
PLHIV  People living with HIV/AIDS
PNS  Partner Notification Services
PrEP  Pre-Exposure Prophylaxis
PSS  Psychosocial Support Services
PWID  People who inject drugs
SACA  State Agency for the Control of AIDS
SAPC  State AIDS program coordinator
SBCC  Social and behavior change communication
SFH  Society for Family Health
TB  Tuberculosis
UK  United Kingdom
UN  United Nations
US  United States
USAID  United States Agency for International Development
USG  United States Government
UNAIDS  The Joint United Nations Program on HIV/AIDS
VIA  Visual Inspection with Acetic Acid
WHO  World Health Organization
MESSAGE FROM OUR COUNTRY DIRECTOR

Results from the 2019 Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS) show a national HIV prevalence in Nigeria of 1.4% among adults aged 15–49 years. Previous estimates indicated a national HIV prevalence of 2.8%. While this sharp decrease demonstrates immense progress in the fight to end the HIV epidemic, we must remember the communities that remain disproportionately impacted by the crisis. In Nigeria, extremely marginalized communities face unique health challenges that require a tailored, targeted human rights-based response. Men who have sex with men (MSM), female sex workers (FSWs), transgender persons, and people who inject drugs (PWIDs) are considered key populations (KPs). According to the federal ministry of health's (FMOH) Integrated Biological and Behavioral Surveillance Survey (IBBSS) and the National Agency for the Control of AIDS (NACA), the rates of HIV amongst KPs (22.9% (MSM), 14.4% (FSWs) and 3.4% (PWIDs)) are significantly higher than that of the general population (1.4%).

Despite accounting for more than one-third of new HIV infections in Nigeria, KPs receive little to no attention from healthcare providers and social service agencies. In 2009, Heartland Alliance International (HAI) launched a large-scale effort to bring high-quality and stigma-free healthcare to KP. Gradually, we were able to expand those services to include people who are incarcerated. With support from the Kingdom of the Netherlands, HAI was also able to evolve its programming to include sexual and reproductive health services for female drug users and FSWs in Lagos and Benue states respectively.

Through this annual report, we highlight HAI’s achievements in Nigeria during fiscal year (FY) 2019 — our 10th and final year implementing the USAID-funded Integrated Most at Risk Population HIV Prevention Program (IMHIPP). Despite the end of the program, HAI remains committed to empowering communities through models based on our theory of change that when marginalized communities achieve healing and justice, they are better able to support themselves and others. We are steadfast in our dedication to fill gaps in gender exclusion and ensure respect for human rights, irrespective of sex, sexual orientation, gender identity, or other differences we may have as humans!

Lastly, we are deeply grateful to the stakeholders who supported our work, including the FMOH, NACA, and government of Nigeria agencies. This report is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of Heartland Alliance International and do not necessarily reflect the views of USAID or the United States Government. We must also note that none of this work would be possible without the unwavering support and dedication from our community members, implementing partners, and most of all — our HAI staff.

Onwards!

Ochonye Bartholomew Boniface, Country Director
ACKNOWLEDGMENTS

HAI acknowledges the efforts of all those who contributed to the successful implementation of IMHIPP among KPs and their partners in Nigeria. We hereby extend our appreciation to the government of Nigeria through NACA, SACA/FACA and the SMOH, FMOH/NASCP, police action committee on AIDS (PACA) and all the other MDAs. Worthy of note is the support from PEPFAR/Nigeria, USAID/Nigeria, CDC, the U.S. Department of State, the embassy of the Kingdom of the Netherlands in Nigeria and other development partners. We appreciate the Global Fund, the KP Secretariat, and all the KP-led organizations in Nigeria for their confidence and cooperation throughout the ten years.

We also recognize and appreciate the leadership and technical support of the Chicago Office of HAI, UNAIDS-Nigeria leadership, and the World Health Organization (WHO) Nigeria. It is our hope that this annual report will provide useful information to enable you to support the KPs response in Nigeria.

BOARD OF DIRECTORS

Prof. Morenike Ukpong-Folayan
Olayide Akanni
Emmanuel N. Onwubiko
Major General Ogbonnaya Njoku (Rtd) mni, FRCPath, OON
Evelyn Diaz, President, Heartland Alliance
Surita Sandosham, Executive Director, Heartland Alliance International

MANAGEMENT TEAM

Bartholomew Boniface Ochonye (MHM), Country Director
Godwin Emmanuel (MBBS, MPH), Deputy Country Director
Paul Umoh (MSW), Director of Programs
Mary Adebowale (ACIPM, ANIM, MBA), Director of Operations
Winifred Adoh-Gompil (NIMAM, MBA), Director of Finance
Tolu Alamu (MPH), Strategic Knowledge Management Lead
HAI’S VISION AND MISSION

VISION
We are committed to creating a society where all marginalized people have equal access to healthcare, legal and social services, and economic opportunity in a rights-based environment.

MISSION
To lead the effort of mitigating the physiological, psychological, and economic impact of HIV/AIDS, injustice and abuse suffered by marginalized and vulnerable populations through targeted education, advocacy, capacity building, economic empowerment, and human rights interventions.

CORE VALUES
- Integrity
- Team Work
- Innovations
- Transparency
- Accountability
- Respect for Diversity

WHAT WE DO
- Differentiated model of care to HIV prevention and treatment and care – One-stop shop (OSS) health facilities, community outreaches, community ART teams, support groups.
- HIV testing and treatment.
- STI, tuberculosis (TB) screening, hepatitis and cervical cancer screening, referrals, and management.
- Sexual and reproductive health services.
- Post gender-based violence (GBV) care and support.
- Mental health and psychosocial support services (MHPSS).
- Community-based legal aid and paralegal services.
- Safety and security trainings.
- Greenhousing and capacity building for community-led organizations.
- Advocate for friendly health policies for KPs and other marginalized groups.
- Provision of sexual and reproductive healthcare services for female injecting drug users and FSW.
WHERE WE WORK

HAI Nigeria is active in the following states of Nigeria:

- FCT
- LAGOS
- RIVERS
- AKWA IBOM
- CROSS RIVER
- BENUE
- NASARAWA
- ADAMAWA
- BORNO
- YOBE
HIV PREVENTION, TREATMENT AND CARE TO KEY POPULATIONS

The U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), through USAID, funds HAI to mitigate the impact of HIV/AIDS on KPs and their sexual partners. KPs include MSM, FSW, PWID, transgender persons, and incarcerated persons. HAI Nigeria implements IMHIPP in three states in Nigeria (Akwa Ibom, Lagos and Cross River states) through building the capacity of local KP-led organizations, establishing community centers, and strengthening partnerships across sectors, communities, and related stakeholders.

The 2014 IBBSS indicates that KPs are at a high risk for HIV/AIDS with a prevalence of 22.9%, 19.4%, and 3.4% for MSM, FSW, and PWID respectively. Barriers to care, such as societal discrimination, GBV, police harassment, and insufficient community-based capacity prevent KPs from accessing the services they need.

Although KPs in Nigeria are difficult to reach, HAI leads the frontier in the provision of a comprehensive and holistic package of services to KPs through community outreach and the OSS model.

Figure I: HIV Prevalence Rate Amongst Key Population

![HIV Prevalence Rate Amongst Key Population](image-url)
THE ONE-STOP SHOP

The OSS is a community based ART clinic model set up to improve HIV prevention, treatment, care, and support services among the most marginalized KPs in a stigma-free environment. The guiding principles of the OSS are to provide acceptable, evidence-based, equitable access to quality prevention, treatment, care services using the OSS integrated service delivery model, and thereby provide evidence for policy and future programming.

The following are the interventions provided under the OSS model

- Community-based responsive care services in safe spaces
- Interventions to manage post GBV issues
- Provision of services to ensure correct and consistent use of condoms with condom-compatible lubricants
- STI management service
- Community-based HIV testing and counselling for KPs, linked to prevention, care, and treatment services
- Provision of TB prevention, screening, and treatment services
- Provision of hepatitis B and C prevention, screening, and treatment services
- Support access to reproductive health options, pregnancy care, and cervical cancer screening
- Community-based care including access to substance abuse services, MHPSS support, referrals, and linkages
- Legal and paralegal services including litigation and legal representation
- Care for orphans and vulnerable children (OVC) and other family members of KPs.

The use of the differentiated model of care for HIV prevention and treatment services – OSS contains health facilities, community outreaches, community ART teams, and support groups of people living with HIV. This has been integral in achieving the strategic objectives of the IMHIPP project in FY 2019.

KEY ACHIEVEMENTS

HIV PREVENTION

HIV prevention interventions used on the project through interpersonal communication (IC) and small group discussions include:

- HIV testing services (HTS)
- Targeted social and behavior change communication (SBCC)
- Community outreaches
- Income generating and empowerment activities
- Condoms and lubricants distribution
- STI screening, prevention, and treatment
- Linkage and referral to anti-retroviral therapy (ART)
- Prevention, diagnosis, and treatment of TB
- Screening and vaccination for viral hepatitis
- GBV and human rights violation services

Figure II: HIV prevention services to KPs disaggregated by community group (FY 2019)

HIV TESTING AND TREATMENT

Figure III shows the number of KPs that received HTS in FY 2019. Best practices include the use of community outreaches, focal service providers, and index case testing.
Figure III: Number of KPs that received HTS in FY 2019

<table>
<thead>
<tr>
<th># of participants</th>
<th>FSW</th>
<th>MSM</th>
<th>PWID</th>
<th>Transgender</th>
<th>Prisons</th>
<th>Injecting Partner</th>
<th>Sexual Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>COP Target</td>
<td>N/A</td>
<td>669</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Achievement</td>
<td>63,467</td>
<td>22,819</td>
<td>10,194</td>
<td>N/A</td>
<td>636</td>
<td>598</td>
<td>8,608</td>
</tr>
</tbody>
</table>

Figure IV: Number of KP tested HIV-positive

<table>
<thead>
<tr>
<th># of participants</th>
<th>FSW</th>
<th>MSM</th>
<th>PWID</th>
<th>Transgender</th>
<th>Prisons</th>
<th>Injecting Partner</th>
<th>Sexual Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>COP Target</td>
<td>5,038</td>
<td>2,444</td>
<td>1,056</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Achievement</td>
<td>6,233</td>
<td>1,904</td>
<td>1,038</td>
<td>90</td>
<td>66</td>
<td>592</td>
<td>3,644</td>
</tr>
</tbody>
</table>
During FY 2019, 13,585 out of 106,738 of those who accessed HTS tested positive for HIV, resulting in a positivity yield of 13%.

**Figure V: Percentage of individuals testing HIV-positive**

HAI recorded a linkage rate of 98% with 13,316 out of 13,585 testing positive for HIV linked to treatment (both HAI treatment and non-treatment services/sites).

**Figure VI: Linkage to HIV treatment**
HAI recorded an average of 90% viral suppression rate among KPs on treatment in all service delivery sites.

**Figure VII: Viral load for participants tested HIV-positive**

In the FY 2019, 13,316 key populations were placed on treatment bringing the total number of clients on treatment in the program to 19,278.

**Figure VIII: Key populations on treatment**
CERVICAL CANCER

As part of ancillary services provided by HAI, FSWs are provided with optional cervical cancer screening using the visual inspection with acetic acid (VIA) method. Participants who test positive to precancerous lesions are referred to government hospitals for pap smears and subsequently referred for cryotherapy, if necessary.

Figure IX: Cervical cancer data

![Cervical cancer data graph showing: 130 participants screened, 3 diagnosed with pre-cancerous lesions, 3 eligible for cryotherapy, 1 treated with cryotherapy.]
SEXUALLY TRANSMITTED INFECTIONS (STIS) MANAGEMENT

STIs are considered predisposing factors to acquiring HIV and as such, all KPs tested for HIV are screened for STIs. During FY 2019, 106,736 were screened for STIs and 6,522 were diagnosed and treated.

Figure X: STI screening, diagnosis and treatment

TUBERCULOSIS (TB) SCREENING

During FY 2019, we implemented community TB interventions in four states. TB is an opportunistic infection occurring often in people with weakened immune systems, such as those who are living with HIV. Worldwide, TB is one of the leading causes of death among people living with HIV and as such, HAI screens all KPs tested for HIV for TB as well. Figure XI shows the number of KPs screened for TB, suspected as positive for TB, and referred for treatment through the Genexpert.

Figure XI: KPs screened for suspected TB
HEPATITIS

Hepatitis B virus (HBV) and Hepatitis C virus (HCV) are common co-infection of HIV. Below, shows the number of KPs treated for HBV and referred for HCV treatment.

Figure XII: FY 2019 Hepatitis data

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B Screening</td>
<td>2,403</td>
</tr>
<tr>
<td>Hepatitis C Screening</td>
<td>550</td>
</tr>
<tr>
<td># Diagnosed with Hepatitis B+ result</td>
<td>147</td>
</tr>
<tr>
<td># Diagnosed with Hepatitis C+ result</td>
<td>5</td>
</tr>
<tr>
<td># with Hepatitis B+ result treated</td>
<td>147</td>
</tr>
<tr>
<td># with Hepatitis C+ result referred</td>
<td>4</td>
</tr>
</tbody>
</table>

GENDER BASED VIOLENCE (GBV)

KPs experience heightened levels of violence and stigma, both of which may contribute to their poor uptake of HIV and other STI services. In response, HAI provides post-GBV care services at OSS health centers through trained gender focal persons and nurse case managers in their communities. KPs are provided a safe space to report violence and receive post-violence care. The care provided ranges from MHPSS services to legal, and medical services including, Post Exposure Prophylaxis (PEP), STI and HIV screening, and access to a network of KP friendly pro bono lawyers.

Figure XIII: Gender based violence cascade

- Participants that received post-GBV care after experiencing physical/emotional GBV
- Participants that received post-GBV care after experiencing sexual GBV (SGBV)
IMPLEMENTING THE SURGE HIV RESPONSE

The surge response was necessary to address higher rates of HIV in states located in the southern region of the country. Nigeria has to rapidly scale up prevention, diagnosis, and treatment to reach its 95-95-95 goals and end the epidemic by 2030. According to the 2019 Nigeria AIDS/HIV Indicator and Impact Survey, the HIV Prevalence among adults aged 15-64 years was 1.5%, (1.9% among women vs. 1.1% among men) (NAIIS, 2019). Given Nigeria’s population of 182,202,000, this makes Nigeria’s AIDS epidemic the second largest in the world with 1,764,483 persons living with HIV/AIDS (PLHIV) (NAIIS, 2019). In 2017, only 47% of PLHIV were on lifesaving antiretroviral treatment (ART) and only 44.5% (46.9% among women and 40.2% among men) had suppressed viral load (VLS) (World Health Organization, 2017).

Akwa Ibom had the highest HIV prevalence (5.5%) in the country, the second highest unmet need for ART, and a lower population with VLS. For this reason, Akwa Ibom was classified as a “surge state” by PEPFAR in order to receive intensive attention. The two other project states — Cross River and Lagos — have lower HIV positivity, but only slightly better coverage of ART and VLS.

The surge state program package strategy was implemented to close the treatment gap and achieve epidemic control by 2020 in Akwa Ibom, Cross River and Lagos states.

Figure XIV: Surge state program package strategy

<table>
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<th>Surge State Program Package Strategy</th>
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<tbody>
<tr>
<td>- Enhance site management</td>
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<tr>
<td>- Expand services to reach incarcerated prisons</td>
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<tr>
<td>- Use of local KP-led community based organization to create demand for services and facilitate community entry</td>
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<tr>
<td>- Use of community ART teams and focal service providers (FSPs)</td>
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<tr>
<td>- Cluster states into zones for effective community saturation</td>
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<tr>
<td>- ART optimization using dolutegravir (an antiretroviral medication) based regime</td>
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<td>- Implement multi-month dispensing (MMD) for client retention in care</td>
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<td>- Use of dried blood sample (DBS) for sample collection for mobile KPs</td>
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<tr>
<td>- Conduct index case testing</td>
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<tr>
<td>- Conduct community viral load testing</td>
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<tr>
<td>- Reach KPs through social media</td>
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</tbody>
</table>

HIV PREVENTION AND TREATMENT AMONG INCARCERATED PERSONS

Due to inadequate health infrastructures, incarcerated persons in Nigeria are disproportionately impacted by HIV/AIDS. They lack access to prevention, care, treatment and other services including MHPSS. High HIV transmission rates are also accompanied by high rates of other infections, like TB and hepatitis.
In Nigeria, the HIV prevalence among incarcerated persons is 2.8%. That is, double the general population prevalence of 1.4%. For the female prison population, HIV prevalence stands at 6.9% compared to 2.7% for the male population. In addition to implementing prevention interventions in prison settings, we must also improve the availability and quality of health services. During FY 2019, HAI expanded its HIV prevention and treatment service provision to include incarcerated persons while being mindful of our philosophy of care, global best practices, and ethical considerations when working with vulnerable populations.

Figure XV: Prison intervention data

Of the total number of participants reached, 10% of participants tested HIV-positive.

**USING SOCIAL MEDIA TO REACH KEY POPULATIONS**

**SOCIAL MEDIA-BASED CAMPAIGNS TO INCREASE CONDOM USE AMONG KEY POPULATIONS**

JSI Research & Training Institute, Inc. implemented a total market approach on condoms and lubricants. One of the interventions was to design and roll out social media-based campaigns to increase condom use among KPs.
**Use of whatsapp as a condom use promotion channel**

| Conduct orientation for 15 CBO programme staff (representative of MSM, PWID, FSW groups) in Lagos | Conduct orientation of 18 program staff (representative of MSM, PWID, FSW groups) in Akwa Ibom |
| Each trained programme staff creates a whatsapp group and recruits a maximum of 100 peers - especially targeting unreached peers | Each trained programme staff creates a whatsapp group and recruits a maximum of 100 peers - specifically targeting peers not currently attending physical sessions |
| 15 whatsapp groups in Lagos is reaching about 1500 peers are expected to conduct peer sessions weekly | 18 whatsapp groups in Akwa Ibom with about 1800 members are expected to conduct weekly sessions |

**WHATSAPP CLOSED GROUP CAMPAIGN**

Following the orientation of 33 CBO program staff (15 in Lagos and 18 in Akwa Ibom) on the innovative uses of social media to create linkages between KPs and HIV service delivery points, HAI launched a campaign in April 2019 to promote condom use through closed WhatsApp groups in Lagos and Akwa Ibom states.

The Keep it Safe and Sweet (KISS) campaign on WhatsApp ran from April to July 31, 2019. At the end of the implementation period, 627 KPs (279 in Lagos and 348 in Akwa Ibom) were provided with condoms and water–based lubricants.

**SOCIAL MEDIA FOR INCREASED ACCESS TO SERVICES AND EDUCATION**

Other social media mediums used to reach participants included:

- **Facebook**: The use of infographics, posters and flyers as graphic visual representations of information were used as a way of presenting information to beneficiaries quickly and clearly. Topics included HIV self-testing, human rights, condom and lubricant use, PrEP, undetectable=untransmittable (U=U) and Tuberculosis.

  ![Facebook](Image)

  **Facebook likes 2,116**

- **Toll free help line**: HAI Nigeria set up a toll free number (0800-222-333-444) that allows beneficiaries to place free calls for information on healthcare services, mental health and access to justice support. The number, which is now included in all information and education materials, allows for OSS referrals for those in the HAI project states and other government and donor-funded facilities in non-project states.
SEXUAL AND REPRODUCTIVE HEALTH RIGHTS FOR ALL (SARRA)

Heartland Alliance International (HAI) with funding support from The Kingdom of Netherlands is currently implementing the Sexual and Reproductive Rights for All (SARRA), in Benue and Lagos states. This is an inclusive, intersectional human rights and movement-building project designed to reach 8000 marginalized women and girls with reproductive health information and services. The project is building the capacity of grassroots marginalized and vulnerable organizations - Mistletoe Community Health and Rights Initiative (MCHARI) in Lagos and Hope Sisters Initiative (HSI) in Benue. In line with the Netherlands’ human rights policy “Justice and Respect for All,” this project empowers marginalized women regardless of social status, sexual orientation, gender identity to secure their sexual and reproductive health and rights; including those who engage in transactional sex and those who use drugs and alcohol.

SARRA is piloting and documenting promising practices to advance the rights of these marginalized communities, developing the foundation for locally driven advocacy, and launching models for increased collaboration between sexual and reproductive health services that will be scaled up in the future. In only one year, this project has already achieved:

- Sensitization of 6,145 Female Sex Workers (FSW) in 20 local government areas (LGAs) on SRHR issues.

- Screened and treated 311 vulnerable women including female who use drugs with STIs through the community led medical outreaches.

- Advocated for improved community engagement with brothels, the Ministry of Women Affairs, National Human Rights Commission, NAFDAC, YEDI, NDLEA and the Ministry of Justice.

- Screened and provided mental health and psychosocial support services to 17 female sex workers and 9 women who use drugs.

- Reached 245 female sex workers and 50 women and girls who use drugs with family planning commodities and services.

- Distributed 6464 pieces of condoms, 2,150 pieces of sanitary products, 3,500 emergency contraceptive pills and 3,500 combined oral contraceptive pills to program participants.

- Identified and cared for vulnerable 58 women and girls who experienced gender-based violence (GBV).

- Mobilized GBV support groups to host community exchanges in a safe space, exchange experience and promote each other’s self-esteem and skills to prevent and respond to violence,

- Conducted technical trainings on program management and organizational leadership for vulnerable community led organizations Mistletoe Community Health and Rights Initiative (MCHARI) in Lagos and Hope Sisters Initiative (HSI) in Benue

- Created and helped the community design reporting tools, education and informational materials for awareness raising and publicity on SRH.
ACCESS TO JUSTICE AS A PATHWAY TO HIV TREATMENT FOR KPS

Supporting access to justice for KP persons is a critically important part of protecting human rights and ensuring that KPs are able to obtain life-saving HIV testing and treatment. HAI’s interventions recognize that health outcomes are enhanced when vulnerable and marginalized populations are able to challenge discrimination and secure their human rights. When KP persons are arbitrarily arrested, detained, and subjected to harassment and violence, not only are their human rights violated, but they are also effectively prevented from accessing health facilities and participating in ongoing treatment programs. Denial of the human rights of KP persons drives the HIV epidemic and increases its impact both on individuals already impacted by HIV and those at risk of contracting HIV.

HAI’s human rights-based response to KP HIV programming aims to address the impact that HIV and human rights have on each other. Human rights-related HIV programs include: stigma and discrimination reduction; legal services; monitoring and reforming laws, regulations and policies relating to HIV; rights education for people living with HIV and KPs; sensitization of lawmakers and law enforcement officials; human rights training for healthcare workers; reducing gender-related discrimination; community responses to HIV and human rights.

FSWs, MSMs, and IDUs have the highest risk of contracting and transmitting HIV. Yet they also have the least access to prevention, care, and treatment services because their sexual orientation is often stigmatized and criminalized. Respect and protection of human rights make it possible for KPs to benefit from prevention activities, HIV testing services (HTS), and treatment services. It also builds their trust in healthcare systems, which is essential for community-based interventions.

The table below illustrates the positive impact that HAI’s access to justice services have had on KP persons. When they are free from police custody, they are able to access health facilities and receive testing and treatment services. Additionally, when KP persons receive court representation and assistance with dispute resolution, they are more likely to feel the security and freedom of movement necessary to visit health and MHPSS facilities. Access to justice creates a virtuous cycle wherein KP persons experience human rights protection and enhanced health outcomes.

Figure XVIII: Results from using access to justice as a pathway to HIV treatment

<table>
<thead>
<tr>
<th>Result type</th>
<th>Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reached with access to justice services</td>
<td>378</td>
</tr>
<tr>
<td>Facilitated release from police custody</td>
<td>197</td>
</tr>
<tr>
<td>Provided court representation</td>
<td>96</td>
</tr>
<tr>
<td>Provided alternative dispute resolution</td>
<td>85</td>
</tr>
<tr>
<td>Provided HIV testing services</td>
<td>146</td>
</tr>
<tr>
<td>Numbers tested positive and accessing treatment</td>
<td>65</td>
</tr>
</tbody>
</table>

Of the total number of participants reached, 45% of participants tested HIV-positive.
INTEGRATION OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT SERVICES (MHPSS)

Besides HIV and AIDs, KPs and other vulnerable groups (refugees, long-distance drivers, military personnel, migrants, trafficked persons, internally displaced persons and mobile workers) experience high rates of psychological distress and substance abuse as a result of low levels of social support, stigma, discrimination, chronic stress, and violence (including gender-based violence)(Crowell, T, 2017; Mgopa, 2017; Olufunmilayo, 2014) Poor mental health further increases risk of HIV infection and also poses a serious challenge to treatment uptake and effectiveness for KPs and other vulnerable groups (UNAIDS, 2018). HIV intervention programs can therefore improve their effectiveness if they also address comorbid mental health psychosocial problems.

In order to enhance identification of KPs who are experiencing significant psychological challenges that may impact their thoughts, emotions, or behaviors, HAI designed and introduced the use of a trauma informed Mental Health and Psychosocial Support (TI-MHPSS) screening form and protocol for providing non-specialized, brief psychosocial support (PSS). The TI-MHPSS screening form has three domains that assess KPs mental health, substance use behaviors and exposure to GBV. The administration of the TI-MHPSS screening takes between 10 – 15 minutes, including provision of focused, non-specialized PSS and/or referral for specialized MHPSS services.

With the roll-out of the TI-MHPSS screening and protocol for brief intervention, HAI’s MHPSS services are fully integrated into routine healthcare services offered to KPs at the OSSs. HAI recommends that the TI-MHPSS screening be administered to program participants based on the following guidelines:

- All clients who report or present with signs of psychological distress (at every visit)
- All clients who are newly enrolled to treatment (at first visit during enrollment)
- All clients previously lost to follow-up and returned to treatment (at first visit upon returning to treatment)
- All clients who report experiencing or are exposed to GBV (at every visit)
- All clients reviewed by the switch committee² (at every switch review)
- All clients who report injecting drugs or are at-risk of substance misuse (at every visit)
- All clients on treatment (at least once every three visits)

² A switch committee is comprised of clinical and mental health professionals that review a participant’s case if the first line of ART treatment was ineffective. The switch committee’s primary responsibility is to gauge the efficacy of switching a participant to the second line of ART treatment.
MHPSS ACHIEVEMENTS IN FY 19

In FY 19, 302 project participants across Lagos, Cross Rivers, Akwa-Ibom and Benue states were reached with individual TI-MHPSS screening or services. Below is a breakdown of these interventions by MHPSS services offered, the KP type reached, and mental health referrals for KP-participants that received a positive screen on TI-MHPSS screening tool.

Figure XIX: KPs and their sexual partners (SPs) who received MHPSS services
Figure XX: # screened by KP group (# with significant psychological distress)

- **MSM**: 84
- **PWID**: 44
- **Transgender**: 1
- **Prisons**: 32

- # with significant psychological distress by KP group
- # with positive risk assessment (risk of harm to self or others)
- Total # of participants screened

Figure XXI: # of KPs referred for MHPSS services as a result of a positive screen on TI-MHPSS screening tool

- **FSW**: 7
- **MSM**: 7
- **PWID**: 3
- **Transgender**: 1
- **SP**: 2
FY 19 MHPSS PARTICIPANT TESTIMONIALS

“Counseling has made me understand that being HIV positive would not stop me from living a completely normal and healthy life with the right treatment, consistency and adherence to medications. I am a member of HAI-Nigeria PLHIV support group meeting and have learnt so much about prioritizing my health and achieving behavioral change given my risky behavior. I have learnt so much about my rights as KP in the broader society and how to be security conscious in my everyday life”.

— 22 year-old Transgender, female

“I was shocked hearing that I was HIV-positive but was encouraged through counseling to commence ART medication. I am responding to treatment and I can say that I am healthy and strong now. Although, I lost my job and have nothing to turn to, I have benefited a lot from Heartland Alliance. I now know how to manage my relationship, live a happy and healthy life. I want to use this medium to appreciate USAID and Heartland Alliance”.

— 35 year-old FSW

“I lost two of my sisters to HIV. I was confused when I was told of my status because I could not imagine how to manage myself or cope with the finances. Through Heartland Alliance, I have been taken out of darkness and picked up. My story has changed from worse to better. Thank almighty God for whom in his kindness has made Heartland Alliance come to existence. I have hope again”.

— 36 year-old MSM

“Before coming in contact with HAI, I was really leading a risky lifestyle and was a drug addict. Now I can boldly say that I am no more the same drug addict. I have been taught many safety measures and harm reduction methods. From a community mobilizer for peers, HAI-Nigeria (HAN) has picked me out of the bunk to become a peer educator for the PWID community. This has led to a great change in my life at this time, as I am no longer an addict to drugs. Today I am an Outreach Coordinator with HAI-N and am responsible and happy to help reduce discrimination and criminalization among PWIDs around me. All thanks to HAI”.

— PWID Outreach Coordinator

“So far, it has become much easier screening participants for mental health problems with the TI-MHPSS form because I now understand the type of questions that I should ask when I suspect a patient is experiencing psychological problems”.

— Healthcare provider, HAI-Nigeria
STAKEHOLDER ENGAGEMENT

Stakeholders’ engagement is a core Heartland Alliance strategy to create an enabling environment for KPs. This level of engagement helps further sensitize key stakeholders on HAI’s work and services offered as well as acceptance of KPs at the community level. It also falls in line with HAI’s strategic objective to create an enabling environment for KP community-based programming through advocacy for KP-friendly health policies.

HAI has been able to build and sustain relationships with various government and private sector stakeholders. During FY19, HAI made concerted efforts to strengthen these relationships and ensure that the underserved and vulnerable populations HAI works with get access to health and rights services.

**These efforts included engaging with:**

National Agency for Control of AIDS (NACA), United Nations Office on Drugs and Crime (UNODC), United Nations Program on AIDS (UNAIDS), and the United States Agency for International Development (USAID) in the first national needs assessment of HIV/AIDS, drug use and related health services in Nigerian prisons.

Frontline AIDS, World Health Organization (WHO), PWID community groups, Federal Ministry of Health, and other stakeholders in the finalization and development of the National Harm and Drug reduction guideline.

**Impact:**

- Advancement of KP-responsive health provisions
- Inclusion of KP thematic areas in national HIV technical working groups
- Involvement and collaboration on KP-sensitive policy reviews
- Organizational development and organizing of transgender organizations in Nigeria
HAI SHOWCASES ITS WORK IN NIGERIA AND AROUND THE WORLD

INTERNATIONAL DAY AGAINST HOMOPHOBIA, TRANSPHOBIA AND BIPHOBIA (IDAHOBTB) 2019

With the generous support of the Embassy of the Kingdom of the Netherlands, HAI commemorated the international day against transphobia, homophobia, and biphobia (IDAHOTB) on May 20, 2019 with the theme “Justice and Protection for All”. The event was an opportunity to promote the shared values of inclusivity and human rights.

The objectives of the event included:

- Raise awareness of human rights violations against LGBTQI communities in Nigeria.
- Provide information on alternative judicial mechanisms for human rights protection.

The event, which took place at the Thought Pyramid featured a presentation by Hajiya Maryam Kadiri from the National Human Rights Commission (NHRC) on using quasi-judicial mechanisms as means to access justice for LGBTQI persons. She posited the NHRC as an alternative and effective means of accessing justice for LGBTQI populations.

A highlight of the event was the panel discussion on “Navigating the justice system: The LGBTQI Nigerian Experience.” The LGBTQI panelists moderated by HAI program officer, Michael Akanji, discussed what it was like to be LGBTQI living in Nigeria, the challenges faced in accessing justice and the way forward. Guests at the event had the opportunity to ask questions and share recommendations.

A total of 45 guests were in attendance including representatives from Amnesty International Nigeria, the United Nations Development Program, the embassies of Belgium, Germany, Spain, Canada, Sweden and Great Britain and representatives from LGBTQI-led organizations and community members. The event was successful in reiterating to those present that more needs to be done to achieve inclusive justice and protection for all in Nigeria.
In late July 2019, HAI participated in the 10th annual International AIDS Conference on HIV Science in Mexico City, Mexico. The action packed conference brought to the fore new HIV research from all over the globe through symposia, bridging and plenary sessions, oral and poster abstracts. HAI brought attention to its work in Nigeria through the presentation of two poster abstracts written by the Director of Programs, Paul Umoh and Program Officer, Rudolf Uji.

Posters presented included:

- High-risk sexual behaviors as a determinant to HIV infection among MSM in Nigeria
- Using the one-stop-shop (OSS) based point of service (POS) strategy for effective prevention, care and treatment of key populations in Nasarawa state, Nigeria.

Program Officer, Toluwanimi Jaiyebo and Strategic Knowledge Management (SKM) lead, Tolu Alamu presented the abstracts on behalf of the lead authors, supported by HIV/AIDS technical advisor, Clinton Trout and M&E Program Officer, Nora Bouacha. The conference was a great opportunity to learn from best practices and new evidence in HIV science globally with an emphasis this year on patient centered care.

To access both the abstract booklet or the final posters please visit our website at:
HEARTLANDALLIANCE.ORG/INTERNATIONAL/NEWS/HAI-AT-INTERNATIONAL-AIDS-CONFERENCE-2/
BACKGROUND

Enrollment, retention, and adherence to antiretroviral therapy (ART) treatment among female sex workers (FSWs), men who have sex with men (MSM) and people who inject drugs (PWID) is key to reducing HIV incidence among key populations (KP), who are known to be highly affected by the HIV epidemic in Nigeria. Understanding the dynamics of community-based ART is key to prevention, care, and treatment. Heartland Alliance International (HAI) employed an innovative One-Stop-Shop (OSS) based point of service (POS) approach for reaching KP in Nasarawa State, Nigeria. The POS approach is a physical OSS outpost used in order to provide holistic, stigma-free care to clients outside of physical OSS coverage, including ARV pickup, STI syndromic management, and other ancillary services.

A core advantage is availability, proximity, and client-centered approach where program participants are managed professionally. A trained focal service provider (FSP) manages the cluster of clients at the POS. The objective of this analysis was to explore whether this POS approach improves linkage, adherence, and retention of KP in HIV treatment.

METHODS

HAI, through the Integrated Most At Risk HIV Prevention Program (IMHIPP), linked 481 KP to care using the POS strategy between January 2017 and August 2018. This is a descriptive, cross-sectional analysis. We routed program data from participant enrollment forms, care cards, and participant satisfaction questionnaires from three POS located in the local government areas of Akwanga, Ajaga, and Lafia for analysis and summary.

RESULTS

Of the 2,033 participants linked to HIV services within the period, 1,552 (76%) accessed care through a physical OSS, while 481 (24%) accessed care via the POS (Figure 1). POS clients experienced improved outcomes compared to static OSS clients in adherence (347 (61%) vs. 222 (39%), retention rates (414 (86%) vs 451 (29%), and viral load suppression for those who are eligible (380 (92%) vs 325 (72%). An analysis of data from 200 client satisfaction questionnaires showed client satisfaction was higher at the POS (92%) compared to the OSS (60%) (Figure 2).

CONCLUSIONS

The above findings suggest that reducing distance to HIV services results in better client adherence, uptake, retention, and satisfaction. This strategy can take care closer to the program participants in hard-to-reach areas, which will help in achieving the 90-90-90 goals. The use of POS should be considered and scaled up for care to key populations in a bid to achieving an AIDS-free generation.
PHYSICAL ONE STOP SHOP (OSS)

FIGURE 1

DISTRIBUTION OF PARTICIPANTS BETWEEN PHYSICAL OSSs AND POS

76% Physical OSS
24% POS

POINT OF SERVICE (POS)

FIGURE 2

DISTRIBUTION OF PARTICIPANTS BETWEEN PHYSICAL OSSs AND POINTS OF SERVICE

<table>
<thead>
<tr>
<th></th>
<th>Physical OSS</th>
<th>POS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adherence (e.g., prompt ARV pickup)</td>
<td>39%</td>
<td>61%</td>
</tr>
<tr>
<td>Retention</td>
<td>29%</td>
<td></td>
</tr>
<tr>
<td>Viral load test result (&lt;1000CP/ML)</td>
<td>72%</td>
<td>92%</td>
</tr>
<tr>
<td>Client satisfaction</td>
<td>92%</td>
<td>60%</td>
</tr>
</tbody>
</table>

This poster is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of Heartland Alliance International and do not necessarily reflect the views of USAID or the United States.
BACKGROUND

Men who have sex with men (MSM) are an important key population (KP) in HIV programming in Nigeria. Evidence from the Integrated Biological Behavioural Surveillance Surveys show an increasing burden of HIV infection from 13.7% (2007) to 17.2% (2010) to 22.9% (2014). The vulnerability of KPs to HIV infection is heightened by several behavioral, biomedical and structural factors notable amongst which are high number of sex partners, high concurrency of sexual partners, inconsistent and low condom use, high prevalence of recurrent sexually transmitted infections (STI), poor access to STI treatment services, and poor access to HIV prevention, treatment and care services. In order to address this trend, it is important to further identify factors influencing HIV infection among MSM.

METHODS

A total of 299 MSM were recruited using convenience sampling techniques in urban and rural areas of two Nigerian states, Rivers and Kaduna. Data was collected using structured questionnaires on high-risk sexual behaviors. Participants included MSM who have accessed HIV prevention services, those who had never received HIV prevention services from any formal structure, and those who served as peer educators in formal HIV prevention services schemes for MSM. Descriptive and bivariate methods were used to analyze the high-risk sexual behavior of MSM. Pearson's chi-square and Fischer’s Exact test were used to test significance of associations where appropriate.

RESULTS

This analysis shows that there are significant differences between rural and urban respondents across multiple behavioral categories. The mean age at first sexual debut for all respondents was 17.1 years + (4.7) (95% CI: 17.3- 18.5). The age of sexual debut ranged from 5 to 35 years with the modal age being 20 years. The mean age of sexual debut for MSM residents in urban areas was 18.9 + (4.5) (95%CI: 18.2-19.6) and that for MSM residents in rural areas was 15.9 + (4.3) (95%CI: 15.0 -16.8). However, more sexually active MSM in the rural areas also reported using condoms regularly in the last 3 months (p =0.03), using condoms during their last sex act (p=0.001) and using condoms during their last anal sex act (p=0.03) and had more than one sex partner (p=0.001). Overall, MSM in urban areas engaged in more HIV sexual risk behaviors when compared with MSM residents in rural areas (25.9% vs 8.7%; x2 =9.43; p=0.02). These behaviors included irregular use of condoms, history of transactional sex and having more than one sex partner.

Results in figure 1 show a significant difference in the age of sexual debut among MSM in rural and urban areas (30.8% vs 19.8%; x2=22.46; p<0.001). Also observed was the high proportion of MSM in rural areas who had been sexually abused (22.0% vs 8.0%). Table 1 displays the categorical breakdown of this behavioral profile in more detail.
CONCLUSIONS

In conclusion, our study found that while a significantly large number of MSM are willing to access HIV prevention services especially from peer-led organisations, capacity, quality and stigma related factors distracts from their willingness to access HIV prevention services especially in public and private health care centres.

To reduce the rate of new infections among MSM, information targeted at reducing HIV risk should be produced. Targeted outreach for MSM, especially in rural areas, should be encouraged, and continuous training is required for healthcare providers to provide friendly health services for MSM.

FIGURE 1

HIV SEXUAL RISK PROFILE OF MSM BY RESIDENTIAL AREA

<table>
<thead>
<tr>
<th></th>
<th>Urban</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Abuse</td>
<td>8%</td>
<td>22%</td>
</tr>
<tr>
<td>Early Sexual Debut</td>
<td>31%</td>
<td>31%</td>
</tr>
<tr>
<td>Transactional Sex</td>
<td>23%</td>
<td>90%</td>
</tr>
<tr>
<td>More than one Sexual Partner</td>
<td>70%</td>
<td>69%</td>
</tr>
<tr>
<td>Used Condom at last Sex</td>
<td>82%</td>
<td>8%</td>
</tr>
</tbody>
</table>

FIGURE 2

SEXUAL HEALTH PROFILE OF SEXUALLY ACTIVE RESPONDENTS BY AREA OF RESIDENT (N=292)

<table>
<thead>
<tr>
<th>S. no</th>
<th>Variables</th>
<th>MSM Rural (81)</th>
<th>MSM Urban (201)</th>
<th>X²</th>
<th>p value</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Age of sexual debut</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Below 13 years</td>
<td>20 (22.0%)</td>
<td>16 (8.0%)</td>
<td>27.32</td>
<td>&lt;0.001</td>
<td>28 (9.4%)</td>
</tr>
<tr>
<td></td>
<td>14 – 17 years</td>
<td>36 (39.6%)</td>
<td>40 (19.9%)</td>
<td></td>
<td></td>
<td>73 (24.4%)</td>
</tr>
<tr>
<td></td>
<td>18 years+</td>
<td>27 (29.6%)</td>
<td>113 (56.2%)</td>
<td></td>
<td></td>
<td>140 (48.8%)</td>
</tr>
<tr>
<td></td>
<td>8 (8.8%)</td>
<td></td>
<td>32 (15.9%)</td>
<td></td>
<td></td>
<td>58 (19.4%)</td>
</tr>
<tr>
<td>2</td>
<td>Consistent use of condom in last 3 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Always</td>
<td>44 (48.4%)</td>
<td>71 (35.3%)</td>
<td>4.85</td>
<td>0.03</td>
<td>115 (39.4%)</td>
</tr>
<tr>
<td></td>
<td>Irregularly</td>
<td>45 (49.4%)</td>
<td>128 (63.7%)</td>
<td></td>
<td></td>
<td>173 (59.2%)</td>
</tr>
<tr>
<td></td>
<td>No Response</td>
<td>2 (2.2%)</td>
<td>2 (1.0%)</td>
<td></td>
<td></td>
<td>4 (1.4%)</td>
</tr>
<tr>
<td>3</td>
<td>Used condom at last sexual act</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>75 (82.4%)</td>
<td>138 (68.7%)</td>
<td></td>
<td></td>
<td>213 (72.9%)</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>8 (8.8%)</td>
<td>56 (27.8%)</td>
<td>12.09</td>
<td>0.001</td>
<td>64 (21.9%)</td>
</tr>
<tr>
<td></td>
<td>No Response</td>
<td>2 (2.2%)</td>
<td>2 (1.0%)</td>
<td></td>
<td></td>
<td>4 (1.4%)</td>
</tr>
<tr>
<td>4</td>
<td>Use condom during last anal intercourse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>78 (85.7%)</td>
<td>138 (68.7%)</td>
<td></td>
<td></td>
<td>216 (74.0%)</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>11 (12.1%)</td>
<td>42 (20.9%)</td>
<td>4.53</td>
<td>0.03</td>
<td>53 (18.2%)</td>
</tr>
<tr>
<td></td>
<td>No Response</td>
<td>2 (2.2%)</td>
<td>21 (10.4%)</td>
<td></td>
<td></td>
<td>23 (7.9%)</td>
</tr>
<tr>
<td>5</td>
<td>Number of sexual partners in last 3 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>One</td>
<td>4 (4.4%)</td>
<td>34 (16.9%)</td>
<td>10.21</td>
<td>0.001</td>
<td>38 (13.0%)</td>
</tr>
<tr>
<td></td>
<td>More than one</td>
<td>82 (90.1%)</td>
<td>141 (70.1%)</td>
<td></td>
<td></td>
<td>223 (76.4%)</td>
</tr>
<tr>
<td></td>
<td>No Response</td>
<td>5 (5.5%)</td>
<td>26 (13.0%)</td>
<td></td>
<td></td>
<td>31 (10.6%)</td>
</tr>
<tr>
<td>6</td>
<td>*Engagement in transactional sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Paid for sex</td>
<td>20 (22.0%)</td>
<td>50 (24.9%)</td>
<td>2.09</td>
<td>0.15</td>
<td>70 (24.0%)</td>
</tr>
<tr>
<td></td>
<td>Received gift for sex</td>
<td>18 (19.8%)</td>
<td>38 (18.9%)</td>
<td></td>
<td></td>
<td>56 (19.2%)</td>
</tr>
<tr>
<td></td>
<td>Paid and or received</td>
<td>21 (23.1%)</td>
<td>63 (31.3%)</td>
<td></td>
<td></td>
<td>84 (28.6%)</td>
</tr>
<tr>
<td></td>
<td>No transactional sex</td>
<td>70 (76.9%)</td>
<td>138 (68.7%)</td>
<td></td>
<td></td>
<td>208 (69.6%)</td>
</tr>
<tr>
<td>7</td>
<td>Number of respondent with HIV sexual risk behavior</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>5 (5.5%)</td>
<td>14 (70%)</td>
<td>13.27</td>
<td>0.004</td>
<td>19 (6.5%)</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>24 (37.4%)</td>
<td>69 (34.3%)</td>
<td></td>
<td></td>
<td>103 (35.3%)</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>44 (48.4%)</td>
<td>66 (32.8%)</td>
<td></td>
<td></td>
<td>110 (37.7%)</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>8 (8.7%)</td>
<td>52 (25.9%)</td>
<td></td>
<td></td>
<td>60 (20.5%)</td>
</tr>
</tbody>
</table>

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