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Towards STD/AIDS Awareness and Prevention in Plateau State, Nigeria: Findings from a Participatory Rural Appraisal

Ernest Massiah

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Acronyms and Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CBO	Community Based Organization
CHEW	Community Health Extension Worker
CSW	Commercial Sex Worker
HIV	Human Immunodeficiency Virus
LDTD	Long-distance Truck Drivers
LGA	Local Government Authority
NASCP	National AIDS Surveillance and Control Programme
NGO	Non-governmental Organization
PHC	Primary Health Clinic
PRA	Participatory Rural Appraisal
STD	Sexually Transmitted Disease
TB	Tuberculosis
TBA	Traditional Birth Attendant
VHW	Village Health Worker

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Most of all, we are grateful to the residents of the three LGAs who participated in this STD/AIDS Beneficiary Assessment.

Executive Summary

This is a report on the findings of a participatory rural appraisal carried out in several communities of Nigeria's Plateau State. It is the first phase of a World Bank-supported project to prevent sexually transmitted diseases and Acquired Immunodeficiency Syndrome (STD/AIDS) in that area. The Participatory Rural Appraisal (PRA) findings provide valuable information on local development and health priorities as well as on popular beliefs and understandings related to STD/AIDS. While the community-level analysis is expected to contribute to improved design of Plateau State's STD/AIDS program, perhaps, more importantly, the process of undertaking the PRA set in motion new partnerships among state and local health officials, community leaders and organizations, selected target beneficiaries, and university faculty and students. With follow-up, these evolving relationships can provide vital building blocks for more effective state and local efforts to prevent the spread of STD/AIDS.

The PRA Team, Methodology and Process

The research was planned by a core team of personnel from the State Ministry of Health, AIDS Action Managers in the three participating Local Government Authorities (LGAs are the lowest administrative level in Nigeria), a faculty member from the local university, and a representative of the World Bank. The university faculty member coordinated the research and prepared the draft report on the field work. University students who spoke English and the local languages served as interviewers for the field work, which took place in April 1995.

In the PRA approach, an interview team goes into a community and deploys research methods designed to enable people to express and share information and to stimulate discussion and analysis. A total of sixteen methods were used to engage a dozen target groups in the research. The research methods used included card sorting, matrix ranking, social and institutional mapping, and in-depth interviews. Some team members expressed initial reservations over the qualitative nature of the PRA methodology. As the team worked together to identify, experiment with, and revise the methods, these concerns were overcome.

To present the initial research findings, four local dissemination meetings were held with representatives from the target groups and LGA and state health officials. The sessions provided an opportunity to report back and verify the conclusions in the draft reports, and allowed the communities to become more actively involved in

the dialogue on priorities for action and their means of implementation. All of the communities expressed a desire to be more actively involved in STD/AIDS prevention activities, and identified a series of initiatives that would be needed at the LGA and State levels to sustain their participation.

The active involvement of local and state government personnel in all stages of the PRA has provided officials with a more realistic understanding of he dynamics of sexual behaviours, communities' interpretation and acceptance of IEC messages, and the potential for community involvement in the supervision and evaluation of interventions. This should prove useful as they now take steps to design a more effective and participatory program. The PRA initiative tapped into the research and evaluation capacity of the local university, thereby strengthening the links between academia, the government, and community-level groups. While encouraged by the possibilities of greater partnership with the government, the communities also expressed fatigue: many new initiatives have failed to be sustained because they lack the necessary follow-up and inputs. The PRA process may have identifiedm possible new partnerships and lines of accountability for more effective STD/AIDS activities, but the next phases in the process, the design and implementation of new programmes, will test the strength of these linkages.

Key Findings from the PRA

Health care in general, and STD/AIDS in particular, rank low among communities' development concerns

Lack of access to water, the storage of water, and low farm incomes are consistently cited as the main problems facing the residents in the three LGAs. Although somewhat less pressing, lack of adequate health care is also a major concern for each of these communities. The principal health problems identified by women are childhood diseases: measles, dysentery/diarrhoea and hypertension; men rank their chief concerns as meningitis, typhoid and hernia. Medical personnel identify the same priorities, with the addition of abortion-related complications in women under 20 years old. STDs, including AIDS, are not considered priority health concerns.

Local beliefs on STD/AIDS causation, symptoms, and prevention shape community behaviors

Causation. The three modes of STD/AIDS transmission most commonly observed by the target groups are: sexual intercourse, contact with urine, and sharing objects/belongings of someone with a disease in the genital region. Sexual promiscuity is identified as a source of transmission and associated with prostitutes and women who have traveled abroad. There is a strong belief that overseas women contract STD/AIDS through sexual intercourse with dogs and Westerners. Stepping over, on, or by an area where someone has urinated, as well as "*indiscriminate urination,*" are thought to transmit STDs. Sharing of clothes, and, in particular, instruments for shaving and nail cutting, also are associated with the spread of STD/AIDS. While medical personnel have more accurate information about STD/AIDS, some of them believe that AIDS could be transmitted by mosquitoes and via saliva (and therefore advise clients against kissing).

Symptoms. Most people associate STDs with the presence of physical symptoms: discharges from the genitals, pain while urinating, and stomach cramps or swelling in the genital region. Men report looking for "flecks" on a woman's lips and changes in her gait as signs of the presence of an STD. Service providers did not mention the existence of asymptomatic STDs and the need for medical examinations and laboratory confirmations. AIDS is frequently associated with an extremely emaciated physical state. According to one community health extension worker (CHEW), if one has AIDS the *"eyes will blotch out, the hands and legs will thin,* [there will be a] *swollen abdomen* [and a] *big head."* The difference between AIDS and HIV is not commonly understood.

Prevention. The main measures identified by the target groups for preventing STD/AIDS are monogamy, examining the partner's genital area for signs of infection, avoiding areas where people urinate, and refraining from sharing personal possessions. Self-medication is practiced widely; many commercial sex workers (CSWs) use penicillin-based creams as antibiotics (and lubricants). Men report using medications or traditional medicines prior to and after sexual intercourse with non-regular partners. Service providers advocate a reduction in the number of sexual partners but are ambivalent about promoting condom use. Most medical personnel are concerned with the occupational risk associated with working with AIDS patients, and are concerned about the need to screen blood and sterilize needles.

Low levels of condom use

All target groups report low levels of condom use. Men generally accept condoms as contraceptives. They do not, however, associate condom use with STD/AIDS prevention, except when they are used with CSWs or non-regular partners. Men also complain that condoms reduce sexual pleasure. Both men and women are uncomfortable with the notion of using condoms for disease protection, as this violates the trust in their relationships and could indicate infidelity. Women fear that by suggesting condom use they may be physically attacked for their perceived infidelity and attempt to control the sexual act. Men and women also express fears that condoms may have negative side effects, such as syphilis in men or may cause women to require surgery as condoms can become lodged in the womb. Among CSWs, the cost of regular condom use is high for those who have few clients. Condom use is not evenly promoted among health care providers. Some providers express reluctance to promote condom use because doing so may provide individuals with a false sense of protection (due to breakage), or may encourage promiscuity in youth.

Perceived risk of contracting AIDS is low, but fear of people with AIDS is high

As the disease is associated with promiscuity and overseas contact, most people do not believe themselves to be at risk of contracting AIDS. Although men report having many sexual partners, the only populations they perceive to be promiscuous are CSWs and youth. In Jos North, an urban area, some residents feel that AIDS could increase, but feel they are protected because it is a Christian community. The low levels of perceived risk also relate to the limited information available about AIDS. According to one woman, *"I hear say AIDS there I never see any body when*

AIDS catch them. I never see any body when AIDS kill them. All I hear the AIDS there, AIDS there."

The primary community responses toward people with AIDS are fear, pity, and the need for quarantine. People suggest that the clothes and houses of people with AIDS should be burned, areas where they have been should be washed, and they should be reported to the police and imprisoned. Central to these reactions is the belief that AIDS is contagious and can be contracted via social contact. Health providers are primarily afraid of the occupational risks associated with working with blood products and attending to someone with AIDS. While apprehensive, the majority express a desire to provide care and sympathy to individuals they believe will soon die.

Provider-switching is common

Three factors contribute to extensive "switching" between traditional and Western medical systems for the treatment of STD/AIDS and other diseases. First, people perceive that the treatment and cure of illnesses as distinct acts: hospitals are believed to remove the symptoms of an STD, while traditional medicine is believed to be effective in removing the cause of the STD. If the medications given by one health system do not relieve symptoms, patients often seek treatment from the other medical system or another provider. AIDS, as a new and fatal disease, is believed to be best dealt with by hospitals.

Second, people look beyond the formal health system due to its many inadequacies, including the lack of drugs and functioning equipment and long waiting periods for service. For STD treatment, men prefer going to pharmacists because they provide diagnosis and treatment on the spot; and, they are ashamed to use PHC facilities, believing them to cater exclusively to maternal and child health needs. The lack of female doctors and the relative lack of privacy deters some women from using government PHC facilities for the treatment of STDs. Compared to clinics and hospitals, access to traditional healers is easier and the length of time spent waiting to receive care and medications significantly lower. There is no clear consensus on the impact of financial cost on service utilization; however, many prefer the financing plan offered by traditional healers whose services can be paid for over time and in kind.

Third, providers' and clients' perceptions of each other influence the use of health services. Ethnic and gender stereotypes about patients are common among public sector service providers. They frequently mention that their clients' illiteracy makes them ignorant and unable to understand information about diagnosis and treatment regimens. In almost every target group complaints were made about how they are treated at clinics. According to one woman, *"doctors and nurses don't care about patients at all, they don't even ask you what your problems are. They just treat you very quickly."*

STD/AIDS education needs to be strengthened

Information on preventive measures, including on condom use, is given infrequently by health care providers, and is not always accurate. In exit interviews at PHC clinics with ante-natal women, the main AIDS-related message recalled is that AIDS could be contracted via blood should a transfusion be needed during delivery; few women recalled being told about the

sexual transmission of the HIV virus or about condom use. Few of the patients at STD clinics are informed of their diagnosis and none of those interviewed were told what medications they are being given or how they worked.

Posters are the main mass media channel for AIDS education. Discussions with target groups on their understanding of the most widely distributed STD/AIDS poster reveal that: 1) most people, including clinic staff, have never seen it; 2) few people can read its English text; 3) the illustrations communicate messages that are perceived to be about personal hygiene and not about STD/AIDS prevention; and, 4) the depiction of a person with AIDS in an emaciated physical state furthers the belief that people with AIDS can not lead productive lives, and that transmission of the virus can be prevented if one learns to identify and then take precautions with persons with certain physical symptoms.

1. The Participatory Research Framework

Project Rationale

According to a 1993/94 Sentinel Survey, the HIV and syphilis prevalence rates in Nigeria are approximately 3.8 percent, a significant increase over the prevalence levels observed in the 1991/92 survey.[1] With an estimated prevalence rate of 8 percent in 1994, Plateau State has among the highest HIV and syphilis levels in the country.

This report presents the findings of a participatory rural appraisal (PRA) carried out in three communities of Nigeria's Plateau State. It is part of the World Bank's involvement in efforts to prevent sexually transmitted diseases and AIDS (STD/AIDS) in that area. Prior research on STD/AIDS in Plateau State primarily focused on disease epidemiology, and did not fully involve State and local health officials or communities. This PRA examines the social aspects of the diseases, and engages both state- and local-level officials in research design, implementation, data collection, and analysis. A main objective of the research is to contribute to improved design of the health education component of Plateau State's STD/AIDS program.

Perhaps, more importantly, however, PRA research processes help identify local information and analysis, and often catalyze new partnerships among local officials, community leaders and organizations, and target beneficiaries. Over time, these new relationships can contribute significantly to more effective local development efforts. Thus, a second major objective of the PRA is to begin to identify and develop capacity at the local level that would be able to collect systematically, and in a participatory manner, information for program planning, monitoring and redesign.

The research was supported by a grant of US$20,000 from the World Bank's Systematic Client Consultation Program of the Africa Region. Ernest Massiah (Africa Technical Human Resources III), the project coordinator, developed the research methods and conducted the training; Foluso Okunmadewa (World Bank Resident Mission, Lagos) supervised the field work and assisted in the training of the research team. The Ford Foundation provided a grant and technical input during the later stages of the project.

The Research and Field Teams

The core research team consisted of State Ministry of Health personnel, AIDS Action Managers in the three participating Local Government Authorities (LGAs are the lowest administrative level in Nigeria), a faculty member from the local university, and a World Bank representative. The

team organized the research and collaborated in planning all phases of the study.[2] In addition, all members of the team participated in the field work, either in advising target communities, making logistical arrangements, or supervising interviewers.

The State AIDS Coordinator and the Research Coordinator provided overall supervision for the field work. Five-member field teams were created for each of the LGAs, and included the respective LGA AIDS Action Manager, a State AIDS Program official, and three University students. The students, who spoke English, Hausa, and one of the local languages, were recruited and trained by the research team to serve as interviewers.

Initially, the teams were skeptical about using PRA methodology, which some considered too simplistic relative to more quantitative approaches to field research. As the team reviewed, experimented with, and revised the PRA research methods over a six-month period in preparation for the field work, these concerns were overcome.

The Research and Action Agenda

The research was structured to elicit findings on the following eight issues:

- Communities' perceptions of their priority health and non-health problems, and the role of STD/AIDS within these rankings.
- Knowledge and beliefs surrounding STD/AIDS of the various target groups.
- Sexual behaviors practiced by the primary target groups, and the contexts in which these behaviors occur.
- The reasons for and extent of medical pluralism—or provider shopping—as it relates to the treatment of STD/AIDS.
- The willingness of and modalities for traditional healers, chemists, and pharmacists to become involved in project activities.
- Public and private sector service providers' knowledge and perceptions of STD/AIDS prevention and treatment, and their perception of the needs in their target communities.
- Appropriate communication channels for the diffusion of STD/AIDS prevention and treatment messages.
- The actions that communities believe should be taken by: (a) individuals, (b) State and LGA officials, and (c) other institutions.

The developmental, or process, objectives of the PRA were to:

- Create a methodology and a set of methods for obtaining information about STD/AIDS in conjunction with personnel working at the lowest administrative level that could be used in their subsequent supervision/monitoring exercises.
- Strengthen the capacity of the State Ministry of Health to conduct similar research in the future.
- Provide personnel at the Federal level in the National AIDS Surveillance and

Control Programme (NASCP) with a methodological approach that could be disseminated nationally.

- Create new partnerships between the local university and LGA and State health officials by building academic capacity to conduct and assess PRAs, and to monitor and evaluate community-level STD/AIDS programs.

Methodology

This study utilized qualitative research methodologies common to PRA and Rapid Rural Appraisal. A total of sixteen research methods were used in the field. Some of the methods focus on the same issues in order to determine consistency of responses and the perspectives of different target groups on the same issue. The principal data collection methods include:

Social and Institutional Mapping: Groups are asked to draw a map of their community on a piece of paper or on the ground and to indicate the main community institutions, including public and private health facilities and hotels (brothels), and their importance. They are also asked to draw a map of their desired arrangement and location of community institutions.

Semi-Structured Interviews: Key community members—elders, teachers, local policy makers, traditional healers, pharmacists, doctors, and nurses—are administered in-depth open ended interviews.

Exit interviews: Short exit interviews are conducted with clients of Commercial Sex Workers (CSWs), ante-natal women, and STD patients. The interviews are held outside of the facilities and designed to get information rapidly on condom use, knowledge of STD/AIDS, and quality of health care services.

Mystery Client Interviews: Male and female interviewers, pretending to have an STD, seek treatment from pharmacists and chemists. The information they are told is recorded after the visit.

Matrix Ranking: Groups are asked to list their main health and community problems. Then, for each category of problem, groups are asked to rank them in order of priority.

Focus Group Interviews: Discussions are conducted with students and CSWs. The groups are comprised of five-to-eight people.

Card Sorting: In each community, single-sex groups of between six and nine men and women are shown cards illustrating specific health- and sex-related behaviors being performed by each sex. The group is asked to identify the behaviors which are easy or hard to perform and the reasons for their choice.

Interview guides were developed for the semi-structured and focus group interviews. Due to language and cultural considerations interviewers were instructed to be flexible in their interview approaches.

Table 1 shows the relationship between the research methods and issues, and was used to guide the development of the methods. Table 2 indicates the particular methods used with each target group.

Table 1: Relationship Between Research Issues and Methods

Issues	Methods
Perceptions of priority community and health problems	Social Mapping Matrix Ranking - Community and Health Problems
Perceptions of illness causation, treastment and prevention; local terminology for illnesses and STD/AIDS	Semi-structured interviews; Focus groups; Card Sort
Access to and usage of health services, by gender and target group; perception of health services and service providers	Semi-structured interviews; Ranking of services; providers; Card Sort; Exit Interviews; Mystery Client Interviews
Sexual behaviors - desires (actual and perceived, taboos	Semi-structured interviews; Focus groups; Card Sort
Perceptions of condoms; detrminants of condom usage and availability	Semi-strucutred interviews; Gender Analysis; Focus Groups; Exit Interviews; Short Questionnaires with Clients of CSWs
Relations between traditional healers, western trained service providers and pharmacists	Semi-strucutred interviews.
Experience with and attitude towards community participation; role of community institutions; community dynamics	Social Mapping; Institutional Mapping; Semi-structured Interviews
Sources of information about health; exposure to and understanding of health information	Social Mapping; Semi-strucutred interviews
Knowledge, attitudes and needs of service providers and teachers	Semi-structured interviews

Table 2: Methods and Target Groups

Target Population	Methods
Women (community)	Matrix Ranking; Social Mapping; Description of STD; Card Sort;
Men (community)	Matrix Ranking of Service Providers; Semi-structured interviews
Commercial Sex Workers (CSW)	Focus Group Interviews; Semi-structured interviews
Clients of CSW	Exit Interviews
Secondary School Students	Focus Groups; Semi-structured Interviews
Long-Distance Truck Drivers	Semi-structured interviews
Ante-natal Clinic Attendees	Exit interviews
STD Clinic Attendees	Exit interviews
Service Providers	Semi-structured interviews
Traditional Healers	Semi-structured interviews
LGA/State Health Personnel	Semi-structured interviews
Opinion/Traditional Leaders	Semi-structured interviews

Selection of Research Sites

At the time of the research, Nigeria was divided into thirty States, each of which were further divided LGAs. The three Plateau State LGAs selected for the PRA are target areas for a proposed World Bank Nigeria STD Prevention Project. Within each of these LGAs, the selection of specific communities was determined by: the presence of PHC facilities; urban/rural characteristics cultural/ethnic characteristics; and, ease of access for interviews.

An LGA is comprised of six-to-eight health districts, of which two or three were chosen from each of the three LGAs. The district containing the LGA-level general hospital was included, as well as one or two additional districts provided they contained at least one private or public health facility.

The specific LGAs and communities selected were:

Jos North LGA: This is one of two LGAs that comprise the city of Jos, the Plateau State capital. The city developed in the earlier part of the century as a tin mining settlement. As the state capital, the city has tertiary level educational and health facilities and houses the state-level administrative and legislative offices. It has an estimated population of 500,000. Three communities were interviewed. The first, *Laranto,* is comprised mainly of people from ethnic groups that are indigenous to the state. Laranto's large timber and grain markets attract people from all parts of the state, and it is an important destination for long-distance truck drivers (LDTDs). The state-level Jos University Teaching Hospital has an STD clinic. The second community, *Abba Na Shenu,* is more traditional and has a strong Hausa and Muslim presence. The third community, *Apata,* has a large Ibo population and lacks a commercial center.

Mangu LGA: This semi-urban LGA resides approximately 70 km Southeast of Jos. The research was conducted in *Mangu Town,* the largest settlement in the LGA, and in the rural community of *Kombun.* The main ethnic groups in the LGA, the Mwaghaval, Pyem, Chakfem, and Jipal, are equally represented in the two sample sites. Kombun is situated in the largest health district in the LGA and is accessible by paved road.

Langtang LGA: Langtang North LGA is located about 200 km southeast of Jos, and is primarily rural with a few large semi-urban settlements. Transportation is still problematic and for most communities only available on market days. The research was conducted in *Langtang Town,* the LGA capital, and *Zamko,* a more rural community. The main ethnic group in the LGA is the Taroh; there are also small Hausa communities.

Conduct of the Fieldwork

Three field teams worked in each LGA for twelve to fourteen days in April 1995. Again, the five-member teams included three interviewers, the respective LGA's AIDS Action Manager, and an official from the Plateau State AIDS program. The latter served as the Field Research Leader, and was responsible for organizing the schedule of interviews, checking the notes taken by the interviewers, and making modifications to the research plan, when necessary. The LGA AIDS Action Managers made all of the logistical arrangements, informed communities and

village elders of the purpose of the study, and introduced the field team to the community. The AIDS Action Managers also conducted some of the interviews—especially with potentially difficult populations such as commercial sex workers (CSW) and village elders. Interviews were conducted the most frequently in Hausa, the prevalent language in the area. Other language/ethnic groups used in the fieldwork include Berom, Fulani, Mwaghavul, Nprom, Afirare, Anguta, and Taroh.

Sample Size

Table 3 provides a matrix of the number of people interviewed by target group and LGA.

Beyond the Data: The PRA Process Considered

An important obstacle to building productive partnerships between local communities and public sector institutions is the perception by many officials that community participation is synonymous with contributions of physical labor, and not with local involvement in program research, planning, monitoring and evaluation. The active engagement of local and state government personnel in the design and conduct of the PRA exercise increased their understanding of the value of applying participatory principles more broadly. The two weeks of field work made the

Table 3: Sample Size

Target Group	Jos North	Mangu	Langtang
Service Providers			
Western - public facilities	3 doctors, 5 nurses	2 doctors, 10 nurses	3 doctors, 5 nurses
CHEW	2 doctors, 4 nurses	10	3
Western - private facilities	3 doctors, 5 nurses	1 doctor, 2 nurses	2 doctors, 3 nurses
Traditional Healers	8	3	3
Pharmacists	3	1	1
Chemists	3	1	-
Patent Medicine Dealers	-	1	1
Community Members	3 groups female; 3 groups male	2 groups male; 2 groups female	1 group male; 2 groups female
Ante-Natal Women	17	21	13
CSW	2 Focus Groups (FG)	1 FG	1 FG
Male Clients of CSW	10	4	3
Students	1 FG boys 1 FG girls	1 FG boys 1 FG girls	1 FG boys 1 FG girls
Long Distance Truck Drivers	19	8	6
STD Patients	5 females, 5 males	3 males, 2 females	1 male, 1 female
Mystery Clients interviews with Pharmacists/Chemists	2 male clients	2 male clients 2 female clients	2 male clients
State and LGA Officials	5	8	5

officials more aware of their personal biases and assumptions, the issues of concern to the various target groups, and specific opportunities for working with the communities. Prior to this experience, many of them assumed they knew more than the "indigens" about local perceptions and knowledge of STD/AIDS, patterns of health service utilization, and the effectiveness of public health education programs. Evidence of a growing commitment to participatory principles can be found in the Plateau research team's provision of technical assistance to groups in Nigeria and the Benin Republic on how to organize STD/AIDS PRAs.

A key step in the PRA process was the local dissemination meetings attended by representatives from the target groups and the health officials. In reporting back to the communities that participated in the field work, principles of transparency and accountability were upheld. The follow-up also provided an opportunity for the communities to make recommendations for action, and made government officials aware of the support and resources that they could obtain from the communities. Importantly, however, the communities also expressed fatigue, and referred to the launching of many initiatives that are not sustained due to the lack of necessary follow-up and inputs. While the PRA process set in motion new partnerships and lines of accountability for moving the effort forward, the next phases in the process will provide crucial tests.

The recruitment of a faculty member from the local university as the research coordinator helped to establish a link between academia and local government, and provided valuable input to the project. Frequently, the research and evaluation capacity in such institutions is unknown by technical government staff. Also problematic, university curricula do not always reflect national or local needs. Out of the partnership established, increased interest is being expressed in the University to examine PRA approaches further and to carry out dissertation research on community-level STD/AIDS issues. Also, the university will continue to work with the State AIDS program in monitoring and evaluation, and health officials plan to work with the university to strengthen AIDS education courses and the public health focus of other relevant courses.

These various "processes" proved to be time-consuming, which can be an obstacle for development planners who are anxious to get tangible results in the field within fixed fiscal or project cycles. The research was especially slowed by difficulties of communication between Plateau and Lagos and the conflicting administrative schedules of the agencies involved. The delays, however, may have helped to ease the introduction and dissemination of the new PRA approaches in the participating institutions.

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[1] The statistics are extrapolated from specific populations (ante-natal patients, commercial sex workers, tuberculosis (TB) and sexually transmitted diseases (STD) patients, and long distance truck drivers. The syphilis prevalence rate is based on data from only 15 states. Plateau State's highest HIV prevalence rates are found in STD and TB patients, and ante-natal women.

[2] The team agreed that no decisions would be taken unless all members of the team had been consulted and had discussed the matter as a group.

2. PRA Findings: Community Priorities and Institutions

Priority Development Concerns

Men and women are asked in each of the research sites to identify the main institutions in their community, the importance of these institutions to them, and whether they perceive these institutions as belonging to the community. They are then asked to identify the institutions they would like to see in the community. This exercise is done to gain a better understanding of how people view their community, identify their priority problems, and ascertain the overall priority attached to health concerns.

In each LGA access to and storage of potable water is identified as the primary concern followed by the need to raise agricultural production and improve access to markets. This relates closely to the belief that poverty has increased, making it is necessary to improve agricultural yields and increase access to credit and markets. While the lack of adequate health care services and drugs is a concern in the LGAs, they are secondary to broader poverty-related concerns.

Policy makers and public sector health service providers are also interviewed on the priority concerns of individuals in their LGA. The sizable overlap between the matrix ranking of policy makers and that of community groups shows that political authorities are aware of the issues that concern their constituents. Officials

Box 1
How to Read Institutional Maps

The circles and boxes in the map represent the relative importance and accessibility of institutions to the group. The large circle represents the community, and the smaller circles signify key institutions. The importance of an institution is depicted by its size—the larger the box or circle, the more important the institution. Institutions that are placed outside of the larger circle represents the perception that they do not "belong" to the community; and, in the case of the idealized maps, these are institutions that should be located outside of the community.

A focus group of women in Zamko community, Langtang drew the two maps below, and explain them as follows:

Water. This is a basic necessity but the sources are too distant.

Hospital. The hospital is built but not equipped; it should be on the outskirts of the community so that people could not catch infectious diseases. Existing private facilities do not belong to the community, as they could close at any time.

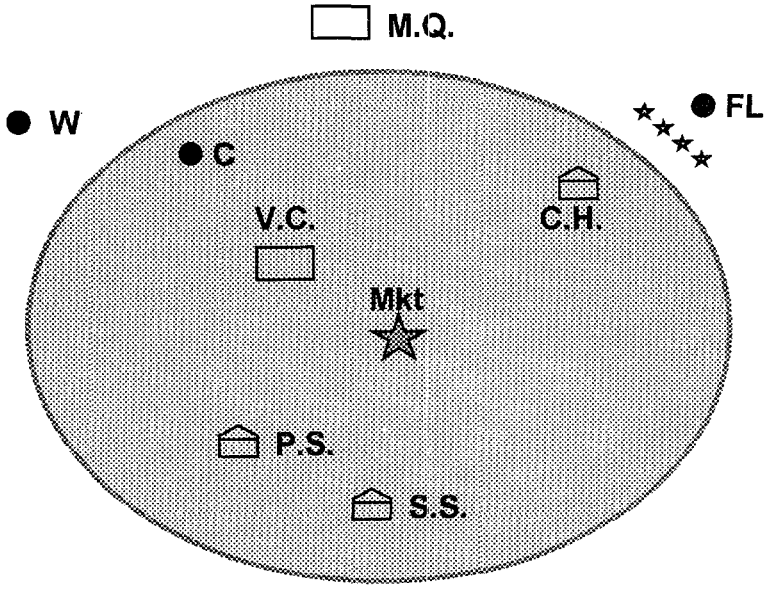
Market. It must be easily accessible, grinding machines in the market must be close to its center for ease of access.

School. More government schools would be cheaper than private education.

Bank. It would provide loans for market women, protect money against theft, and allow them to save.

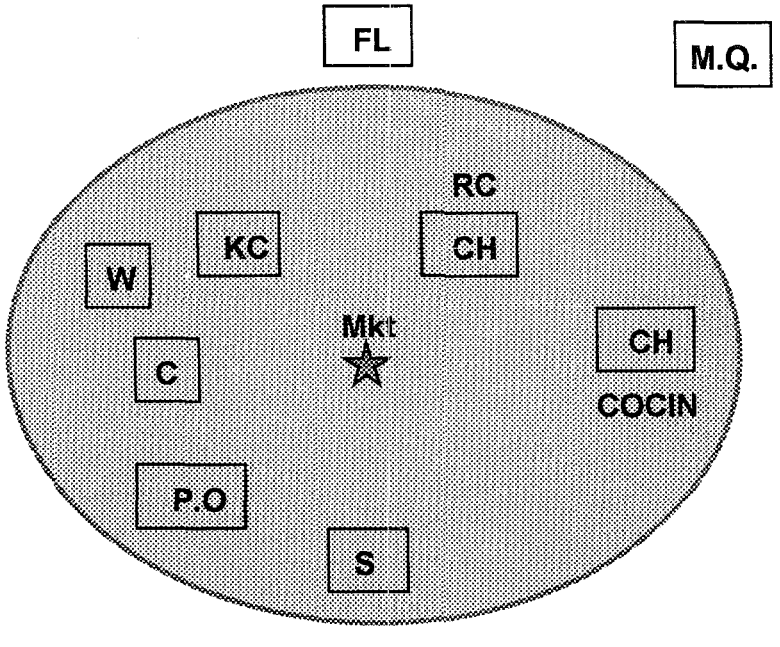
Church. It is located outside the community and controlled by missionaries.

MAP 1: Ideal Community Institutions
(Illustrated by Women in Zamko, Langtang LGA)



Key	
Mkt	Market
C	Clinic
FL	Farm land
W	Water
MQ	Mosque
CH	Church
PS	Primary School
SS	Secondary School
VC	Viewing Center

MAP 2: Ideal Community Institutions
(Illustrated by Women in Zamko, Langtang LGA)



Key	
Mkt	Market
C	Clinic
PO	Post Office
W	Pipe Home Water
MQ	Mosque
CH	Church
S	Schools
VC	Viewing Center

caution nonetheless that without financial resources they are unable to address many of their communities' needs.

Priority Health Concerns

To ascertain communities' perceived health needs, respondents are also asked to list and rank their main health concerns. STDs and AIDS do not feature significantly in any of the rankings, with the exception of one group of women in Langtang Town (see Table 4). They rank AIDS as their fourth health priority; and they also rank gonorrhea as a problem. In general, women perceive childhood diseases as priorities, and they rank them higher than men do. Among women, the main health concerns are measles, dysentery/diarrhea, and hypertension; men's main health concerns are meningitis, typhoid, and hernia. Malaria is mentioned more by men than by women.

Doctors and nurses identify similar health priorities with some notable exceptions. In each LGA, for example, doctors at private and public hospitals indicate complications arising from abortion as a priority health problem, particularly among girls under age 20. Relatedly, one of the health concerns secondary school girls express is the fear of pregnancy and having abortions.

With respect to two high risk populations, CSWs rank their reproductive health top among their health concerns, and LDTDs give priority to piles, headaches, and backache.

Community Organizations

Two types of community-based organizations have evolved in the LGAs: groups established at governmental request, such as the Health and Village Development Committees, and organizations formed around local women's, civic or religious concerns. In most of the communities studied government-sponsored organizations have either not met in a long time or were never established. In the cases of groups that once functioned, such as the Village Development Committees, the lack of sustained support is cited as a reason for their failure. According to a group of women in Laranto, Jos North: *The problem with the committees is that after meetings are held with us once or twice the organizers of such meetings don't come again and most of the time they don't supply the women with enough materials to develop their skills, for example in soap making, mat making. As a result, we feel it is a waste of time and everyone has to disperse.*

The exception to this pattern is the government-sponsored groups which conduct fortnightly sanitation activities. In some areas participation in sanitation days is the only health activity that involves the entire community. However, government officials generally perceive community participation to be limited to contributions of local labor. According to one LGA official, *"Community participation means acceptance of our education to them and taking part which makes our work very easy."*

Meanwhile, village-based organizations have developed in all of the communities to address common concerns. Indeed, local leaders and groups are willing to become fully involved—financially, technically and managerially—in developing and implementing strategies to address priorities and problems that they identify. For example, Langtang church leaders organize communal labor groups, or *Gaya,*

for building repair and agricultural work. Community groups also construct market stalls, schools and clinics; dig wells; work on agricultural pests control; and maintain drainage systems. In Jos North, one community buys drugs and provides them at subsidized rates in PHC clinics. Nevertheless, in the absence of sustained support such as credit or technical assistance from outside and within the community, even many of these local initiatives have not been sustained.

Table 4: Ranking of Health Problems

Jos North LGA

Laranto		Apata	
Men	**Women**	**Men**	**Women**
Fever	Meningitis	Malaria	Hypertension
Meningitis	Gastro-enteritis	Tuberculosis	Malnutrition
Typhoid	Typhoid	Typhoid	Diabetes
Tuberculosis	Measles	Cough	Anemia
Hypertension	Malaria	Gastro-enteritis	Measles
Asthma	Tuberculosis	Piles	Pneumonia
Pneumonia	Hypertension	Hypertension	Whooping Cough
Epilepsy	-	Meningitis	Asthma

Mangu LGA

Kombun		Mangu Town	
Men	**Women**	**Men**	**Women**
Typhoid	Headache	Hypertension/Typhoid	Hypertension
Ulcer	Typhoid	Meningitis	Appendix
Worms	Hypertension	Diarrhea	Diabetes
Meningitis	Worms	Measles	Ulcer
Bilharzia	Measles	Worms	Diarrhea
-	Dysentery	Malaria	Rheumatism
-	Diarrhea	-	Fever
-	-	-	Measles

Langtang LGA

Zamko		Langtang	
Men	**Women**	**Men**	**Women**
Snakebite	Eye Problem	Hypertension	Meningitis
Drug Abuse	Diarrhea	Typhoid	Measles
Diarrhea	Cold/Chills	Appendicitis	Diarrhea
Hernia	Convulsion	Hernia	AIDS
Meningitis	Chest Pain	Malaria	Appendicitis
Measles	Liver Cirrhosis	Dysentery	Diabetes
Malaria	Whooping Cough	-	Pneumonia
Bilharzia	Measles	-	Gonorrhea

3. Community Knowledge, Behaviors, and Practices Related to STD/AIDS

Beliefs and Knowledge of STD/AIDS

Box 2 and Table 5 provide highlights of local beliefs surrounding the causes and symptoms of STD/AIDS. In general, the field research indicates that diseases which affect the genital area are believed to be transmitted via three routes:

Sexual intercourse

It is thought that promiscuity spreads AIDS, and that this type of behavior is common among youths and men. It also is felt that certain types of women—namely, prostitutes or women who have been abroad and have sex with animals or western men—transmit these diseases. Lastly, sex for pleasure—as distinct from sex related to promiscuity or to procreation—is believed to cause STDs and AIDS.

Contact with urine

STDs are believed to be transmitted by stepping on or being in an area where someone with an STD urinates, "indiscriminate" urination, or using the same toilet as someone with an STD. The research is unable to identify why urination is thought to lead to disease. Many traditional healers conduct examinations of urine as part of their diagnostic procedure, which may suggest why urine plays a role in local health belief systems.

Box 2
Beliefs about STD and AIDS Causation

Making use of dirty toilets can cause disease that affects sex organs, walking barefooted can also cause these diseases and urinating at market places indiscriminately can also cause these diseases. - Ante-natal clinic patient, Langtang

AIDS. It is got through sex and through the bathroom if an infected person passes urine before you. Also from the toilet after an infected person passes stool in the toilet. - Ante-natal clinic patient, Langtang

If a person dreams of having sex with a women and discharges and it goes back to stomach it causes gonorrhea. - Traditional healer, Jos North

It is got from zaki, sweet fruits and contaminated water; excreting near a drinking pond can cause AIDS. - Traditional Healer

I don't know anything about AIDS but we believe that when ever one has it will be washed out during menstruation. - Commercial Sex Workers

[AIDS] was from abroad, those who go there for business and some ladies abroad allow themselves to have sex with animals such as monkey, dogs for money and when they find that they have the disease they come back and spread the disease with healthy people. - Female Secondary School student

AIDS is brought by hunger - that is only those who are not well off are getting it...caused by poor feeding, malnutrition and poor environment. -Community Men, Jos North

I heard AIDS could be spread like chicken lice on the radio. - CHEW, Langtang

Sharing objects
There is widespread belief that STD, and AIDS in particular, could be transmitted through the sharing of personal items such as razors and clothes. Fingernail cutting, which would involve the sharing of scissors, is mentioned by all target groups as a behavior that increases the risk of contracting AIDS. Additional means of contracting STD/AIDS are from the breath of someone with AIDS, eating with such a person, or wearing that person's clothes or underwear.

Table 5: STD Symptoms and Causes

Disease	Symptoms	Causes
Gonorrhea	Dry lips, unclear eyes dull hair	Sexual intercourse, promiscuity
(Arwa Nungwan-Tarow)	Prolonged or painful urination	Using same toilet as infected person, indiscriminate urination, blood transfusion
(Ciwon-Sanyi - Hausa)	Swollen penis, white pus in urine, fever, stomach pains	Borrowing clothes from infected person Hair on the inside of the vagina
Syphilis	Swollen penis, wound on penis	Sexual intercourse, at birth from infected mother, stepping on infected urine
(Tunzere - Tarow)	Penis in lower abdomen, boils	Urination in same place as infected person
(Tunjere - Hausa)	Leprosy-like symptoms, loss of body hair	Incomplete ejaculation while dreaming remains sediment in abdomen
	Water flowing from the anus and vagina	Heat from pit toilets Sitting where an infected person sat
AIDS	Loss of weight, fever, body swells, bad gums, vomiting consistent headache, big stomach, big head, water coming out of a woman's anus, sunken eyeballs, yellow comp'exion	Sexual intercourse, unsterilized or infected needles/razor blades, fingernail cutting, indiscriminate urination, a dirty environment, sex with dogs, blood transfusion, the breath of a victim, lying on victim's bed, sharing shoes, kissing an infected person, eating with someone with AIDS, women who had been abroad, eating uncooked monkey meat, from injections, sweat of someone with AIDS, contact with crabs on the lips of someone with AIDS.
Mai-Pita	Cut on penis	Sexual intercourse, when a woman refuses to have sex when the man is ready
Kabab ciki (infertility)	-	Clotted blood after birth, men sleeping in bad position, not taking warm water after birth
Pubic Lice Misham (Taroh)	Lice	Dirt in genitals, lack of proper care
Mpah-Myar (Taroh) Yankan Gashi (Hausa)	Cut on penis	Forceful sex with woman who has a lot of genital hair, hair cuts penis

Among the target groups, students are most aware about the sexual transmission of AIDS and other STDs. While they are able to name all of the main STDs, they nevertheless express many commonly held misconceptions about STDs, including that AIDS is caused by mosquitoes, women who have been abroad, and fingernail cutting.

Knowledge levels among service providers is not uniformly high. Some believe that AIDS is caused by swallowing the saliva of an infected person, and they urge individuals to avoid kissing. One nurse observes that the disease is transmitted merely by coming into contact with an infected person; and a CHEW suggests that mosquitoes can spread the disease. Pharmacists and traditional healers have heard about AIDS but they are not all aware that the disease is sexually transmitted.

Symptoms

Men diagnose STDs in themselves when they see discharges of blood or pus, feel pain while urinating, or have difficulty walking. None of the men interviewed mention that STDs could be asymptomatic. To detect STDs in women, men look for vaginal discharges, "flecks" on the lips, changes in a woman's style of walking, or the loss of erections upon starting intercourse. Women identify six symptoms for self-diagnosis of STDs: pains in the lower abdomen, discharge from the vagina, yellow stains in the urine, itching in the vagina, swelling of the vagina/groin region, and painful urination. Table 5 provides further detail on community beliefs surrounding STD symptoms and causes.

Service providers are well informed of STD symptoms with the exception of AIDS. For example, some believe that AIDS causes hair loss and discharge from the penis. The levels of knowledge among CHEWs are much lower, with one stating that, with AIDS, the *"eyes will blotch out, the hands and legs will thin, [there would be a] swollen abdomen [and a] big head."*

Attitudes Towards Individuals with HIV/AIDS

Most health care providers interviewed, including those in Western and traditional practices, have treated STD patients. Very few, however, have seen or treated someone with AIDS. Approximately one-half of the service providers expressed fear of contracting AIDS while attending to an individual with the virus. This notwithstanding, many providers report that they would provide care and sympathy to such individuals. In none of the interviews does the distinction between having AIDS and being HIV-positive emerge, nor do observations that HIV-positive individuals could lead healthy, productive lives. Generally, service providers view HIV/AIDS as being synonymous with death.

The many negative perceptions about working with AIDS clients relate to beliefs that the disease could be transmitted through social contact or blood products and to misconceptions about the symptoms of the disease. Doctors and nurses are most concerned about AIDS transmission through infected needles and blood transfusions. Pharmacists and chemists, however, believe quarantine is needed. Indeed, one pharmacist stated, *"I will not allow him* [individual with AIDS] *into my shop. Don't you know it has no cure and is a*

contagious disease? If he come here, I will wash the place he has stepped on." CHEWs as a group express the most negative attitudes towards working with individuals with AIDS. Many of them recommend quarantine, and a CHEW in Langtang observes: *"I would feel like vomiting, as the AIDS patient will always be smelling."*

At the community level, respondents consistently express fear and pity towards individuals with AIDS, and believe that those infected need to be quarantined. In Langtang, one community member suggests that the belongings of someone with AIDS should be burned when the person dies. Jos North communities observes that persons with AIDS should be treated in the hospital and reported to the police. Again, these reactions reflect underlying uncertainties and fears regarding the transmission and fatal impact of the disease.

Prevention

Common Methods

Service providers advocate abstinence and sticking to one partner as the main preventive measures for STD/AIDS, and infrequently promote condom use. In considering issues of prevention, providers place much emphasis on measures to reduce their own occupational risks associated with treating individuals with AIDS. Many providers mention the need to screen all blood and to use sterilized blades and instruments.

As explored in Box 3, CSWs report use of three preventive measures in addition to condom use. First, they conduct physical examinations of their clients, including squeezing a client's penis to see if pus or any other discharge emerge, and pressing their stomachs to see if this causes any pain. Similarly, the clients examine CSWs for signs of vaginal discharge by wiping white handkerchiefs on their vaginas. Second, CSWs, and particularly those in urban areas, go for regular medical examinations In some cases, these check-ups involve vaginal examinations and stool and urine tests. Third, auto-medication is also used for prevention. CSWs apply penicillin-based ointments to their vaginas after having sex to prevent infection. They also use these ointments as lubricants, and are familiar with the names of specific creams that they buy regularly. Self-medication is also reported as a preventive measure by many clients of CSWs, and they go to chemists and traditional healers for medicines prior to or between visits with CSWs. Of final note, CSWs link unclean toilets to STDs, and some report that they clean hotel toilets as another preventive measure.

Box 3
Approaches to Diagnosis of STDs by Commercial Sex Workers

Some of the men before you check them will rush and urinate the pus away but we insist that before they go out to piss we press their prick to see if discharges are coming out.

I will touch his stomach and press it hard, if he feels pains then I will know he has disease.

A woman who has this disease will not be able to stand up and there will be stomach ache.

We check them by using a white handkerchief to press his penis to see if he has a disease.

The men that come check us using white toilet paper to see if we have disease.

Community members identify their main STD/AIDS preventive measures as abstinence or monogamy and avoidance of areas where people urinate. As explored further below, condom use is infrequently mentioned and often associated with its contraceptive function. Among the individuals who believe that STDs, and AIDS in particular, are transmitted by the sharing of personal items, some report that they refuse to share razors and have bought their own pair of nail scissors.

Perceived Risk

The limited and *ad hoc* adoption of preventive measures is closely linked to the lack of a sense of perceived risk. As AIDS is associated with promiscuity, visitors, and women who have traveled abroad, most individuals do not consider themselves at risk. In Jos North, for example, women believe that their Christianity will protect them, while men in Laranto feel that the disease only affects the youth because they are promiscuous. The low levels of perceived risk may also be related to the limited availability of information about the disease and the communities' limited contact with people from the state who have AIDS. As one CSW said, *"I hear say AIDS there I never see any body when AIDS catch them. I never see any body when AIDS kill them. All I hear the AIDS there, AIDS there."*

Only one of five officials interviewed in Langtang perceives AIDS to be a serious problem, while another admitted that he has never heard of the disease. Local officials mention some problems with STDs more generally, but they associate the diseases with youth truancy and promiscuity. Similar perceptions can be found in Mangu, where the risk of AIDS spreading is thought to be slight. In Jos North, there is greater understanding of the potentially large impact of the disease because the city serves as an important transit point.

Awareness of and Attitudes Towards Condom Use

Condom use is low among all of the target groups, including among the high risk populations of CSWs, LDTDs, and clients of CSWs. In fact, very few people report that they have even seen a condom or know how to use them.[1] Secondary students are most knowledgeable about how condoms work, but few of them (particularly female students) have ever seen one. In Langtang LGA, none of the STD clinic patients have ever seen a condom. While most CSWs know of condoms, many of them never use them and some have never seen one. Key obstacles to condom use include:

Cost. Condoms are too expensive for certain populations. For example, some CSWs report that they could not afford to use a condom with every client. CSWs working in rural areas average three-to-four customers on a good night, earning 20 to 30 naira per sex act; at 10 naira each, CSWs argue that condoms are too expensive. Other quotes on condom prices range from 2.5 naira for one to four for 20 naira.

Condom breakage. Many condom users complain that they break during sex. Condom breakage may be related to the unavailability of appropriate lubricants, the size of the condoms, and storage conditions.

Beliefs about negative health effects. One of the traditional beliefs about syphilis is that it is caused by sperm re-entering a man's body through his penis. This leads some men to refuse to use condoms due to the belief that, by "trapping" the sperm, the device causes syphilis. Some women and female students believe that condoms can become dislodged during sex and enter the womb and other internal organs, which can cause bleeding or even death. In Mangu, women report that they know of condoms having to be surgically removed from the womb. Some service providers also express concern that condom use could lead to cancer.

Loss of sexual pleasure. Most men complain that condoms reduce sexual pleasure.

Rural-urban location. Knowledge, availability and use of condoms are lower in rural areas.

Skepticism among health service providers. Many providers believe that condoms, although useful in preventing disease, frequently break and provide a false sense of protection. Many providers in rural LGAs believe people are too uneducated to use condoms properly and therefore do not promote their use. Also, many providers do not support condom distribution to youth, as this would promote immorality and promiscuity.

In addition, the determinants of condom use are closely tied to behaviors surrounding sexuality and sexual relations. In all communities, the timing and duration of the sexual act is determined by men and a clear distinction exists between sex for procreation and sex for pleasure. Married women view sex as a means of satisfying their husband's desires and not their own, and as a means for procreation. They associate condoms with sex for pleasure in extra-marital affairs, and consider these immoral acts practiced by "loose" women or prostitutes.

Married women are therefore reluctant to purchase condoms or suggest their use to their mates, as this could be perceived as evidence of their own infidelity or immorality. In addition, women do not think they should purchase condoms because they do not "use" them or have control over the sexual act. Furthermore, men perceive the notion of women taking the initiative in determining the timing and nature of sexual interaction as an attempt to usurp the man's role and control their husbands. Such behavior is unacceptable to most men, and some indicate that they would respond violently (see Box 4). At a more basic level, many women are very uncomfortable presenting a condom to their partners because they do not know how to use it.

Men who approve of family planning are more supportive of condom use, but, again, primarily for contraception and not to prevent STDs. Men who report having sex for pleasure or extra-marital relationships are also more supportive of condom use, and specifically for STD prevention. Women with spouses who use condoms view this as an indication of the desire of their husbands to space births; however, the same women also think condoms will protect them from disease. Male students see sex primarily as a rite of passage and form of enjoyment, and associate condoms with STDs and family planning. Most male students do not see themselves at risk of getting an STD or are worried about teenage pregnancies. Hence, they perceive no need to use condoms, which they feel

reduces sexual pleasure. On the other hand, female students are very concerned about unwanted pregnancies andsupport condom use as a contraceptive device.

Box 4
Perceptions of and Attitudes Towards Condom Use

If not nursing a baby and she say use a condom I will beat hell out of her and sex her without condom. - Long distance truck driver

It is not for our age but it is for children to use during sexual intercourse because they are more promiscuous .- Community women, Jos North

I don't allow my customer to use it on his bura (penis) to have sex with me. I will allow him to go with his money, because it can enter my stomach during sex and disturb me. - Commercial Sex Worker

It is risk some say because if it pass into the girl's vagina it may lead to her death. - Secondary School Student

People say it is not pleasurable and it is dirty .- Long Distance Truck Driver

I will feel discouraged going to buy them because I will be ashamed... as people will know I will use them with a harlot. I will feel shy if the person in the chemist knows me. - Male secondary school student

The say it is a dirty game- they believe is being reused and it becomes clumsy. - Nurse

Frequency and Type of Sexual Behavior

Jos North CSWs report having an average of five clients a day; in rural areas, the number of clients is about three a day.

While the main type of sex reported is vaginal, CSWs in urban areas report that anal sex is increasingly in demand. The price for anal sex can be as high as 4,000 naira in urban areas, while vaginal sex costs between 50 and 200 naira. The majority of men claim to have sex two-to-three times a week. Among LDTDs, the average number of sexual interactions is once a week when they are traveling and three-to-four times a week when at home.

The average age for the initiation of sexual activity is sixteen years for girls and eighteen years for boys; in Jos North sexual activity as young as ten is reported.

Determinants of Health Service Utilization

There is evidence of extensive switching between Western and traditional medicine (see Box 5). Each of the communities interviewed contains two-to-four traditional healers compared with one PHC. Private clinics and hospitals are also available but are used less frequently due to higher costs. The sequencing of visits between Western and traditional health systems is determined by: 1) beliefs about the causation and appropriate treatment of the illness; 2) characteristics of the health delivery system; 3) cost and access to services; and, 4) the perceptions of providers and clients towards each other and of the quality of health services.

Beliefs about Illness Causation and its Appropriate Treatment

A clear distinction is made between treatment and cure of an illness. Treatment is associated with the abatement of symptoms, while the latter is linked to interventions that remove the cause of an illness.

A group of women in Jos North explain that hospitals are the first choice for the treatment of syphilis because the medicines given there will "*kill the eggs of the tunjere* [syphilis]," but then traditional medicine will be necessary to cure the disease.[2] As one CSW succinctly explained: *In some it will not show in urine but it will be eating up the groin. Even if take injection it will not die but will be dormant for some time before it starts again. Therefore, using traditional medicine is better. Using orthodox medicine will only make the sickness to lie dormant.*

Box 5
Preferred Sequencing of Providers

Men, Kombun Community, Mangu LGA

Illness	First Choice	Second Choice	Third Choice	Fourth Choice
Typhoid	Hospital	Traditional Healer	-	-
Gonorrhea	Chemist	Hospital	Traditional Healer	Death
Syphilis	Chemist	Hospital	Traditional Healer	Death
AIDS	Hospital	Traditional Healer	-	-
Hernia	Hospital	Death	-	-

Reasons for choice:

Gonorrhea and Syphilis: Go to chemist first because of shame, the chemist would provide privately and be discreet, if the chemist does not work one has no choice but to go to the hospital because they have drugs, the hospital drugs might not heal completely but traditional drugs heal completely.

Women, Laranto Community, Jos North LGA

Illness	First Choice	Second Choice	Third Choice
Meningitis	Hospital	Clinic	Traditional Healer
Diarrhea	Clinic	Hospital	Traditional Healer
Typhoid	Hospital	Clinic	-
AIDS	Hospital	Traditional Healer	-
Gonorrhea	Clinic	Hospital	Traditional Healer
Syphilis	Hospital	Traditional Healer	

Reasons for choice:

Meningitis: Serious problem only doctors know how to treat it; if hospitals cannot cure it we go to the clinics; when we have tried all ways without working then we have to go to the traditional healer.

Diarrhea: Clinic is the nearest place; if the sickness persists we go to the hospital; if the two treatments do not work we go to the traditional healer.

Typhoid: Hospital cure this very fast; if it persists the next place to go is clinic.

AIDS: One has to be serious with AIDS treatment because it can kill .... we go to hospital; when the sickness cannot be solved the next place is the traditional healer.

Gonorrhea: Clinic first but if the clinic cannot cure the victim the second place to go is the hospital; the traditional healer for the next treatment since everybody like traditional medicine.

Syphilis: The hospital first in order to treat and kill the eggs of the tunjere; but if the medicine from the hospital cannot cure it we have to go to the traditional healer.

Table 6 lists what community members believe are the most appropriate treatments for STDs. Again, western medicine is used to treat the symptoms of most STDs, but there is always a traditional medicine that can be taken in conjunction or on its own. AIDS is the only disease that is referred exclusively to a Western provider because, as a new illness, there are no established traditional therapies. Moreover, most people, believing AIDS can not be treated or cured, view the hospital and not the clinic as the first treatment site.The practice of provider switching is also related to expectations about the course of treatment and the time within which medications should have an observable effect. Some patients report that hospital treatments take too long to relieve symptoms and therefore they turn to traditional medicines. Thus, if STD symptoms continue clients do not return to where they had last been treated but instead go to another type of provider. When there is no improvement after all types of providers have been consulted, most individuals resign themselves to their fate.

Characteristics of the Health Delivery System

Other factors relating to the health system itself greatly shape the way health services are used. These include:

Drug availability. Some men do not use clinics and hospitals because drugs are never available and they must then go to a chemist. They prefer to go to the chemist first where they can obtain both a diagnosis and the required drugs. Patients at STD clinics also complain about the lack of drugs and the length of time it takes to get test results. In addition, patients believe that drugs sold on the open market cost more than those at clinics and hospitals. There is also concern that drugs provided by chemists may be fake and not provide effective treatment.

Perceived Function of Treatment Site. Both men and women view PHC facilities as being exclusively for women and children, and men are unlikely to use them. *"Clinic is meant for woman. The man only goes to hospital,"* as one group of men from

Table 6: Appropriate Treatments for STD/AIDS

Name of STD	Appropriate Treatment
AIDS	No cure; injection to prevent person passing it on to others; go to the hospital
Ciwin Sanyi (Gonorrhea)	Roots of bini mixed with guinea corn powder; mix lemon juice with cow's milk; go to hospital
Tunjere (Syphilis)	Roots of bini mixed with guinea corn powder; go to hospital; traditional medicine applied to the anus
Pubic Lice	Powder from ash, mix with kashi makera and drink
Yankan-Gashi	Cigarette ash on wounds
Kaba	Mangul and whisky

Mangu bluntly explained. The name change from Maternal Child Health Clinics to PHCs has done little to alter these perceptions. Meanwhile, women are reluctant to visit traditional healers as this could be interpreted as an attempt to put a curse on their husbands. They also express reservations about purchasing drugs or condoms at chemist shops, as these visits could be seen as attempts to obtain medicines for inducing an abortion.

Gender of service provider. Women are unlikely to use facilities where examinations would be performed by male nurses or doctors. They believe that female providers would better understand their problems and feel less shame in exposing their bodies to someone of the same sex. Men are less adamant about the need to have a provider of the same sex; however, married men expressed concerns about their wives being given physical examinations by male doctors. Among adolescents of both sexes, there is a strong preference for a provider of the same sex.

Privacy of service. The lack of privacy between patients and providers at public sector hospitals and clinics is frequently cited as a reason why these facilities are not used for STD treatment. The lack of properly enclosed examination rooms and the approach to patient management made potential STD patients feel that the reason for their visit would be apparent to others in the facility. Privacy is not an issue at private facilities; female students believe that visits to a private hospital would be confidential and expect to be better treated than by a chemist or traditional healer. On the other hand, male students say they would patronize both chemists and public hospitals.

Conditions of facilities. Patients are also concerned about, the appearance and cleanliness of the clinics, the limited range of services offered, and the lack of medical equipment. Ante-natal women find PHCs dirty, dark, and in need of renovation. Several women comment on the lack of toilet facilities, a particular inconvenience for pregnant women who must typically wait two hours or more to see a nurse or doctor. Similarly, patients at STD clinics also make observations on the need for repairs, the cramped conditions, and the lack of toilets.

During the interviews, three recommendations were made for improving health services. First, health education classes should be provided on disease causation and prevention. Second, many women want PHCs to expand beyond ante- and post-natal care in order to address a wider range of women's health concerns. Third, more—and/or better functioning—equipment should be made available to PHCs and hospitals, particularly for the performance of simple procedures such as taking blood pressure. The lack of equipment in PHCs leads individuals to seek treatment in hospitals and private health facilities for health problems unrelated to pregnancy. Box 6 presents further suggestions from ante-natal women for improvements in clinic conditions.

Cost and Access to Services

Cost, in terms of both finance and time, are important determinants of service utilization. There is no clear consensus on whether going to a hospital or clinic is cheaper than being attended by a traditional healer (see Box 7). However, the financing plan adopted by traditional healers appears more convenient for

patients: payments can be made over time and in kind.

Box 6
Suggestions for Improving PHC Clinics

Sweep it, remove cobwebs, clean tables, and wash the toilets so that the place would look nice to see. - PHC Clinic, Mangu

I would like the structure to be renovated. And there should be electric supply regularly. - PHC Clinic Langtang

Give the nurses some incentives. - Plateau Hospital

The nurses should be sincere in the way they treat people. They are sometimes harsh to us when we want to ask some questions they shout us down sometime or they may not answer us very well. - Plateau Hospital

Educate us more about illness and their causes. - PHC Clinic, Langtang

If I had the chance I will buy air fresheners and put some in every room in this hospital and also help buy some tins of paint and re-paint the walls. The walls are dirty. -Plateau Hospital

All facilities related to child delivery should be made more available. - PHC Clinic Langtang

I will make equipment for working available. What they measure for blood pressure has gone bad, there are no hand gloves and mucus extractors. - Plateau Hospital

Things like seats. - Plateau Hospital

I would like spirited individuals to assist the clinic with more drugs, as there is always no drugs. They do give us prescriptions to go and buy outside. - PHC Clinic, Langtang

In rural LGAs ante-natal visits at PHC clinics are estimated to cost between 20 and 25 naira; and some women who arrive after 9:00 am are charged a late fee of two naira. Visits to the Plateau Hospital, at an average cost of 100 naira, are more expensive but include fees for laboratory tests and drugs when available. In the urban areas where taxis are more available, women spend an additional 20 to 30 naira traveling to and from clinics and hospitals. Many traditional healers and pharmacists are open on a 24-hour basis. By contrast, PHC clinics have more restricted hours that are often inconvenient to women with agricultural and household obligations. In Langtang and Mangu, most women arrive at PHCs before 8:30 a.m. and spend on average two hours in the clinic, though visits lasting over three hours are not uncommon. At the Plateau Hospital in Jos North the average visit lasts two and one-half hours. The majority of this time is spent waiting to see the nurse or doctor. In rural

Box 7
Choice of Provider for Treatment of STD/AIDS

We go to the hospital first for drugs, when it is not treated then Traditional Healer who helps sometimes, and if they fail too, then we resort to the prayer house for spiritual care and attention and finally we stay at home waiting for death - Women in Langtang on treatment choices for gonorrhea

Traditional healers charge costly than hospital and clinic. They will ask someone to buy cow, goat, fowl and the same time collect money again on only one sickness - Community women, Jos North

For privacy they hardly go to the hospital. They prefer going to the chemists and pharmacists for there is absolute privacy there - Policy maker, Langtang LGA

areas, most women walk to the clinic, requiring an average of fifteen to thirty minutes (but can be as much as 2 hours). In urban areas, the average walking time to a clinic is twenty minutes.

Perceptions and Attitudes of Various Target Groupsabout Each Other

Providers. The cultural, linguistic and gender differences between public health providers and their clients influences providers' perceptions of their patients, and vice versa. As seen in Box 8, doctors and nurses have many stereotypes about patients based on gender, age, educational level and ethnicity. Overall, they view men as being more difficult because they ask questions and do not follow treatment guidelines. Providers perceive youth to be arrogant. In addition, there is widespread rejection of the behavior and beliefs of those who are thought to be "ignorant," "arrogant," or "illiterate"—labels that are frequently applied to villagers or individuals with little formal schooling. Ethnic stereotypes are also common; according to one provider, the Fulani are ignorant and difficult because they don't listen to instructions, they come to see patients outside of visiting hours, and they litter the hospitals and pester those on duty. In some cases, patients are belittled if they do not speak Hausa, the most widely-spoken language among public sector service providers. Providers also express gender-biases, including that women use health services more than men because they can not cope with pain and are more biologically predisposed to have illnesses. One doctor suggested that women, because they live in *purdah*, need the "fresh air" afforded by a clinic visit.

Many doctors and nurses are willing to work with traditional healers, but they express widespread skepticism of the healers' diagnostic ability. Few Western-trained providers believe that they have anything to learn from traditional healers, with the exception of much interest in learning about the techniques used by healers to set broken bones.

Box 8
Providers Perception of Patients and Their Target Communities

Youth are rude...very difficult to work with they are arrogant. They don't have regard for us here. They want everything to be done to them at once. - Nurse, Langtang Hospital

They pretend just like the Yorubas, they praise you in your presence and when you turn your back they abuse you. - Doctor, Mangu

Hausas are very difficult to deal with. They are illiterate, jobless in purdah therefore solely dependent on their husbands. They misinterpret their religion. They seek medical advice late and they interfere with medical intervention. They don't give a free hand to the decision of the doctors due to their religious bias. - Doctor, Plateau Hospital, Jos

Men are difficult to work with.....men tend to be stubborn, some are not willing to tell you their problems. -Hausa speaking doctor, Langtang General Hospital

Ibo patients tend to know too much. The pagans are not patient...they prefer traditional medicine. The patients that are easy to work with are the Moslems....they are cooperative and are willing to listen to instructions concerning their health. - Nurse, Langtang General Hospital

I find it difficult to work with the Tarok people those who are illiterate and come from the villages. They don't speak Hausa....A lot of times they are not given all the information they need on health issues because I can't communicate with them. - Staff nurse, PHC Clinic

Patients. Most target groups complain about the attitudes of clinic and hospital staff. CSWs report that unless they show they can pay for services they are not treated properly at hospitals. They mention having to bribe staff to be admitted to hospitals and feel they are sometimes overcharged. According to one CSW, *"Some doctors and nurses don't care about patients at all, they don't even ask you what your problems are. They just treat you very quickly."*

In interviews, many individuals express concerns about the manner in which providers speak to them and the lack of information they are given about their illnesses. For example, exit interviews with patients at PHC and STD clinics reveal that most of them are unable to recall their diagnosis, if they have been given one. Nor can they recall the medications prescribed and the treatment regimen they are expected to follow.

Traditional Healers. Most traditional healers believe that hospital and clinic staff have inappropriate interpersonal skills. According to a traditional healer in Langtang, *"There is delay in the hospital; when it comes to attending to a patient, when you don't have money one is treated like a dog."* Most of the traditional healers express a willingness to work collaboratively with Western-trained staff and help doctors improve their communication skills. The majority of traditional healers in the interviews have lived and practiced in their communities for at least 10 years; and, unlike PHC or hospital staff, most of them speak Hausa and at least one of the other local languages.

LGA and State Officials. In contrast to the behaviors and practices reported by the communities, officials believe that most people go to PHC clinics and hospitals for health care services, and particularly for STDs, and do not regularly seek treatment from traditional healers. Officials maintain that public health facilities are widely preferred because they are better staffed and equipped, easily accessible, cheap, and provide genuine drugs. Few officials acknowledge the need to address the qualitative dimension of service delivery—e.g. the need for improvements in interpersonal communication between patients and providers or in clinic management and supervision.

The Role of Chemists, Patent Medicine Dealers, and Pharmacists

Face-to-face interviews with chemists, patent medicine dealers, and pharmacists show them to be knowledgeable about STD causation, keen on collaborating with clinic and hospital staff, and committed to selling STD drugs only to patients with a prescription. This was not found to be the case with the "mystery client" interviews (in which male and female members of the research team approach these providers and pretend to be suffering from an STD).

As explored in Box 9, the mystery clients' diagnoses are often based on the relative ability to pay for treatment. The majority of patients are sold a combination of pills and, in some cases, told that they need injections. The mystery clients are not informed of what medications they are being given, and merely receive simple instructions on what color pills to take and in what order. A female mystery patient who asks how a prescribed cream should be used is told to read the instructions on the tube. Few of the mystery clients are told about the cause of their illness, STD

Box 9
Treatment Given by Chemists to Mystery Clients

In Langtang, a male (mystery) patient approached a pharmacist and a chemist and informed them that he had a pain in his genitals and "a whitish discharge" from his penis. Both providers asked when the symptoms started. The pharmacist informed him that he had a "woman disease". Both wrote prescriptions for the illness, the pharmacist, gave a prescription for six medicines. These medications cost 135 naira. The pharmacist also wanted to administer an injection, but said that he could not do so because the sun was hot and asked the 'patient' to return later in the day. The chemist prescribed three medicines, supposedly, amplixlox, tetracycline and nitrofurantoin, and charged 65 naira. He suggested that they be taken before the end of the day and said that they would cure the illness.

In Jos North, a male (mystery) patient was offered three treatment options: Full Treatment for 320 naira; Not Full Treatment, which involved medicines that would not work so fast, for 120 naira, Half Not Full Treatment for 60 naira. The last treatment consisted of two red pills, two white pills and 32 purple pills. The 'patient' was told to take them at home and that his urine would turn dark yellow.

prevention, condom use, or the need to return for a follow-up visit.

Training and Supervision of Health Service Providers

Most of the public sector staff have not received any training in the last three to four years, which is often the length of time they have been in their posts. The lack of training is most evident among CHEWs. Existing in-service training generally focuses on family planning or midwifery, and the providers indicate that no training has been offered on the prevention, treatment, and care of STDs or other diseases that are prevalent in their communities. In contrast, the majority of providers in private hospitals and clinics have received in-service training within the last two years.

Supervision of staff performance is *ad hoc* or non-existent, particularly for doctors. According to one doctor, *"nobody comes here to supervise my work, because I am the Medical Superintendent here. But this should not be so, due to the poor administrative system this...has been overlooked so I do what I can."* Supervision of nursing staff is done more regularly, but with somewhat less efficiency in rural areas. Senior nursing staff are generally not supervised and do not expect to have their performance evaluated.

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[1] Condoms are known as condom ruba, condom, rain coat, and Durex (a brand name). In addition, a series of names in Hausa and the local languages are used, such as: Hulan maza kuta, Fulan maza kuta, Sock na baba (Hausa), and Atangia-achei (Taroh). In Jos North, condoms are also called evidence, protector, screw driver, and cap.

[2] The dichotomy between treatment and cure is also observed for non-sexually transmitted diseases. For example, men in Langtang state that they would first go to the hospital for hypertension treatment, as the tests done there would "detect" the disease; but a complete cure would only occur when they have taken traditional medicine.

4. Community Health Information: Sources and Impacts

In rural LGAs interpersonal communication provides the main vehicle for all forms of information dissemination due to limited access to mass media.[1] Credible sources of information for these populations include religious leaders, traditional elders, village chiefs (particularly the *Ponzhi Taroh,* the highest traditional ruler), the district head *(Magajin Garin*), and the town crier—who goes out on the instructions of the village head. Access to mass media is greater in Jos North, where radio is popular among students and women. Many women, however, report that they can not understand the programs broadcast in English. Printed reading materials are available in all areas but reach a small segment of the population due to low literacy levels.

In their identification of health opinion leaders, communities make references to residents who provide treatment on credit or who settle land disputes, and they also mention wealthy individuals engaged in community development. In addition, doctors and nurses are widely identified as credible sources for health information. Female secondary school students cite doctors, pharmacists/chemists, and their parents as credible sources of information. Boys report that they would avoid talking to their parents and would obtain health information by consulting peers who have suffered from the disease in question.

Communities have mixed perceptions of the quality of information provided by health outreach workers. In Langtang and Jos North, CHEWs are viewed as credible, trustworthy and skilled sources of health information. This contrasts with perceptions of traditional birth attendants, who are considered only skilled in matters concerning pregnancy and not as knowledgeable as CHEWs. Some of the Mangu communities refer to information officers attached to the Federal Ministry of Information as reliable and credible sources of health information

Inter-Personal Communication at Public Health Clinics

Exit interviews with anti-natal women reveal that they have limited recall of information provided by the clinics on immunization, family planning, AIDS, and children's diseases. For example, women's understanding of ante-natal examinations is limited. The recall of the visit by a woman in Langtang is typical of other responses in the interviews: *The nurse told me to lie down so that she could check my pregnancy, then I lied down and she checked my pregnancy and after checking the pregnancy she gave me tablets red in color and the red syrup which I don't know their names. Then, the nurse told me to come next Friday for check up.*

In fact, the most frequently recalled aspect of the ante-natal visit is the list of things to bring to the hospital for the delivery: sweaters, baby clothes, olive oil, toilet soap, razors, Dettol, and 500 naira.

Most of the Jos North women report being told about immunizations, while only about half of the women in Langtang and Mangu recall receiving such information. The main messages that they retain are the need for women to be immunized, the scheduling of immunization appointments, and the importance of not missing appointments. The reason for being immunized is not clear to all of the women interviewed, and some can not recall what immunizations they have received.

In general, family planning is discussed less frequently than is immunization, but the main messages that women can recall are that: 1) a variety of contraceptive methods are available; 2) women should stop having children after the fourth birth; and, 3) contraceptives should be used for two-to-three years to space births. The first message is the most frequently mentioned. Comments by women on health education sessions suggest that information is provided on methods that are not available to them, and that the talks are not well understood. For example, a Plateau Hospital women mentions being told about *"something that is put in the armpits"* (Norplant).

AIDS is discussed with anti-natal patients primarily in the context of taking measures to avoid the need for blood transfusions during delivery (See Box 10). Accordingly, many women report that they are told to *"build up extra blood."* Discussions on nutrition also focus on the need to eat foods that will increase the amount of blood in the body. Most women interviewed report that the sexual transmission of STDs and AIDS is either not discussed or the information given can not be recalled.

Inter-Personal Communication at STD Clinics

Exit interviews with STD patients reveal similar patterns of limited communication and recall. Of the five patients interviewed in Mangu, only two are informed that they have contracted their infection through either sex or a toilet seat and only one patient is informed of his specific diagnosis (syphilis). Most patients only receive a urine test, with the exception of one culture test for syphilis. In Langtang, a woman who received a diagnosis of pelvic inflammatory disease reported that the provider did not give her a physical exami-

Box 10
Women's Recall of Discussions on STD/AIDS in Health Facilities

The nurse only told us that anybody that does not have his blood examined, the pregnant woman will be sent away during labor. The nurse did not tell us why, she only said that it is important to have our blood tested so that we will know the type of sickness one has and to know whether one has enough blood. - Plateau Hospital

Protect against mosquito bite. This will enable us to have enough blood in their body so that on the day of delivery they will not be short of blood and result to blood transfusion because they are too many sickness nowadays like AIDS. - Plateau Hospital

They told us to eat good food that will avoid anything that will cause blood transfusion because AIDS is very rampant. They did not tell us much about AIDS. - Plateau Hospital

nation but did take her temperature and blood pressure. STD patients are given a combination of tablets and injections, but none of them are told how the medications work and few know what specific drugs have been prescribed.

The majority of patients are not told anything about STD or AIDS prevention, including the patient with a diagnosed case of syphilis. A Langtang STD patient is advised, however, *"not to eat kola nuts, pepper or alcohol."* The few patients who can recall having been told about AIDS report being informed that it is incurable, new, dangerous, transmitted through sex, and that one needs to use condoms and clean needles. Again, however, most patients are not told about condoms, and none receive free condoms or demonstrations on their correct use. Also significant, clients rarely are asked about previous sexual partners; although one patient with a suspected fungal infection is told to have her husband come in to be examined (which she refuses to do out of fear that he will suspect she is unfaithful and beat her). All patients are asked to return for a follow-up visit.

Effectiveness of Health Education/Community Outreach

The effectiveness of health outreach efforts is hampered by the infrequency of visits by outreach staff, poor targeting of audiences, and weaknesses in program administration and supervision. Infrequent visits by health education workers is identified as a problem by every community. No visitations are reported among the hard-to-reach CSW and LDTD groups. In fact, CHEWs—a primary agent for outreach—report that women are their main target audience. In some communities, men complain about this and recommend that the target groups for outreach programs be expanded (see Box 11).

Some LGA officials observe that health education efforts are having an impact. Others, however, express serious concerns about the program's lack of focus, appropriately trained staff, and coherent implementation. Supporting these latter views is evidence that consistent strategies and plans for selecting health education themes and approaches are largely absent and administrative processes for staff supervision and program evaluation are generally poor or non-existent. Many CHEWs, for example, evaluate their work by the number of people who attend talks or come to clinics.

Box 11
Perceptions of Sources of Health Information

The health talks are not enough, not to speak of enlightenment. The only people who have the opportunity of getting these talks are those women who attend the MCH. In the village such talks are not done - Men, Langtang

VHW, TBA (traditional birth attendant), or CHEW are completely absent from here. It has been a long time since we talked to a CHEW. We don't have health talks, we never had any - Men, Jos North

There has been some campaign going on. The campaign has not deterred anybody - Policy Maker, Langtang

We have never talked to any VHW, TBA, or CHEW because we don't even know them and we are not familiar with such people - Women, Jos North

There is an AIDS Action Manager, but less has been done about enlightenment - Policy Maker, Langtang

Community Interpretations of AIDS Poster

CHEWs find posters to be an effective means of outreach and use them extensively. They assert that the public health messages conveyed by this tool are easily understood by their target audiences. At the State level, resources are available for the reproduction of existing posters, and most requests for program funds include a budget for the production of new posters.

In the course of the interviews, all of the target audiences in the study are asked to comment on poster in Figure 1. It is chosen because it had been printed in large quantities, distributed throughout the State (including to health clinics), and clearly shows the word "AIDS." Significantly, the poster requires both written and pictorial interpretation about caring for people with AIDS and preventing transmission of the virus.

The majority of the sample report having never seen the poster, but a few do recall it at Jos University Teaching Hospital. Among health providers who are supposed to be using the poster in their education efforts, most PHC staff are not familiar with the poster but some hospital staff recall seeing it at work.

Upon studying the poster, many audiences do not understand its messages and suggest improvements (see Box 12). The density of the written text and the wide range of information presented lead most people to rely heavily on the drawings for understanding the poster. Many think it to be concerned with hygiene and cleanliness, and few can make the connection to AIDS. According to one student, *"I don't see how keeping clean relates to AIDS."*

Box 12
Interpretation of AIDS Poster

Keeping neat is a task that must be done, so that you cannot contact any type of disease; with cleanliness sickness will not be difficult to cure. - Long distance truck driver.

Does it mean if all the instructions under the keep clean picture are not kept one will catch AIDS. - Nurse at PHC clinic

Well, I will just agree because I can't read and also cannot get the message. - Ante-natal clinic attendee

We should protect ourselves from diseases by washing our hands. - Secondary school students

De man in de poster get headache and de woman touch the head and .... look on. - Commercial sex worker

There should be health education like teaching us more about the poster. - Nurse at PHC clinic

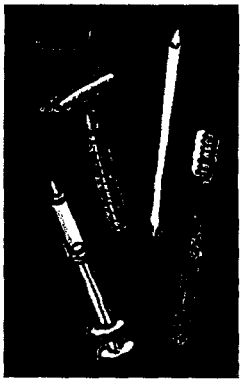
I don't know how someone can get AIDS from the use of a brush. - Nurse at PHC clinic

Less than half of the ante-natal women interviewed are literate, and must interpret the poster solely from the illustrations. None of these women are able to associate the pictures with AIDS prevention, and some unintended interpretations arise. Many women believe that the man in bed is sick with either headache or fever, and, consequently, understand the poster to be about the need to take care of the sick. Some women interpret the poster based on only one or two of the drawings, and believe it to be about food preparation or first aid. In the few cases where AIDS is mentioned, the women think the poster is about taking care of someone with AIDS, and do not relate the actions shown to AIDS prevention.

Figure 1

Care For People with AIDS

PROTECT Your Patient from Infections
PROTECT Yourself and others from AIDS



WASH HANDS

Wash hands often especially after using latrines or toilets, changing soiled bedding and clothing and before handling your own or the patient's food.

COVER WOUNDS

Cover wounds especially on hands or places likely to touch the patient. Use clean cloth or plasters to cover wounds.

KEEP CLEAN

Keep all bedclothes, towels, the patient's body and clothing clean. Especially clean away faeces, blood, vomit and sweat. Use bleach (JIK) on bedclothes or dry them in the sun and iron them.

DON'T SHARE SHARP THINGS

Don't share razors, toothbrushing sticks, toothbrushes or any other things which can possibly draw blood or touch sore.

Adapted from the Uganda School Health Kit on AIDS Control (Item 10)

BY: Ministry of Health (AIDS Control Programme), Plateau State **Reproduced by: Covenant Press Limited, Jos.**

Moreover, many people express confusion over the presence of the brush, spoon, cup, tray, toothbrush, and pencil in the poster. They are uncertain whether the message indicates that AIDS can be transmitted through the use of these items if someone with AIDS has used them. In each target group, comments are made about the exclusive use of English text for the large populations that can not speak the language nor can read. Many suggest that the poster be translated into Hausa and the other local languages.

Most PHC staff and students who are able to read the English text observe correctly that the poster is about AIDS. Generally, PHC staff believe that the poster is self-explanatory and can be understood by their patients. This is true even as many nurses perceive that the poster conveys messages about cleanliness, general hygiene, and other illnesses in addition to AIDS. Expressing a commonly held view, a nurse comments that the poster *"makes them aware of the dangers of communicable diseases like AIDS, tetanus, and tuberculosis."* Many others believe it provides information on how to treat an AIDS patient: *"washing hands after attending to an AIDS patient, covering open wounds before attending to an AIDS patient, and keeping the surroundings of an AIDS patient clean."*

All of the target groups comment on the physical appearance of the man, with some suggesting that he should have been drawn even thinner to portray AIDS more accurately. Others report that his depiction as weak and bed-ridden is what leads them to conclude that the poster is concerned with AIDS. Unfortunately, however, the poster's depiction of AIDS in such a manner may serve to reinforce beliefs that: 1) transmission can be prevented if one learns to identify (and take precautions) with persons with certain physical symptoms; and, 2) infected individuals can not lead productive lives and represent a threat to society.

To improve outreach initiatives, much potential exists for engaging communities directly in the design, production, and dissemination of their own educational materials. Such an approach would tap the creative potential at the LGA level, facilitate the production of more relevant materials, and increase local ownership in the development of AIDS prevention activities.

Knowledge of the proposed World Bank STD Project

The Bank is increasingly taking steps to promote the active involvement of all relevant partners—and particularly community members and local officials— in the development of its projects. In interviews with local LGA officials, however, none recall being informed of the proposed World Bank STD Prevention Project even though a series of meetings were held in each of the LGAs on design of the PRA. The information gap raises questions about the participatory nature of the 18-month PRA planning process involving LGA and State officials and Bank staff. It is a sobering reminder of the filtering of information that occurs and of rapid personnel turnover at the State and LGA levels.

[1] Viewing centers exist in most of the communities studied, but the majority of their television sets are not functioning and require repair.

5. Community Recommendations for STD/AIDS Interventions

Four dissemination meetings were convened following preparation of draft field reports by the research coordinator. These included three community-level meetings convened in each of the LGAs, and one session which brought together representatives from all three LGAs. The fora represented the first time that members from all of the target groups, with the exception of CSW clients, participated in such discussions.

The meetings provided an opportunity to report back and verify the conclusions of the draft reports, and allowed the communities to become more actively involved in deciding priorities for action and how they should be implemented. Most important, all of the communities expressed a desire to be more actively involved in STD/AIDS prevention activities, and identified specific initiatives that would be needed at the LGA and State levels to sustain their involvement.

It is significant that some of the more contentious issues surrounding STD/AIDS were raised in the discussions, such as the distribution of condoms to adolescents and sexual behaviors in the community. In fact, such dialogue was welcomed and encouraged by the LGA and State officials. The PRA research experience no doubt gave the officials a much better context for understanding the issues which surfaced as well as the interventions recommended in the course of the meetings.

Table 7 summarizes the recommendations for action which evolved from the communities in the dissemination meetings. A record of the discussions and recommendations from the individual meetings follow. ***These reports were prepared by the research team and have been edited only for typographical errors.***

Jos North LGA Community Meeting

The purpose of the meeting was to provide LGA officials and representatives of the communities the opportunity to share in, as well as discuss the research findings. In this way respondents could suggest modifications to the findings and also make recommendations for intervention.

The meeting was preceded by mobilization by the AAM in the LGA among community members and LGA representatives. Through the mobilization process the community was further sensitized about the study and the need to share the research findings.

Participation/Attendance

Through the mobilization process, participants to the meeting were selected. This selection was entirely by the community members and the various target groups.

Table 7: Community Perceptions and Analysis
Summary of Recommendations for Action

Level	Recommendations
Individual	Be disciplined, faithful and stick to one sexual partner. Individuals who cannot maintain one sexual partner should use condoms. Each individual should give health education; each one, reach one, teach one. parents should give children health education.
Community, including NGO, CBO	- Opinions leader should be informed about AIDS and carry out AIDS awareness campaigns. - Organize AIDS lectures and talks in mosques and churches and clinics - Make condoms available and delegate a specific individual to distribute same
Local Government	- Provide reactivate, TV/Information center and furnish films on STD/AIDS. - Finance seminars on health education and AIDS awareness - Provide funds for training health personnel - Provide logistics and posters - Should monitor incidence of AIDS - Send AIDS patients to traditional healers
State Government	- Provide funds to the LGA to help STD/AIDS program - Initiate, monitor, and supervise HIV screening in all LGA - Make health education compulsory in schools - Provide mobile cinemas in LGA, buy air time on radio and TV to enhance AIDS awareness - Take AIDS patients to traditional healers for treatment - Foster collaboration between traditional and western healers
Federal Government	- Should take World AIDS Day, December 1, more seriously - Train AIDS personnel and give them more incentives - Advertise condoms, especially their use in STD/AIDS prevention - Ensure adequate budgetary allocation to STD/AIDS control - Should deduct State and LGA funds at source - Provide transportation and other logistics - Foster more collaboration between traditional and western medical practitioners
Donor Agencies	- Provide scientific equipment but without conditionalities - Train personnel at State and LGA levels - Provide STD/AIDS campaign materials. Run workshops and seminars at State and LGA levels

There were conscious efforts to ensure a gender balance to enable respondents feel free to discuss.

The following were the participants:

- Representatives of Each of Laranto, Apata and Abba Na Shehu Community
- One representative each of Students, LDTD, Traditional healers
- Two CSW
- The State AIDS Coordinator, the Director of the Research, AIDS Action Manager, Field Research Leaders
- Representatives of the World Bank

Format of the Meeting

The meeting took the form of [a] participatory workshop. The Research Coordinator summarized the research findings and distributed these to participants. After they had read through, the summaries were itemized and written out on a flip chart. Each item was then presented in English and Hausa after which participants discussed, modified and suggested recommendations. Discussions and indeed the entire business of the meeting were in both English and Hausa.

Community Problems

To the problems of road, water supply and schools, participants added - refuse disposal and general sanitation, and the high level of illiteracy.

Health Problems

In addition to malaria, aches, hypertension, meningitis, participants included worm infestations and insisted on the term water borne diseases. This term includes cholera which they said, frequently breaks out in their communities.

Gender and Sex Roles

Participants agreed completely with the research findings that cultural and religious norms prescribe different roles for women and a different set for men. Roles that conform with these expectations are regarded as proper and easy, roles which do not are regarded as difficult and improper. A female doctor conducting a pelvic examination on a female patient is proper, but the same is not true when the doctor is male. In the latter case, the situation is perceived as hard, stressful and embarrassing. Also regarded as improper is a woman buying or giving condoms to a man.

Sexual Behavior

Participants accepted that sexual relations are normal; however, sex before or outside marriage is normatively prohibited, virginity at marriage is priced. Further, boys and girls initiate sex at different ages, boys between 17-20, and girls 14-18. Most sexual intercourse involves heterosexual penis-vaginal sex.

Participants acknowledged that in practice there is a lot of sexual relations outside marriage and that there is so much pornography. They also said that there is oral sex, this is however a minority view. Finally, there is also enormous peer pressure on adolescent boys and girls to engage in sex. In addition, housing problems which compel some parents to live in single rooms exposes children to the sexual acts of parents. Such exposure could lead to the children to experiment with sex.

Perception of STD/AIDS

There was general consensus that STD/AIDS are caused by sexual intercourse, stepping over the urine of an infected person and blood transfusion. Participants also agreed that treatment for STD is sought in both Western and traditional medical sources. Determinants of which source is first contacted include the patients sense of shame or shyness (for STD) and therefore the need for privacy, belief in efficacy (for example of herbs over tables for malaria or pile) and consideration for costs.

As revealed during the LGA meetings, while the three consideration are important, the general consensus is that cost of treatment is the most crucial. In term of ranking therefore, cost comes first followed by the need for privacy and per-

ceived efficacy in descending order. The major forms of prevention are abstinence, use of condoms and screening of CSW client.

Perception of Condoms

Condoms were recognized by the majority of the participants which are known variously as *raincoat, Hulan maza* and *Saban Baba.*

Participants suggested that women who buy condoms should not be regarded as promiscuous. They specifically recommended condoms to men who have many sex partners. Some participants said Islam does not allow the use of condoms. This view which a majority felt originated from wrong interpretation, is attributed to inadequate enlightenment. The consensus is that *disease* prevention rather than pregnancy prevention aspects of condom usage should be emphasized.

Health Workers and AIDS

Participants agreed with the research findings that health workers indicate willingness to work with AIDS patient.

Collaboration between traditional and Western Healers

Participants agreed that there is little collaboration between the two at the moment. They suggested more collaboration.

Health Information

Participants agreed that health information are received through informal channels such as opinion leaders, churches and mosques and from formal sources - radio, television and posters. Only a few understood the AIDS poster which they felt could be improved by reducing the number of pictures. Proper places for posters were identified as churches, mosques, road junctions and markets.

Specific Recommendations

Participants made specific recommendations thus:

- This research should be used as a basis for "Each One, Reach One, Teach One" about AIDS.
- Cost of living should be brought down.
- Religious leaders need be involved in STD/AIDS campaign.
- Two members from each community should be appointed to educate community members.
- Intervention to include both urban and rural areas.
- Efforts should be made to foster collaboration between traditional and western medical care providers.

Government should sponsor a national documentary to enable a lot more people to become more aware of AIDS.

Mangu LGA Community Meeting

The Mangu LGA/Community Meetings were held on June 5, 1995. The purpose of the meeting was to take the research findings back to the community and to enable them discuss and modify these.

The meeting was preceded by mobilization by the AAM among community members, LGA officials and target groups.

Attendance/Participation

Participants were drawn from the same group who were respondents in the study.

Accordingly, participants were selected by their own communities and target groups from Mangu and Kombun; while the target groups were CSW, LDTD, Students, Traditional healers. The LGA officials include the Chairman, the supervisory councilor for health and the PHC director. The SAC, RC, AAM, FRL and two note takers were also participants.

Format of the Meeting

The meeting took a participatory seminar format in which the research findings were summarized and distributed to participants. After the participants had read the summaries, these were itemized and written out on flip charts. Each item was then presented after which participants discussed, debated and modified the findings. Suggestions and recommendations were also made.

All presentations and discussions were in both English and the Hausa languages for the benefit of those who spoke only one of the languages.

Community Problems

The participants accepted that the general problems in the communities were water, roads, electricity and unemployment.

Health Problems

According to participants, most of the community health problems relate to water and mosquitoes. There is thus typhoid, cholera, malaria, in addition there are childhood diseases such as measles, diarrhoea and fever.

It was emphasized at the meetings that poverty was a major health problem. According to participants, poverty is related to several factors such as the inability to purchase fertilizer which has implications for income as well as for food production. Furthermore, participants pointed out that growing level of poverty has tended to encourage promiscuity among women who "sell themselves" to obtain money. Poverty also compromise the capacity to pay for treatment.

Gender and Sex Roles

Participants said there are cultural norms which define men's roles as distinct from women's roles. The man is the bread winner while the woman complements the husband's roles in addition to being a wife/mother. Roles which reflect and conform with these expectations are regarded as appropriate and easy.

These cultural expectations, participants noted, are changing as a result of western education and the diffusion of western culture through films and the media. These changes were said to be faster in the towns than in the villages.

Sexual Behavior

Sexual relations are not allowed before and outside marriage. This cultural norm is however frequently violated in contemporary society because of the following reasons:-

- Increased financial burden especially for hose maintenance schooling leads many school girls into sexual activities often with older men of "sugar daddies". The second situation leads many married women to extra marital sexual activities, some times with the consent of the husbands who care about the proceeds .
- Inadequate housing has forced parents to share the same room with their

children. In this process, the children often watch their parents have sex.

- Peer pressure forces many youth into sex. These youths claim that until you have sex with a girl friend, she would not take you seriously.

STD/AIDS

According to participants, STD/AIDS are caused mainly by sexual intercourse and incomplete ejaculation. STD other than AIDS are said to be common. Participants said STD were not listed as health problems because the secrecy with which victims seek care does not allow for any information of its prevalence. STD are treated in Western and Traditional sources.

Perception of Condoms

Most of the participants know about condoms although only a few had used them. Participants said condoms help prevent unwanted pregnancy as well as the transmission of STD.

Participants said condoms should only be sold to adults. Furthermore, participants also recognized good and bad condoms. The bad ones were said to slip into the woman's womb. Should this happen, surgery would be needed or the woman might end up with cancer.

Health Workers and AIDS

Participants said health workers would be willing to treat AIDS patients. They said the possibility of health workers contracting AIDS from patients was remote. However extra precautions were recommended for health workers treating AIDS patients.

Collaboration Between Traditional and Western Practitioners

The participants said collaboration between traditional and western health providers would be beneficial to society. This collaboration is however hampered by the perceived unwillingness of traditional healers to share their knowledge. The cloak of secrecy enshrouding traditional medical practice is thus a stumbling block to the successful collaboration.

Health Information

Health messages in Mangu and Konbum communities are received through the LGA Information and Health departments, traditional rulers and health workers. The radio, TV and newspapers are also important media for health messages. Posters are also frequently used to disseminate health messages. The general consensus is that the AIDS poster used for the study was difficult to understand.

Recommendations and Suggestions

Participants made specific recommendations on who can and should be done to resolve particular issues.

Community Problems

Participants recommend that these be resolved through :-

- More government funding and construction of pipe bore water
- Government should crack down on corruption and looters of public funds
- The state government should repair and build roads

- State and federal governments should provide more electricity

Health Problems

The state government should provide drugs in hospitals and clinics.

STD/AIDS

Health workers should help sensitize and enlighten the people about the causes, prevention and treatment of STD/AIDS

Collaboration Between Traditional and Western Medical Practitioners

There should be more mutual referral of patients from one source to the other.

Health Information

The state and local government should make posters to enlighten the people.

Langtang LGA Community Meeting

The Langtang LGA Community Meeting was held on June 16 1995. Some of the participants for the meeting confused it for another meeting (Launching of Vitamin A Supplement Campaign) which preceded the community meeting.

The meeting was made possible because of mobilization by the LGA AAM.

Attendance/Participation

The meeting drew participants from both Langtang town and from Zamko, the two communities where the research was conducted. Participants who were selected by their own communities and target groups included the LGA chairman, PHC director, Supervisory councillor for health, representatives of students, LDTD, CSW, traditional healers, western medical care providers. Also at the Langtang meet were the SAC, RC, FRC, AAM and two note takers.

Format of the Meeting

The meeting was conducted in a participatory seminar format. The research findings were summarized and distributed. The summaries were also itemized and written out on a flip chart. each item was presented in English and Hausa languages for the benefit of those who did not speak one of the languages.

Community Problems

Participants added the need for feeder roads to list the community problems; the other were snake bite and safe water. In their opinion feeder roads will facilitate easier transportation of food from the rural areas to the urban. It would also facilitate the movement of people. For participants, while the incidence of snake bite has decreased, the cost of anti-snake venom are prohibitive and should be remedied.

Health Problems

Participants said their communities were afflicted by diarrhea, measles, malaria and typhoid. It was however argued that the prevalence of typhoid might have been exaggerated due to unreliable tests which were said to almost always read positive.

Gender and Sex Roles

The participants agreed that the traditional separation between women and men's roles were gradually changing. These changes were attributed to adverse economic conditions which now compel men, most of who can no longer afford house helps, to carry out household chores.

Women were also said to be freer now to go out, work and pursue careers. This increased freedom, in the participants view, should include the liberty to buy condoms for their husbands.

Sexual Behavior

According to participants, cultural norms forbid sex before and outside marriage. This cultural norm is however frequently violated because of economic hardship which compel many to engage in piece meal "sex for sale".

Participants said most of the burden of running the household (food, school fees, health needs etc.) was borne by women. This burden has led many to premarital and extramarital sexual relationship.

Perceptions of STD/AIDS

According to participants, STD/AIDS are caused by sexual intercourse, blood transfusion and stepping over the urine of a victim. Participants were however divided on this last cause of STD. Some insisted that not only can stepping over the urine of victims cause STD, even the smell can also do this.

Some participants said government is contributing to the spread of STD/AIDS through the formation of Association of Widows. The idea is that the bringing together young women by government might encourage sexual activities and with these the spread of STD.

Perceptions About Condoms

It was the general opinion of participants that condoms prevent unwanted pregnancies as well as the spread of STD/AIDS. It was then suggested that condoms be made more widely available and be manufactured in different sizes. The last suggestion was thought to guide against breakage which might result from the use of under size condoms by "big men ".

Health Workers and AIDS

According to participants health workers should treat AIDS patients and show them great sympathy in the process.

Collaboration Between Traditional and Western Health Providers

Participants agreed that more collaboration between the two modes of care will be to the benefit of the community.

Health Information

Health messages are received from clinics, hospitals, health workers and the radio. The participants said specific posters be designed for specific communities.

Suggestions and Recommendations

Community Problems

Government should force down the cost of living.

Health problems

Drugs and equipment should be made more available in government hospitals and clinics.

STD/AIDS

An HIV screening Center should be established in the LGA.

- All blood should be screened before transfusion.
- All AIDS Patients should be incarcerated to prevent the spread of the disease.

- Government should screen all incoming people before allowing them into Nigeria.

Sexual Behavior

Every person should be encouraged to have and keep only one sex partner.

Collaboration between Western and Traditional Practitioners

Western practitioners should be encouraged to be more cooperative with traditional healers.

Health Information

More public enlightenment through films and drama is recommended to sensitize people to STD/AIDS.

Report of Meeting of Representatives from Langtang, Jos North, and Mangu LGA

The meeting of representatives of the three LGA in the STD/AIDS Qualitative study was held in Jos the State capital on July 4, 1995. The purpose of the meeting was to bring together representatives from the three LGA in which the research was conducted, share the findings with them and provide the opportunity to debate, discuss and modify the findings. On the basis of these discussions and debates, participants offered suggestions and recommendations on what can and should be done.

The joint three LGA Meeting was preceded by intense mobilization by the AAMs in the local government areas, the SAC in the State capital and the RC who liaised with and coordinated these various mobilization activities.

Participation/Attendance

Participants were selected by their various communities and target groups in the three LGA and included representatives of:

- All communities in the study
- All target groups
- LGA officials (Chairman, PHC Director, Supervisory councillor for Health)
- Western and Traditional Health Service Providers
- The Research Team (SAC, RC, AAM, FRL, and two note takers)
- Representative of the World Bank

Through the mobilization efforts, these various communities and target groups understood and ensured a good gender balance in the representation. This was to ensure that none of the gender categories felt overwhelmed or intimidated .

Format of the Meeting

The summaries of the research report were distributed to participants. These summaries were also itemized and written out on a flip chart and were subsequently presented in English and Hausa. Each item was debated and discussed. The entire business of the meeting was conducted in English and Hausa to ensure full participation of every one.

Community Problems

Participants added refuse disposal and high level of illiteracy to the list of community problems(lack of water and electricity, inadequate medical facilities and schools).

Health Problems

Participants agreed that the summary accurately reflected their major health problems; namely typhoid, worms and water borne diseases in general, malaria, meningitis, hypertension, aches and snake bite. The last problem is particularly acute in Langtang. The sale of expired drugs was also added to the list of community health problems.

Gender and Sex Roles

It was agreed that male and female roles which were traditionally distinct were now merging. This change which was said to be more pronounced in urban than in rural areas was attributed to foreign influence and economic adversity. The latter compels the men unable to pay for domestic servants to carry out house hold chores.

Sexual Behavior

Participants agreed with the research summary that sex before or outside marriage was prohibited and that boys start sexual activities 4-7 years later than girls, and that traditional values about sex were changing. Participants agree that while most people engage in heterosexual (penis-vaginal intercourse, some anal and oral sex also goes on in the society. It was also agreed that there was a lot of pornographic film in the communities particularly in the urban areas.

Perceptions of STD/AIDS

Participants agreed that STD are common but lack visibility because of the of the secrecy with which people respond to them. The most common mode of transmission was identified as sexual intercourse for gonorrhea and syphilis.

It was the general consensus that Western and traditional sources are consulted for the treatment of STD. A new name for AIDS was given in Hausa as *Kanjiki, Tsenke-tsenke* and *Gobe de nisa.*

Perceptions and Usage of Condoms

Condoms were said to be gaining ground but should be used only by adults. It was agreed that women should be at liberty to buy condoms. The CSW in the meeting asked for and received condoms from the research team. Over 300 packets of condoms (of 4 teats) were distributed to participants who asked for them.

After a protracted debate on Islam and the use of Condoms, it was agreed that Islam did not prohibit the use of condoms. More public enlightenment was suggested to clear doubts in people's minds.

Health Workers and AIDS

There was a general consensus that not only should health workers treat AIDS patients, they should also be kind to such patients.

Collaboration Between Traditional and Western Healers

It was the consensus of participants that collaboration between traditional and western healers would benefit society. it was however pointed out that the secretive nature of traditional medicine was an inhibiting factor.

Health Information

Health information is received mostly from informal sources such as mosques, churches as well as from health workers in hospitals. The major channels of health information are radio, TV and posters. Posters were said to be a particularly useful medium for health messages.

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