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REACH Principal Investigator, Richard Joseph, and Ibadan field supervisor, K.K. Bolarinwa, visiting a REACH study community in Ibadan

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HIV/AIDS prevention news stories

Research Alliance to Combat HIV/AIDS
From Idea to Institution
by Richard Joseph

At the inauguration ceremonies for Northwestern University's 16th President, Dr. Morton Schapiro, on October 9, 2009, Thomas Friedman, New York Times renowned correspondent, stated: “We have to innovate our way out of this crisis.” Friedman was referring to the global economic recession and emphasized the vital contributions that must be made by educational institutions and the importance of “entrepreneurship, innovation and creativity.” Two weeks later, President Barack Obama used similar language at the Massachusetts Institute of Technology when he extolled the pioneering research being done on renewable energy. “You are heirs to a legacy of innovation,” he told the audience, “not just here but across America, that has improved our health and our well being and helped us achieve unparalleled prosperity.”

These words reminded me of the memorable address by President Obama in Accra, Ghana, on July 11, which I had the privilege to hear in person. “Development depends on good governance,” he stated. “That is the ingredient which has been missing in far too many places for far too long.” President Obama committed the United States to helping African nations establish a “broader base for prosperity.” Central to that challenge is the rapid improvement of health and education. Efficient and accountable governance, and the building of strong institutions, are essential aspects of such an effort and no more so than in combating the unremitting pandemic of HIV and AIDS. This essay will provide an overview of one collaborative effort to respond to this challenge: the Research Alliance to Combat HIV/AIDS (REACH).

Sub-Saharan Africa is today host to two-thirds of persons infected globally with the HIV virus. This region also experiences three-quarters of global AIDS deaths and has 90 percent of the children worldwide under 15 years infected with the disease. After the identification of the first HIV infected person in Zimbabwe in 1985, the epidemic spread rapidly throughout the region. Nigeria, Africa’s most populous nation, is estimated to have almost three million persons infected with HIV or just under 10 percent of the worldwide total. Other daunting annual statistics in Nigeria include: 280,000 deaths from AIDS, 370,000 new infections, 57,000 children born with HIV. Nigeria now has a total of 2.2 million AIDS orphans while 900,000 Nigerians are being treated with anti-retroviral drugs, thanks in large part to international programs such as the Global Fund for AIDS, Tuberculosis and Malaria, and the U.S. Presidential Emergency Program for AIDS Relief (PEPFAR). Despite the increased efforts devoted to prevention, treatment and care over the past decade, Nigeria today registers 90,000 more new infections than deaths from AIDS annually. Saving lives and avoiding a life-long sickness will depend critically on helping individuals reduce their vulnerability to infection.

In November 2009, REACH teams will visit the twelve communities in four Nigerian states in which research has been conducted since January 2006 on the social and cultural factors that influence vulnerability to infection and the willingness to use testing and care facilities. They will report back to these communities on the key findings from the survey research pursued under the auspices of a collaborative program between Northwestern University and the University of Ibadan and funded by the Bill & Melinda Gates Foundation. In spring 2010, a comprehensive two-volume report of this pioneering program will be presented in public meetings in Nigeria and the United States. At a time when major development initiatives in Africa are being contemplated on health, food, water and energy, the REACH experience, when fully depicted, will have much to tell us about key institutional challenges and opportunities. Here is a brief personal account of its genesis and progress.

Germination and Strategic Actors
At the end of the 1990s, I shared my concerns with Dr. Helene Gayle, then Director of AIDS programs at the Centers for Disease Control and Prevention in Atlanta, Georgia, that the effective tackling of the pandemic in Africa would require the wider involvement of social science researchers.

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Once the virus circulated among the general population, and therefore was no longer restricted to identifiable high-risk groups, the challenges would be exceedingly difficult to overcome. As I was then a professor at neighboring Emory University, Dr. Gayle arranged for me to meet with several of her colleagues to discuss my ideas. I suggested four reasons why Africa was particularly vulnerable to HIV and AIDS: weak governance, debilitated institutions, widespread poverty, and certain cultural norms and behavioral practices. I also shared my belief that the armory of methods for fighting infections that had been developed over decades would not be effective in reducing African vulnerabilities.

Subsequently, I invited Dr. Gayle to give the keynote address at a conference held at the Institute of Caribbean and International Studies (ICIS) at St. George's University, Grenada, in December 2005. The Caribbean, after sub-Saharan Africa, has the highest HIV prevalence rate. That conference, a precursor to the consultations that led to the creation of REACH, called attention to behavioral practices that contributed to high HIV infection rates such as simultaneous sex partners and the sexual abuse of minors. Six months later, Dr. Gayle was appointed by the Bill & Melinda Gates Foundation to direct its HIV, TB, and Reproductive Health Programs.

The next germinating event was a conference of the Task Force on AIDS of the Center for Strategic and International Studies (CSIS) in Washington, DC in January 2003. In one of the sessions, the scholars Alan Whiteside and Alex de Waal presented preliminary results of research work conducted in South Africa. My research associate, Alexandra Gillies, and I took away from this meeting the need to speed up the engagement of social scientists in HIV research. When this idea was conveyed to Professor Henry Bienen, Northwestern's President at the time, he readily agreed and became a consistent supporter of this initiative that was launched at the University's Program of African Studies (PAS).

In June 2003, a symposium on AIDS was held at Northwestern University. Participants included policy advocates and leading researchers such as Dr. Stephen Morrison of CSIS, Dr. Michael Merson, then at Yale University, and Dr. Phillip Nieburg, a long-time CDC officer. During a visit to the University of Ibadan by Ms. Gillies and me in February 2004, a meeting was convened by the Dean of the Faculty of the Social Sciences, Professor Adigun Agbaje, which included colleagues from several departments, to discuss the prospects for an interdisciplinary research program on HIV and AIDS. A parallel meeting was held in the University College Hospital, Ibadan, convened by its Provost, Professor Isaac Adewole. Those meetings demonstrated significant support and a breadth of interest in Nigeria for the proposed program.

**Planning Phase**

The preparation of grant proposal documents now began in earnest. For several months, the aim was to create a broad-based program with the working title, “Program on AIDS-Impacted Societies or PAIS”. In December 2004, with a seed grant from the Office of Northwestern’s President, an international seminar was held at the University of Ibadan entitled “HIV and AIDS Prevention in Nigerian Communities: Strengthening Institutional Responses.” In addition to Nigerian scholars, it included Nigerian AIDS activists and prominent researchers from other West African countries. The sessions at this meeting reflected the evolving orientation of this initiative:

- Advancing Prevention through Social Marketing of Condoms
- Creating Effective Prevention Messages for the HIV-Negative and Untested Populations
- Institutional Capacity and HIV Prevention
- Prevention in the time of Expanded AIDS Treatment
- Improving Communication among Prevention Actors
- Bringing Prevention Back to the Forefront through Rethinking Prevention Strategies
- Building Capacity for Policy-Relevant Research

The planning efforts proceeded in step with the recognition by the Gates Foundation of the importance of scaling up HIV prevention in light of the increasing attention being devoted to care and treatment and especially the provision of anti-retroviral drugs. to test for and monitor the infection in several sites.

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The Foundation identified five countries, including Nigeria, with large populations that could replicate the AIDS pandemic in southern Africa. The others were Ethiopia, Russia, India and China.

The year 2005 was devoted to the preparation and revision of grant proposal documents. The name of the proposed program was changed to Research Alliance to Combat HIV/AIDS (REACH) and the geographical scale reduced from a few countries in West Africa (Benin, Ghana and Nigeria) to Nigeria. Finally, after many exchanges between Foundation officials and teams at Northwestern and Ibadan, a three-year program was approved with a $3 million grant in January 2006.

In addition to the participating faculty at the University of Ibadan, an Advisory Committee was established and coordinated from Northwestern. At PAS a small group of faculty researchers and graduate students set to work designing research instruments and guidelines. The Gates Foundation had wanted a program that would be national in scope. In view of the size and complexity of Nigeria, the decision was made to use as proxies the six geopolitical zones of the country and to create research sites in each one.

By the summer of 2006, insufficient progress was being made. The preliminary work in Nigeria to prepare the field research was unsatisfactory and the research methodology devised proved cumbersome and beyond local capacities. After a disruptive period, two individuals stepped forward to help put REACH on a sure operational course: Professor Robert Murphy, Head of Infectious Diseases at Northwestern’s Feinberg School of Medicine and a pioneering AIDS researcher; and Nkem Dike, who had been hired during the summer of 2006 as Project Coordinator of REACH. She took the reins of the program and has provided it, since January 2007, steady, consistent and effective management. Robert Murphy worked closely with Nigerian team members to design a cross-sectional study of the factors that affect the utilization of testing and care facilities. This second project complemented the semi-longitudinal study of social and cultural factors that influence vulnerability to HIV infection.

Research-related activities in Nigeria have been overseen by a Research Coordinating Committee (RCC), seven of whose nine members belong to the Faculty of the Social Sciences, University of Ibadan. A REACH Advisory Committee (RAC) was reconstituted in spring 2009, consisting of Nigerian and American researchers to provide advice and input as REACH distils the results of the survey research and prepares to evolve as a Nigerian research institution. As the project enlarged in terms of the quantity and quality of work needed to be accomplished, two post-doctoral fellows, Dr. Rachel Weber and Dr. Chukwuemeka Anyamele, were appointed by Northwestern University and hosted at the University of Ibadan for a year (2008-2009). They worked closely with the REACH research team in Nigeria. Dr. Weber, together with Dr. Obono, designed a pilot project on “Adolescents and HIV Prevention” based on preliminary findings about the high risks confronted by this age group. The results of that project will be available in 2010 alongside those of the two multi-state projects. Among REACH’s accomplishments is the intensive training of approximately twenty graduate research assistants both in Ibadan and in the field sites. They have acquired improved research skills that can be applied to other projects and throughout their professional careers.

Crisis, Collaboration, and Innovation
What were some of the major design, administrative, and organizational challenges that REACH had to overcome? They will be listed here followed by key reasons for the success in overcoming them.

- Devising a partnership between a leading American research university and a Nigerian university which, though a leader in Africa, is much less endowed in many regards.
- Conducting a collaborative program in which one of the partners is the recipient of the grant and responsible to the funder for its management.
- Establishing procedures for transferring funds to Nigeria periodically, one part managed in a private bank account and the other by the central administration of the University of Ibadan.
- Reaching agreement on all aspects of the research program by Northwestern and Ibadan personnel as well as by external advisers.
- Obtaining approval for the research protocols and instruments by the joint Ethical Review Board of the University of Ibadan and University College Hospital and by Northwestern’s Institutional Review Board.

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- Creating an innovative model of community-based research that required a high level of buy-in from diverse Nigerian authorities: governmental, private, and communal.
- Obtaining and maintaining the support of the leadership of key institutions: Northwestern, the Gates Foundation, and the Faculty of the Social Sciences of the University of Ibadan.
- Introducing strict financial and monitoring procedures to ensure high transparency and the correct use of program funds.
- Making operational and administrative changes in response to unanticipated opportunities and challenges.
- Enhancing capacity and skills at all levels of the program, from senior researchers, through graduate assistants, to field researchers.
- Maintaining a steady flow of information to all participants, interested persons, and local stakeholders.
- Meeting the technical needs of the program as they arise, from computer equipment, electric power, water supply, and the security of research data.

The reason REACH succeeded in meeting and overcoming these and other challenges, and is now in a position to distil findings and make them widely available, can be attributed to several factors:

- The strong and enduring support of the leadership of the Gates Foundation, Northwestern University, and the University of Ibadan. This support has been unswerving, despite the vicissitudes that had to be surmounted and with which these institutions were kept fully informed.
- The forthright character and team-building skills of key personnel. Mention has already been made of Nkem Dike. The same could be said of the senior principal researchers, principal researchers, the field research staff, and graduate research assistants. REACH has benefited from the services of exceptionally committed consultants. Phillip Nieburg has been with REACH since its inception and his contributions cover a wide range. Kim Blankenship of Duke University has provided critical input and so has Jelani Mandara of Northwestern. Not everyone brought into the program has lived up to expected standards. However, most have and this has made all the difference. Rasak Olajide, the programme director in Ibadan, and his two successive deputies, have been very resourceful and highly dependable. And the Senior Principal Researchers and three successive Deans of the Faculty of the Social Sciences have been extremely supportive and effective. Professor Adigun Agbaje, first as Dean and then as Deputy Vice-Chancellor (Academic), has provided bold and timely assistance over six years.
- Trust has been the life-blood of REACH. We have been able to build and refine an institution, accomplish our tasks, and overcome many hurdles because of the trust that has grown among the principal actors. We have also benefited from the normative and operational resources of two different university cultures, one Nigerian, the other American.
- Out of the various components of REACH, we have created one transnational organization. Team-building, open communications and frankness have facilitated the blending of work between two disparate universities and national cultures. Modern communication technologies have greatly facilitated this work in different international time-zones.
- The awarding by the Gates Foundation of a large grant in January 2006, and the confidence that has been maintained despite the change in Foundation officers responsible for overseeing this program, have contributed significantly to the progress achieved. The challenge of HIV prevention is complex and equally so is that of building a transnational research institution and pursuing community-centered research. The astute management of grant funds has made it possible to extend the initial three-year program to five years.

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"I am proudly REACH." This statement made by a graduate research assistant in Benue State during a meeting in early 2009 captures the essence of this endeavor. Ownership, pride and integrity have been inculcated at all levels. These ideals are manifested also among field researchers who grasp that REACH, in the training provided and the duties performed, empowers them to become effective “combatants” against a relentless disease. They have also acquired marketable skills that will improve their employment and career prospects.

A successful institution has to be “organic.” REACH has evolved steadily since its creation and still has much growing to do. Following the completion of the survey research, the REACH leadership in Ibadan will gradually assume greater ownership and develop a structure and operations capable of fulfilling its potential as a Nigerian research institution.

Applying Lessons Learned

In 2004, the Nigerian government issued a new population policy that revised the 1988 National Policy for Development, Unity, Progress and Self-Reliance. Among its enumerated goals, two are particularly pertinent to REACH:

- Acceleration of a strong and immediate response to curb the spread of HIV and AIDS and other related infectious diseases.
- Reduce and eventually eliminate harmful social and cultural practices that adversely affect the reproductive health of the population through the promotion of behavioral change and appropriate legislation.

During the first quarter of 2010, Nigerian government officials at federal and state levels, and international agencies engaged in combating HIV and AIDS, will be presented copies of the REACH Report with data, graphs, and charts, a full display of the methodology and survey instruments, and a set of policy recommendations. The research data will provide a baseline from which further studies can be conducted, in the current research sites or in other states and communities of the Federation. As important as the research results will be not to be overlooked is that an idea, which emerged in one American city, connected with similar ideas among Nigerian scholars and policy advocates, and eventually gave rise to an institution.

The strong support of a major philanthropic foundation, two universities, and many Nigerian government and communal authorities have yielded an institution that can wage more effectively the combat against an intractable and implacable disease. “We have to innovate our way out of this crisis,” to reiterate Thomas Friedman’s remarks. Wherever a severe epidemic of HIV has become entrenched - defined as a prevalence rate above one percent - innovative approaches to tackle sensitive cultural and behavioral practices at community level must be devised. That was the understanding which led to the creation of REACH. It must now be demonstrated how the insights gained can effect behavior change and reduce risks of infection and transmission. Hopefully, REACH will also encourage others to replicate this initiative and build the knowledge and awareness that will eventually turn the tide in this historic global endeavor.

Richard Joseph is the Principal Investigator for REACH, John Evans Professor of International History and Politics of Northwestern University, non-resident Senior Fellow of The Brookings Institution, and a Member of the Board of the Chicago Council on Global Affairs. His many publications include Smart Aid for African Development (2009), co-edited with Alexandra Gillies.

FOOTNOTES


2 The 2.95 million Nigerians estimated to be infected with the disease equal the population of Chicago. The most recent national prevalence rate of Nigeria of 4.6% is approximately equal to that of American communities with the highest level of infection, such as Washington, DC and the Bronx in New York City. See Susan Okie, “Fighting H.I.V., A Community at a Time,” New York Times, October 27, 2009.
For a .pdf version of this article, please send an email to REACH@northwestern.edu.

Fighting HIV, a Community at a Time
from nytimes.com

WASHINGTON — Federal health officials are preparing a plan to study a bold new strategy to stop the spread of the AIDS virus: routinely testing virtually every adult in a community, and promptly treating those found to be infected.

The strategy is called "test and treat," and officials say the two sites for the three-year study will be the District of Columbia and the Bronx — locales with some of the nation’s highest rates of infection with human immunodeficiency virus.

The officials emphasize that this is just a first step. The goal is not to measure whether "test and treat" actually works to slow an epidemic, but whether such a strategy can even be carried out, given the many barriers to being tested and getting medical care.

On the path from infection to treatment, "we lose people at every single step," said Dr. Shannon L. Hader, director of the H.I.V./AIDS administration at this city’s Department of Health.

As many as 5 percent of the adults in the District of Columbia are infected — a rate Dr. Hader says is comparable with those in West Africa — and one-third to one-half do not even know they harbor the virus. (Nationwide, 20 percent to 25 percent of people who are H.I.V. positive do not know of their infections, according to the federal Centers for Disease Control and Prevention.)

And even when infection is diagnosed, "getting people from the field to the doctor is the hardest component," said Angela Fulwood Wood, deputy director of Family and Medical Counseling Service, an agency that operates a mobile H.I.V. testing clinic here. Often, she added, someone who has just tested positive "can walk off that day and decide, ‘I’m going to pretend that never happened.’"

In 2006, only about half of Washington residents who had a new diagnosis of H.I.V. saw a doctor about the problem within six months.

The C.D.C. recommends routine, voluntary H.I.V. testing for everyone ages 13 to 64 as a part of regular medical care. But experts say the recommendation is not being followed in many hospitals, clinics and medical practices.

Even when doctors do offer the test to patients, "a significant number refuse," said Dr. Anthony S. Fauci, director of the National Institute of Allergy and Infectious Diseases, which is to pay for the test and treat feasibility study.

Researchers planning the study have been meeting with hospital and health officials in Washington and the Bronx to discuss making H.I.V. testing a routine part of visits to doctors, clinics and emergency rooms.

Dr. Fauci said testing might also be widely offered in nonmedical settings. "When you have a campaign like this, you’ve got to pull out all the stops," he said. "How are we going to get everybody? Should we have testing in Wal-Mart? Should we have testing at Nathan’s hot dog places?" The test and treat approach is part of a broader shift toward using medicines for H.I.V. to prevent infection. When an infected person starts taking one of the standard three-drug regimens, the level of the virus in blood and other body fluids drops rapidly, often to undetectable levels.

Doctors in developed countries now routinely test all pregnant women for H.I.V. because treatment prevents an infected woman from transmitting the virus to her fetus. In July, researchers conducting a large randomized trial in Malawi reported that giving the antiretroviral drug nevirapine to breast-feeding infants of infected mothers, or giving the mothers a three-drug regimen, protected the babies from infection through breast milk.

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Studies tracking heterosexual couples in which one person is infected have found that after highly effective drugs for H.I.V. became available, uninfected partners were far less likely to contract the virus. Trials are under way to give H.I.V. drugs as a protective measure to uninfected people at high risk.

Current treatment guidelines do not call for antiretroviral drugs until there is evidence of progressive damage to the immune system — generally, until the number of CD4 cells, the white blood cells attacked by the virus, drops to 350 per cubic milliliter or lower. (A normal count is at least 1,000.)

The guidelines are intended to balance the treatment benefits with the side effects from the drugs and the possibility of fostering drug resistance in the virus. But there is mounting evidence that early treatment keeps infected people healthy longer.

And that could have much wider benefits, researchers say. Last January, Dr. Reuben Granich and colleagues at the World Health Organization published a provocative study using mathematical models to predict the effects of universal testing and immediate treatment on a severe H.I.V. epidemic among heterosexuals. They reported that such a policy, if combined with prevention efforts like promotion of condoms and male circumcision, could virtually eliminate transmission of the virus within 10 years.

So far, despite some ambitious efforts, no city or country has come close to achieving universal testing for H.I.V. and treatment for all those infected. But researchers and public health officials are eager to test the potential of such a strategy for stemming the epidemic.

Among specialists, there is already a move toward starting treatment earlier, said Dr. Raymond Martins, chief medical officer of Whitman-Walker Clinic, the largest provider of H.I.V. care in the District of Columbia.

But in low-income neighborhoods in Washington, some people are reluctant to start treatment, said Ms. Wood, whose H.I.V. testing program and clinic are based in Anacostia, a community in Southeast Washington that has long had high rates of drug abuse and H.I.V. infection, as well as a shortage of health services. Early H.I.V. drugs had multiple side effects, including fat deposits on the upper back that created an unsightly hump. “People saw that when others started taking the medicine, they seemed to get worse,” Ms. Wood recalled.

Although the latest drugs have far fewer side effects, many patients still fear that “going on the medicines means I’m starting to get sick,” she added. A critical component of test and treat will be conveying the message: “Don’t wait until you’re sick. Do it early.”

In the District of Columbia, heterosexual sex is the most common mode of transmission reported by patients with newly diagnosed H.I.V. Researchers say that makes the city a strong candidate for test and treat, because the strategy is likely to be more effective in preventing spread among heterosexuals than among drug abusers or men who have sex with men.

In New York City, the Bronx has the highest AIDS death rate of any borough, even though Manhattan has a higher rate of cases. Dr. Monica Sweeney, the city’s assistant health commissioner for H.I.V. prevention and control, said that was because people in the Bronx tended to wait longer to be tested and get a diagnosis.

In the first half of 2008, Dr. Sweeney said, “more than a quarter of the people who were tested in the Bronx had AIDS by the time they received their diagnosis.” By contrast, she added, people who are tested and treated before the immune system has suffered extensive damage “can expect almost a normal life expectancy.”

Health officials in both Washington and the Bronx are already in the middle of campaigns to promote H.I.V. testing and increase the number of new patients who get prompt medical care. In the first year of a program called Bronx Knows, begun in mid-2008, 70 percent of residents with a confirmed positive H.I.V. test were sent to doctors and clinics for care, Dr. Sweeney said.

In the District of Columbia in 2006, only 50 percent of those with new diagnoses of H.I.V. saw a doctor for the problem within six months. Community outreach workers who perform testing are now being retrained to focus on getting their clients into treatment.

“If you’re doing H.I.V. testing, your job doesn’t end with just telling the individual their test results,” said Dr. Hader, of the district’s Health Department.

At a neighborhood fair a few weeks ago in Oxon Run Park in the southernmost corner of Washington, a worker passed a basket of condoms among the crowd waiting in line for hamburgers, while announcements over a loudspeaker urged attendees to visit Family and Medical Counseling Service’s mobile H.I.V. testing unit, inside a brightly painted trailer parked under the trees.

Annie Samuel, a 40-year-old mother of four, smiling and youthful-looking in shorts and a yellow tank top, knocked on the trailer’s door. “I’ve got to get tested,” Ms. Samuel said. “I want to be around to see my kids and grandkids.”

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Beverly Honesty, an outreach worker, seated Ms. Samuel at a table and asked her to sign some forms, then had her swab her gums with a white plastic stick tipped with filter paper to collect antibodies from liquid secreted by gum tissue.

Next, Ms. Honesty inserted the stick into a tube containing a clear solution, part of a rapid test kit that detects H.I.V. antibodies, chemicals made by the immune system that indicate infection with the virus. As they waited for the result, Ms. Honesty quizzed Ms. Samuel about high-risk behaviors and talked to her about unprotected sex, contaminated needles in tattoo parlors and other possible ways of contracting H.I.V. After 20 minutes, she showed Ms. Samuel her result: negative.

Positive results obtained with the kits are reported to the Health Department but are considered preliminary, and must be confirmed by a different test that requires a blood sample.

“There are so many people who test ‘preliminary reactive’ who never return,” said Torena White, who was leading the outreach team that afternoon.

Often, testers following up on such results must repeatedly call clients or send them letters. If someone with a positive test still does not respond, a Health Department worker is dispatched to try to track the person down.

Community testing programs are likely to attract people who suspect that they might have contracted H.I.V. But Ms. Wood said the key to test and treat would be capturing those who did not volunteer for testing because they did not believe they could be infected—"people who are promiscuous at college, the partygoers, the young professionals who go to the club,” as she put it.

“Routine testing at either emergency rooms or physicians’ offices,” she continued. “I think that’s our biggest chance of really catching people earlier.”

To access this article online, go to http://www.nytimes.com/2009/10/27/health/27hiv.html

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Knowledge, Perception and Behaviour of Nigerian Youths on HIV/AIDS
from The Internet Journal of Health 2009 : Volume 9 Number 1

**Background:** The pandemic of HIV remains on the increase with young people at increased risk of infection. This study assesses the knowledge of HIV/AIDS, perception and practices of youths in Lagos, Nigeria.

**Method:** Descriptive cross-sectional survey conducted between May and June 2008 using structured pre-tested questionnaires among 315 randomly selected students enrolled at a tertiary institution in Lagos, Nigeria.

**Results:** The knowledge of some aspects of the disease was quite high in the study group. The overall mean score to a ten HIV/AIDS knowledge questions was 8.3 of 10 points. 73.5% did not perceive themselves at risk of infection and 70.3% have multiple lifetime sexual partners. Those who perceived themselves at risk are significantly (p=0.019) more likely to always use condoms.

If you have access, you can read this article here. If you would like to read the .pdf file, please email REACH@northwestern.edu.