Can Nigeria End Its AIDS Pandemic?
The Design of Knowledge-Based Prevention Strategies

REACH team at the 5th National Conference on HIV/AIDS, Abuja May 2010
Social Dimensions of HIV and AIDS Prevention:

HIV Related Risk Behaviour and HIV Testing and Counselling

Faculty of the Social Sciences
University of Ibadan (Nigeria)

and

Roberta Buffett Center for International and Comparative Studies
Northwestern University (USA)
REACH dissemination event, University of Ibadan, May 2010
Introduction of REACH Study and Methodology

Research Alliance Combat HIV/AIDS (REACH)
Presentation Outline

• Introduction to REACH
• HIV Situation in Nigeria
• Objectives
• REACH Study Sites
• Research Methods
• Current Progress
What is REACH?

• Collaborative effort between Northwestern University and the University of Ibadan

• Other partners involved, such as Benue State University, CRUTECH, Duke University, etc.

• REACH grew out of a 2004 HIV/AIDS prevention seminar

• Launched in January 2006 with support from the Bill & Melinda Gates Foundation
HIV and AIDS situation in Nigeria 2010

- HIV prevalence rate of 4.6%
- 3 million Nigerians living with HIV/AIDS
- 339,000 new infections annually
- Only 14% have had HCT
- 70,000 HIV positive births every year
- 182,000 AIDs deaths in the year
- 911,000 Nigerians requiring antiretroviral treatment - ART
- 2.2 million AIDS orphaned Nigerians
- 244,000 HIV positive pregnant women
Study Objectives

- Description of HIV related risk perceptions and behaviours in low and high prevalence Nigerian communities.
- Description of factors which act as barriers to the use of VCT.
- Investigation of relationships among community profiles, household characteristics, gender dynamics and individual HIV risk perceptions and behaviours over time.
- Dissemination and discussion of study findings with Nigerian policy makers and program personnel for purposes of developing more effective evidence based policies and prevention programs.
Map of Nigeria
Semi-Longitudinal Sites

SELECTED STUDY COMMUNITIES

- OYO STATE
  - OLUNLOYO
  - BADEKU

- CROSS-RIVER STATE
  - UGEP
# Cross-Sectional Sites

SELECTED LOCAL GOVERNMENT AREAS

<table>
<thead>
<tr>
<th>Lagos State</th>
<th>selected local government areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lagos Island</td>
<td></td>
</tr>
<tr>
<td>Ikeja</td>
<td></td>
</tr>
<tr>
<td>Epe</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Oyo State</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ibadan North</td>
<td></td>
</tr>
<tr>
<td>Ibadan Southwest</td>
<td></td>
</tr>
<tr>
<td>Atisbo</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benue State</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Makurdi</td>
<td></td>
</tr>
<tr>
<td>Otukpo</td>
<td></td>
</tr>
<tr>
<td>Kwande</td>
<td></td>
</tr>
</tbody>
</table>
Research Methods

• REACH used a social science-led and community-based approach
• Triangulation of approaches, including ethnographic approach, qualitative and quantitative methods
• Community mobilization and engagement of local leadership structures to ensure cooperation and buy-in
• Ethical approval from Institutional Review Boards (IRB) of the two collaborating institutions, and strict compliance in the field
Qualitative Instruments

- 41 Focus group discussions (FGDs), 13 in-depth interviews (IDIs), and 10 key informant interviews (KII) conducted in field sites
- Participants included students, out-of-school adolescents, HIV policy makers and experts, teachers, household heads, sex workers, farmers and petty traders
- Field assistants were deployed to live and work in the targeted communities to observe and follow-up leads on risk behaviour patterns.
Quantitative Instruments

• Household and Individual Questionnaires
• Random selection of households in selected Enumeration Areas
• Verbal Autopsy
• Cross-sectional: 2,453 households across Benue, Lagos and Oyo States
• Semi-longitudinal: 1,033 households in Badeku, Olunloyo and Ugep (Oyo & Cross River States)
• Data collection in English and local languages
Central to REACH operations is expanding the number of well-trained scholars in Nigeria competent to conduct policy-relevant research on HIV/AIDS. REACH capacity building included:

- Ten principal and co-principal researchers
- More than 20 Graduate Research Assistants trained and support for their doctoral training.
- About 80 field staff, mostly university students, trained in various data collection techniques
Current Progress

• Data collection completed in all sites by April 2009

• Data entry, cleaning and preliminary analysis completed

• Project Reports have been prepared and published

• Dissemination on-going at different levels – Local Communities, University of Ibadan, National and international communities

• Scholarly articles are being prepared for wider distribution

• Ideas for further research are emerging from the results of the project.
Gender and High Risk Behaviour

Quantitative Results
## Gender distribution

<table>
<thead>
<tr>
<th>Demographic characteristics</th>
<th>Study communities</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ugep</td>
<td>Olunloyo</td>
</tr>
<tr>
<td></td>
<td>439</td>
<td>448</td>
</tr>
<tr>
<td><strong>Gender:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>57.2</td>
<td>39.1</td>
</tr>
<tr>
<td>Female</td>
<td>42.8</td>
<td>60.9</td>
</tr>
</tbody>
</table>
Age distribution
Gender and HIV prevention knowledge

![Bar chart showing percentage of male and female knowledge levels in preventing HIV.](image)
Risk perception

How worried are respondents that they may already be infected by HIV?

<table>
<thead>
<tr>
<th></th>
<th>Not worried at all</th>
<th>Worried a little</th>
<th>Worried a lot</th>
<th>Unsure</th>
<th>No response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ugop</td>
<td>58.5</td>
<td>9.6</td>
<td>31</td>
<td>0.2</td>
<td>0.7</td>
</tr>
<tr>
<td>Olunloye</td>
<td>73.4</td>
<td>14.1</td>
<td>12.1</td>
<td>0.4</td>
<td></td>
</tr>
<tr>
<td>Badeku</td>
<td>12.3</td>
<td>7.5</td>
<td>78.7</td>
<td>1.4</td>
<td>2.1</td>
</tr>
</tbody>
</table>
Risk perception

- Higher levels of anxiety in Badeku (76.7%), relative to Olunloyo (12.1%) and Ugęp (31%)

- Trend could reflect desensitization as information on HIV risk factors become available to urban and semi-urban communities.
  - Information overload or inundation among communities where there is greater exposure to NGO advocacy and intervention.
Risk perception

Data also show lower levels of anxiety in urban Ugep and peri-urban Olunloyo (58.5% and 73.4%, respectively) than in rural Badeku (12.3%). Questions assumption that ruralites are inherently more fatalistic than urbanites.
First intercourse

<table>
<thead>
<tr>
<th>Community</th>
<th>Age young men begin sexual intercourse in this community</th>
<th>Age young women begin sexual intercourse in this community</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8-12</td>
<td>13-17</td>
</tr>
<tr>
<td>Ugep</td>
<td>34.6</td>
<td>53.1</td>
</tr>
<tr>
<td>Olunloyo</td>
<td>15.2</td>
<td>63.4</td>
</tr>
<tr>
<td>Badeku</td>
<td>67.8</td>
<td>26.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>30.9</td>
<td>53.8</td>
</tr>
</tbody>
</table>
First intercourse

Percent distribution of respondents by age at first sex

<table>
<thead>
<tr>
<th>Age in completed years</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤13</td>
<td>5.2</td>
<td>2.2</td>
</tr>
<tr>
<td>14</td>
<td>2.3</td>
<td>0.4</td>
</tr>
<tr>
<td>15</td>
<td>10.1</td>
<td>2.8</td>
</tr>
<tr>
<td>16</td>
<td>4.2</td>
<td>5.7</td>
</tr>
<tr>
<td>17</td>
<td>6.6</td>
<td>6.3</td>
</tr>
<tr>
<td>18</td>
<td>35.4</td>
<td>28.6</td>
</tr>
<tr>
<td>19</td>
<td>5.9</td>
<td>2.6</td>
</tr>
<tr>
<td>20+</td>
<td>43.2</td>
<td>50.1</td>
</tr>
</tbody>
</table>
Declining female age at first intercourse

- Declining female age at first intercourse follows a global trend in the context of global moral changes. The biological argument of differential pubertal development is not adequate to explain these patterns outside its convergence with gender, economic and cultural factors.
## Number of partners

<table>
<thead>
<tr>
<th>Selected characteristics</th>
<th>Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ugep</td>
</tr>
<tr>
<td>How many sexual partners do you have</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>23.6</td>
</tr>
<tr>
<td></td>
<td>27.5</td>
</tr>
<tr>
<td>Sex: Male Female</td>
<td></td>
</tr>
</tbody>
</table>

**Total**

<table>
<thead>
<tr>
<th>Sex: Male Female</th>
<th>Ugep</th>
<th>Olunloyo</th>
<th>Badeku</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>411</td>
<td>431</td>
<td>141</td>
</tr>
</tbody>
</table>

**Sex:** Male Female
## Transactional sex

<table>
<thead>
<tr>
<th>Selected characteristics</th>
<th>Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ugep</td>
</tr>
<tr>
<td>Is it common practice in this community to have sex for money, gift or other favours?</td>
<td>No</td>
</tr>
<tr>
<td>Sex: Male</td>
<td>8.5</td>
</tr>
<tr>
<td>Female</td>
<td>6.4</td>
</tr>
</tbody>
</table>
Conclusions

- Men are four times more likely to have >1 sexual partner outside marriage or regular sexual relationships. Persons aged 25-39 years are more likely to have >1 sexual partner outside a regular relationship.

- Sexual networking subsists on the basis of a system of transactional sex. The exchange of money or gifts for sex is fairly common in the study communities and points to the need to intersect HIV intervention with a gender-sensitive pro-poor approach.
Thank you
Findings from Qualitative Data on HIV/AIDS risk behaviour and Use of Voluntary Counselling and Testing
The factors that affect risk behaviour are:

- Transactional sex
- Age of sexual debut and lack of parental oversight
- Misconceptions about HIV/AIDS
- Sexual partnerships beyond spouses and primary partners
- Mismatched sexual desires
- Fatalism/denial of AIDS
- Condom use
- Alcohol use
- “Syndrome” of the denial of AIDS
Transactional Sex

“When you are in need of employment, there is nothing you can do [other] than to give yourself [sexually]. At times you want to buy favour in the office with your boss; if he is a male there is nothing [else] you can do so that when promotion comes you can be promoted”.

“Some children love money. They are never satisfied with whatever money their parents are giving them. They will be telling their parents that they want to buy what someone else bought and the parents keep telling them to be patient and they refuse. This also encourages this [transactional sex] act”
Newspaper article from Nigeria

Pastor, brothel owner fight over 11-year-old prostitute
Age of sexual debut and lack of parental oversight

“Some start having sex at the age of 13 years. I have seen it in this community. As the world is now, it is not compulsory that the child should be matured unless [for] those ones who have the fear of God in their heart. There are some who reach 20 years before they start having sex because of the way they are [raised]”.

REACH
Child rights and underage marriage

Lawyers appraise statutory provisions

The controversy generated by the recent report of a marriage between a former governor, who is now a Senator aged about 60 years, and a 13-year-old girl continues to simmer. Public opinion remains divided on the morality and legitimacy, or otherwise, of the act.

ERIC IKHILAE and JOSEPH IBUEZE examine some pros and cons under the nation’s family laws and sought lawyers’ views on the issue.
Age of sexual debut and lack of parental oversight

“Parents must be able to [sexually] take care of themselves at home. There are some children who are fifteen years old living with their parents in their single room; husband and wife, many want to have sex and these children may be seeing them, trying to do the same”.
High density housing conditions in Nigeria
An example of “face me I face you” housing in Nigeria
“There is another way they are using to protect against HIV/AIDS. This can be done by using herbs. Most non-literate who have sex with women take these local herbs immediately they finish sex, believing that all the things they might have contracted from the woman will be urinated having taken the medicine...."
Sexual partnerships beyond spouses and primary partners

“One day I was sitting beside my neighbour’s shop, I was listening to some men discussing about how they [sexually use] women. Some of them will say onen jang konana oji (meaning nobody eats only one type of soup)..... Some men will say the other girl’s thing is like water while another is thick. So they are tasting to see whether the other one has water or not (cuts in) in the process of tasting, they forget AIDS is real. They will say that they are always protecting themselves. The funny thing is that after all this they will go and look for a decent girl to marry”
Mismatched sexual desire

“Some women if they say they are not in the mood, then the men say, well if you are not in the mood, let me go and look for somebody (outside the relationship) that is in the mood”

“Some men leave their wives when they refuse sex. Even some women, you will hear a woman saying that her husband doesn’t sexually satisfy her”.
Fatalism

“I’d like to add that many people are still in denial. Many of them simply do not agree that the disease exists. Some of them say aji aji nabede (meaning: whether you ate or not, you will still die)”

“Many do not agree that the disease exist in the community. Some of the young boys say in Lokurr dialect that Lope ipo daja(meaning: something must kill a man)”
“...on the issue of using condom, as far as I’m concerned, I have used it before; there is nothing there in terms of enjoyment for the husband. We accept that this thing prevents infection from man to woman. It is the man that is supposed to decide whether to use it or not.”
Alcohol Use

Alcohol, a catalyst for risky sexual behaviour, is widely consumed in Nigeria. Some participants argued that alcohol use in small quantity for beginners, or large quantity for habitual drinkers, could cloud the judgment needed to minimize HIV risks associated with sex.
“Syndrome” of the denial of AIDS

“Some people do not agree that the disease exists in the world because the disease is not visible to the naked eye. It is not something that can be seen as such but is something that works in the blood. This is why some people are in denial”

“...they tell you it does not exist. They used to say that as long as the sexual organ exist among humans, the virus cannot stop”
Factors that affect the use of HCT

• Stigma against HIV-infected people and fear of testing positive for HIV
• Cost as determinant of VCT use
• Access to VCT centres
• Attitudes of health care providers
• Confidentiality concerns
• Errors in test results
Barriers against use of VCT

- Stigma against HIV-infected people
- Fear of testing positive for HIV (Don’t want to know status syndrome)
- Location of test centres are known and recognizable by community. The unintended effect is that of deterring users who would not like to be seen entering the centres for test because the community is likely to perceive them as sufferers or persons likely to test positive in small communities.
Barriers Cont’d

• Cost as a determinant of VCT use

“The cost [for HIV testing] is too expensive”. The average cost is about N700 (i.e., US$4.60)

• Access to VCT Centres: They are few and far between in Nigeria

• Attitudes of healthcare providers

• Confidentiality concerns

“The attitudes of healthcare workers deters people from seeking test/counselling because they talk too much”.

REACH
Conclusion

• As amply shown in the findings from the qualitative data, the challenge is to recognize that improvement in the economic well-being of the populace through good governance as well as the development/implementation of sustainable community based intervention programmes are critical to behaviour change in the control of HIV/AIDS and use of HCT in Nigeria
Survey findings on HIV Counselling and Testing in Benue, Lagos and Oyo states, Nigeria
Overview of Presentation

- Pattern of HCT Utilization
- Reasons for HCT uptake
- Barriers militating against HCT uptake
- Opportunities to scale-up HCT
- Conclusion
Findings show the need to know HIV status

Most respondents did not have correct knowledge of HIV prevention- e.g.

- 49% knew condoms prevent HIV
- 22% knew screened blood prevent HIV

- Report of recent casual sex, multiple sex partners and STI diagnosis without consistent condom use
## Knowledge of HCT centre and testing history

<table>
<thead>
<tr>
<th></th>
<th>Male n = 1258</th>
<th>Female n = 1195</th>
<th>All n = 2453</th>
</tr>
</thead>
<tbody>
<tr>
<td>Know where HIV test can be taken within a day’s travel</td>
<td>73.8%</td>
<td>65.8%</td>
<td>69.1%</td>
</tr>
<tr>
<td>Had HIV test within last 12 months</td>
<td>19.4%</td>
<td>21.2%</td>
<td>20.3%</td>
</tr>
<tr>
<td>Never had HIV test</td>
<td>62.2%</td>
<td>67.3%</td>
<td>64.8%</td>
</tr>
</tbody>
</table>
Rural-Urban distribution of persons who had recent HCT

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban (1628)</td>
<td>19.3%</td>
<td>24.3%</td>
<td>21.6%</td>
</tr>
<tr>
<td>Rural (878)</td>
<td>19.3%</td>
<td>15.4%</td>
<td>17.3%</td>
</tr>
</tbody>
</table>
Influence of education on HCT Uptake

- p<0.0001 for HTC trends by education, among “All,” among Males, and among Females
### Reasons for HCT: Non-routine PITC

#### Most frequent reason

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worried about being infected</td>
<td>11.4%</td>
</tr>
<tr>
<td>Provider initiated</td>
<td>52%</td>
</tr>
<tr>
<td>Involuntary</td>
<td>10.1%</td>
</tr>
<tr>
<td>Voluntary</td>
<td>22.9%</td>
</tr>
<tr>
<td>Other reasons</td>
<td>2.8%</td>
</tr>
<tr>
<td>No response</td>
<td>0.7%</td>
</tr>
</tbody>
</table>

This chart shows the distribution of reasons for HCT, with Provider initiated being the most frequent reason at 52%.
HCT mostly took place in Hospital Settings
### People who tested and who did not test: Barrier difference

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Tested in last 12 months</th>
<th>Have not tested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Think Partner is opposed to HIV test</td>
<td>19.8%</td>
<td>80.2%</td>
</tr>
<tr>
<td>Will have difficulty to disclose to wife or sex partner</td>
<td>24.5%</td>
<td>75.5%</td>
</tr>
<tr>
<td>Cost of HIV test is high</td>
<td>23.8%</td>
<td>76.2%</td>
</tr>
<tr>
<td>Persons found to be infected with HIV will die soon</td>
<td>13.7%</td>
<td>86.3%</td>
</tr>
<tr>
<td>Providers do not keep test results confidential</td>
<td>26.2%</td>
<td>73.8%</td>
</tr>
<tr>
<td>People will say “bad things” if HIV test is positive</td>
<td>21.7%</td>
<td>78.3%</td>
</tr>
</tbody>
</table>
## Opportunities to scale-up HCT

<table>
<thead>
<tr>
<th></th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Willing to receive HCT at home if providers bring the test</td>
<td>86.8%</td>
</tr>
<tr>
<td>Support that doctors and nurses should offer routine HIV test in other illnesses</td>
<td>86.6%</td>
</tr>
<tr>
<td>Willing to seek HCT if sure of follow-up treatment in case they are HIV positive</td>
<td>84.8%</td>
</tr>
<tr>
<td>Accept that couples should collectively receive HCT</td>
<td>76.9%</td>
</tr>
</tbody>
</table>
Conclusion

• HCT (either client or health worker initiated) has been unable to reach many who need testing
• Non-routine PITC appears to have reached more individuals than client-initiated testing
• There are innovative opportunities to scale-up PITC and client-initiated testing as suggested by the study
• Reducing identified barriers will enhance the prospect of HCT uptake
Thank you for your attention
Thoughts on Increasing HIV Testing and Counselling Uptake in Nigeria
Why HIV testing and counseling?

- “Universal access” approach
- “Know your status” makes sense
- for HIV-infected: access to care and treatment
  - planning for future (children, etc)
  - less transmission to others if aware of infection, including in HIV-discordant couples
- for HIV-uninfected: relief?
  - prevention counseling reinforced
HIV Counseling and Testing  
Policy Goals

UNAIDS/WHO’s:  
universal knowledge of HIV status

NACA’s: to increase HCT uptake through “the establishment and support of a network of HIV testing & counseling...that will provide universal access to...quality services.” (2009)
Characteristics of an Optimal HIV Counseling and Testing System

- HCT services widely available and widely known
- Services affordable (costs of test and travel)
- Stigma-free (family, friends, providers, system)
- *Always* post-test counseling
- Routine support for *disclosure* after HCT
- If infected, *always* referral to care (and follow-up)
- Self-monitoring (data) $\Rightarrow$ self-correcting (policy)
  - obstacles routinely identified and addressed
- High uptake of HCT
Obstacles to Effective HCT

- **System**: test kit shortage, trained staff, records; referral to care vs. enrollment
- **Structural**: cost, time, distance, education
- **Privacy**: clinic confidentiality, perceived stigma
- **Fear**: of being infected; of having to disclose; of having blood drawn;
Household SES, by gender of head of household

![Bar chart showing the percentage of households in different SES quintiles for male and female heads of household.](chart.png)
Proportion of REACH respondents with HCT in prior 12 months, by socioeconomic status

Socioeconomic Quintiles

P<0.05 for males and p<0.0001 for females
Influence of education on HCT uptake

Completed Education Level

- No formal
- Primary
- Secondary
- Post-secondary

Recent Completed HCT (%)

- All
- Males
- Females

p<0.0001 for HCT trends among every group
REACH respondents’ completed education, by gender

![Bar chart showing the proportion of completed education levels (No formal education, Primary, Secondary, Post-secondary) for male and female heads of household (HoH), with p-value <.0001.](chart_image)
Rates of recent HCT, by gender and age group

<table>
<thead>
<tr>
<th>Age Group (Yr)</th>
<th>All</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-17 (N=227)</td>
<td>3.5%</td>
<td>2.7%</td>
<td>4.4%</td>
</tr>
<tr>
<td>18-24 (N=583)</td>
<td>19.9%</td>
<td>17.6%</td>
<td>22.6%</td>
</tr>
</tbody>
</table>
Number of women with births, antenatal care, HIV test and receiving test results

- Birth in last 3 years: 154 (100%)
- Had ANC in pregnancy: 133 (86%)
- HIV tested with ANC: 54 (35%)
- Returned for test results: 39 (27%)

Steps of HIV Testing and Counseling in 154 Pregnancies
Provider-Initiated Testing & Counseling (PITC)

- PITC v. HCT (or VCT) – note C-T sequence
- also called “routine” or “opt-out” testing
- PITC increases uptake, increases concerns
  - “weaker” consent; “opt-out” vs. explicit
  - “inadvertent” coercion (Dr. – patient setting)
    - mandatory testing in disguise?
  - family conflict (women blamed)
  - gender-based violence
- open discussion / public education first
Counseling and Testing for Couples

• Started in Uganda in early 1990s;
  – Now in many countries
• Mostly married couples so far:
  – Expanding to other stable sexual partnerships
• Counselors support “mutual disclosure”
• ➔ less transmission in discordant couples
Other Useful Approaches to ↑ HIV Testing and Counseling Uptake

- Integration of HCT into other health services (e.g., TB, STI, reproductive health)
- Rapid tests, use of finger-stick blood, use of saliva
- Task shifting (to lay HCT providers)
- Mobile clinics: e.g., community market, bus station
  - Four-fold HCT uptake increase
- Door-to-door teams: >85% accept; ↓ cost /client;
- Routine post-test support for disclosure to others
- Routine HCT for ART patients’ families;
Approaches to increasing HCT uptake in Nigeria (I)

- Several approaches already being planned by NACA (e.g., routine testing, more sites, rapid tests, mobile teams, etc.)
- Clarify current policies (e.g., age of consent)
- Address objective barriers we know about already (e.g., HCT cost and travel, house-to-house testing, post-test disclosure support,
Approaches to increasing HCT uptake in Nigeria (II)

• More analysis of existing REACH data set (e.g., role of poverty in non-testing; low ANC uptake)

• Additional operational research (e.g., reasons for not returning for test results, PITC benefits and pitfalls, community HCT, client satisfaction;)

• Ongoing monitoring of HCT uptake by specific ethnic, geographic and behavioural risk groups.
Principles of HCT Policy Change

• Make changes on if based on data;

• Identify and address obstacles directly

• Use operational research to be sure that new approaches work
Rate of **completed** antenatal HCT, by woman’s educational level

<table>
<thead>
<tr>
<th>Completed Educational Attainment</th>
<th>Had HIV test during ANC</th>
<th>Went back to receive test results</th>
</tr>
</thead>
<tbody>
<tr>
<td>No formal education</td>
<td>14.4%</td>
<td>12.5%</td>
</tr>
<tr>
<td>Primary</td>
<td>42.6%</td>
<td>51.2%</td>
</tr>
<tr>
<td>Secondary</td>
<td>49.5%</td>
<td>65.2%</td>
</tr>
<tr>
<td>Post-secondary</td>
<td>81.5%</td>
<td>92.3%</td>
</tr>
</tbody>
</table>
HCT rate in prior 12 months, by awareness of nearby HCT site

<table>
<thead>
<tr>
<th>Aware of HCT site within day’s travel?</th>
<th>HCT in prior 12 months</th>
<th>Relative HCT ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES (N=1723)</td>
<td>28.0%</td>
<td>6.4</td>
</tr>
<tr>
<td>NO (N=730)</td>
<td>4.4%</td>
<td>1.0</td>
</tr>
<tr>
<td>All (N=2453)</td>
<td>20.8%</td>
<td></td>
</tr>
</tbody>
</table>
Why be tested if anti-retroviral treatment is not available now?

• AIDS = HIV + OI (opportunistic infection)
  – TB, the most common OI, is treatable;
  – Other drugs to prevent pneumonia;
• Reduce chances of infecting others;
• Make plans for family, etc.
Rates of recent HCT, by gender and rural-urban location

<table>
<thead>
<tr>
<th>Location</th>
<th>All</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban (1628)</td>
<td>21.6%</td>
<td>19.3%</td>
<td>24.3%</td>
</tr>
<tr>
<td>Rural (878)</td>
<td>17.3%</td>
<td>19.3%</td>
<td>15.4%</td>
</tr>
</tbody>
</table>
Thank you
OUT OF REACH?
Ending Nigeria’s AIDS Pandemic
The reduction of HIV transmission rates in Nigeria depends on the design and implementation of locally-relevant prevention strategies that respond to cultural, socioeconomic and institutional realities of the targeted populations.”
REACH core commitments

• Treat the community as a research partner
• Increase the number and skills of Nigerian HIV/AIDS researchers
• Build bridges to national and local policy makers
• Mobilize government officials, media, and other influential actors behind REACH findings
Can Nigeria curb its HIV pandemic?

- REACH: <20% tested in prior 12 months (<7% in 2008 DHS)

- 65% of adults never tested

- 62% of pregnant women not tested (plus tested but did not return for results: 73%)
Nigeria’s persisting HIV pandemic

• HIV transmission not slowing
  – About 1000 Nigerians infected daily

• 3 million HIV-infected in Nigeria, second only to South Africa

• African rate: 5 infected for every 2 starting antiretroviral drugs
Paradigm shift **needed** in HIV prevention and treatment

- **Antiretroviral treatment (ART) costs will consume growing share of health budgets**

- **External contributions likely to rise slowly**

- **Global goal of universal ART access fading** (4 million on ART of 10 million requiring treatment/14 million with new WHO guidelines)

- **Twin challenges:** drastically **reducing** HIV infections / **closing** AIDS Treatment Gap
AIDS Treatment & Finance Gap

Prof. Robert Murphy, Abuja, May 4, 2010

<200 CD-4 Count Treatment Start in Poor Countries: 350,000 now treated in Nigeria
- Untreated estimate 200,000

<350 CD4 Treatment Start in Rich Countries: 1,500,000 Nigerian estimate

Benefits: reduced contagion, better response, longer on 1st regimen, better adherence, less toxicity, reduced mortality & morbidities

Cost of meeting WHO/UNAIDS guidelines in Nigeria: astronomical

Many structural hurdles to be overcome
Enhanced HIV Prevention Strategies (EHPS)

1) Mobilize traditional and other community leaders

2) Provide incentives to groups, communities and health facilities to increase HCT levels

3) Use myriad networks to disseminate accurate information and confront stigma based on ignorance

4) Target specific barriers to HCT using community surveys like REACH
Enhanced HIV Prevention Strategies: Set Specific Annual Goals

5) Reduce proportion of sexually active adults not tested within last 12 months
6) Reduce proportion of never tested adults
7) Reduce estimated daily HIV infections
8) Increase antenatal HCT (REACH: 27%)
9) Reduce HIV-infected newborns (56,000 annually)
10) Reduce education, income, residential, gender, age discrepancies in HCT
EHPS Core Components

A. Optimal HIV Counseling and Testing Scenario (REACH Interim Report, Ch. 7)

B. **KYS** – Know Your Status

C. **RUN-HCT**: Routinize, Universalize, and Normalize HIV Counseling and Testing

D. **PTC** – Post – Test Counseling/Get Your Results
EHPS Core Components (II)

E. Community level focus - community action programs

F. HIV Prevention for vulnerable children, especially girls (*No Safe Place*)

G. REACH Plus – further in-depth epidemiologic analysis of existing REACH data (*Biostatistics Collaboration Center*)
REACH Plus
Opportunities and Challenges

i. Control and manage REACH data by Nigerian entity

ii. Additional communities can be studied based on Optimal HCT Scenario

iii. Wider pool of REACH researchers for national Nigerian effort

iv. REACH training manual and REACH institute for researchers and assistant

v. *Freedom from AIDS Conference, October 2010 (Nigeria’s 50th Anniversary Event)*
Enhanced Nigerian-U.S. Collaboration

• U.S.-Nigeria Bi-national Commission signed April 6, 2010

• Nigerian-U.S. public health collaboration already at significant level

• Approximately 300,000 Nigerians receiving ART through PEPFAR
U.S. Global Health Initiative (GHI)

• $63 billion proposed for six-year (2009-2014) global health strategy
  – HIV/AIDS listed first among 9 GHI target areas
  – 70% of proposed funding goes to HIV/AIDS

(GHI policy brief issued by Kaiser Family Foundation, April 2010)
U.S. Global Health Initiative (GHI)

Slowing rate of new HIV infections would allow:

– more effective HCT programs

– closing gaps in HCT coverage

– balanced use of resources for other health priorities
Bold African Initiatives on HIV/AIDS

• South African government’s new major effort to tackle AIDS pandemic

• As Botswana, South Africa will offer HIV tests to nearly all adults entering the public health system

• And Nigeria???
Enlightened and Sustained African Leadership Imperative

- Museveni Leadership -> Ugandan Gains
  Museveni Wobbling -> Ugandan Slippage

- Mbeki’s Denials -> South African Deaths
  Zuma’s Commitment -> South African Hope

- Obasanjo’s support -> Nigerian national response
  Goodluck and Patience Jonathan -> A bold and comprehensive Nigerian AIDS Initiative?
Stopping a virus that just won’t stop

- HIV – engineered to survive
- Mutates frequently: “artful dodger”
- No vaccine after a quarter-century
- Long incubation; infected persons contagious while asymptomatic
- Otukpo (Nigeria) respondent: “as long as sexual organs exist…the virus cannot stop”
Lessons from REACH

1) **Ignorance**: Greatest HIV Ally
2) **Knowledge**: Strongest **Weapon** to Stop Transmission
3) Expand attitudinal and behavioral community profiles through survey research
4) Rapidly *increase* testing and counseling
5) **KYS** : **Know** Your Status
6) **RUN-HCT**: Routinize, Universalize, and Normalize HIV Counseling and Testing
7) **PTC**: Enhance Post-Test Counseling
8) Reaching across Boundaries: Nations, Cultures, Institutions, Communities, Social Strata, Disciplines
There is no Cure: Enhance Prevention

“Our goal is zero-transmission”

Professor John Idoko, Director-General
Nigerian National Agency for the Control of AIDS
May 4, 2010
REACH Principal Investigator and NACA Director General during 5th National Conference on HIV/AIDS, Abuja, Nigeria. May 2010