



HIV/AIDS Prevention in Nigerian Communities: Strengthening Institutional Responses

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Faculty of the Social Sciences,
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and the Program of African Studies,
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EXECUTIVE SUMMARY

An international seminar on “HIV/AIDS Prevention in Nigerian Communities” was convened at the University of Ibadan on 9–11 December 2004. The seminar attracted sixty scholars, activists, and policy makers from Nigeria, Cameroon, Ghana, Senegal, and the United States. The Program of African Studies (PAS) at Northwestern University and the Faculty of the Social Sciences at the University of Ibadan jointly organised the seminar to meet two main objectives: First, to provide an opportunity for experts to share information and analyses pertinent to HIV/AIDS prevention in Nigeria; second, to distill ideas for launching a Research Alliance to Combat HIV/AIDS (REACH) in 2005 that will conduct pioneering collaborative research aimed at curbing transmission of the HIV virus.

All participants agreed that the seminar met its objectives. The organisers express their profound appreciation to Nigeria’s National Action Committee on AIDS (NACA) and Northwestern University for their generous sponsorship.

Participants were challenged to be practical and forward-thinking in their presentations and discussions. This report summarises key points from the

proceedings, highlighting recommendations for further research and analysis. Limited success at slowing the epidemic in much of Africa points to the need for new approaches, strategies, and tactics to improve prevention; to succeed, it is now widely acknowledged, these efforts must take into account the characteristics and dynamics of the affected social groups and communities.

This report documents insights by Nigerian researchers that not only contribute to the global debate on HIV/AIDS prevention but also offer fresh perspectives, energies, and commitments to the cause. It presents highlights from the seminar’s seven sessions and from the keynote address by Professor Femi Soyinka. Sessions were titled as follows: ‘Driving Factors in Nigerian Communities’; ‘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 and Collaboration among Prevention Actors’; and ‘Building Capacity for Policy-Relevant Research.’

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In its 2005 review of the national response to HIV/AIDS, NACA stated that infection rates will likely be on the rise in Nigeria for the rest of the decade. In his keynote address, Professor Femi Soyinka emphasised that ‘prevention is still key despite the gains in treatment and care’. ‘Ten years of prevention advocacy,’ Professor Layi Erinosho argued, ‘including the promotion of condom use, have had little demonstrable impact because they were not designed in response to the specificities of Nigeria’s risk environments and group practices’. Professor Paul Nkwi noted that in a country as diverse as Nigeria, communities must identify ‘the practices that sustain lives and those that endanger lives’. Such practices, he added, ‘are embedded in community structures and behavioral norms’.

In the words of media specialist Mr Akin Jimoh, ‘Messages and interventions were largely unguided by research. In many cases, groups at risk do not see themselves in the messages’. Now that prevention efforts have been under way since the infection was identified in Nigeria two decades ago, the time has come, according to Dr Adegbenga Sunmola, ‘to assess which ones have worked and what combination best suits a local environment’.

To meet these and other challenges discussed during the seminar, REACH is setting the following goals and priorities:

- Contribute to the creation of evidence-based prevention programmes in Nigeria, relevant to specific groups and communities, in place of the typical top-down and generalised strategies.

- Bring together the knowledge and skills of multidisciplinary teams of sociologists, anthropologists, psychologists, communication specialists, political scientists, economists, and epidemiologists.
- Involve Nigerian communities as active partners in this research and encourage them to engage in improving the design, implementation, and evaluation of prevention strategies and messages.
- Examine issues of gender relations, sexual practice, the attitudes of youths, and divergences in belief systems that impede effective action by interveners.
- Make its findings readily accessible to policy makers and practitioners at federal, state, and local levels and develop models of operational research and evidence-based prevention strategies that can be replicated elsewhere in Nigeria.
- Contribute to a more balanced and comprehensive national response by focusing on reducing infection rates even as greatly expanded resources, both human and financial, are being directed to improving treatment.
- Insist on the highest level of transparency, efficiency, and adherence to norms of research ethics that are both international and locally relevant.
- Assist Nigerian researchers in strengthening their capacity, through international partnerships, to implement the first cycle of research projects in 2005–08 and to meet other challenges posed by the epidemic in the years ahead.

PROCEEDINGS

The seminar opened with remarks by several distinguished persons. Representing the vice-chancellor of the University of Ibadan, **Deputy Vice-Chancellor 'Biola Odejide** welcomed the participants and stressed his university's commitment to combatting HIV/AIDS nationwide and to addressing its threat to the university community. **Dr Kayode Ogungbemi**, representing NACA, gave a brief overview of his agency's work and responsibilities. Encouraging seminar participants to identify knowledge gaps that social science research might fill, he singled out the need for local-impact assessments of current prevention efforts. NACA will soon begin to emphasise research in its own operations by starting an internal research unit.

Professor Adigun Agbaje, dean of the Faculty of the Social Sciences at the University of Ibadan, used his opening remarks to emphasise the faculty's dedication to applying their expertise to resolving the HIV/AIDS crisis. **Mr Francis Ogundiran**, representing the Oyo State Commission for Health, echoed these remarks and stressed the state government's recognition of the need to reverse the tide of the epidemic. He also welcomed the vital contributions that can be made by Nigerian researchers and their international partners.

Professor Eghosa Osaghae, vice-chancellor of Igbinedion University (on leave from the University of Ibadan), highlighted several points. He said that it is important for more women, who are disproportionately affected by the epidemic, to become involved in research and to supply critically needed insights. He recommended increasing efforts to bridge the gap between advocacy and research communities and reducing the current urban bias in planning HIV/AIDS interventions.

Professor Richard Joseph, director of the Program of African Studies at Northwestern University, delivered final opening remarks, which included recollections of his experiences as a lecturer at the University of Ibadan in the late 1970s. He emphasised that HIV/AIDS must be combatted, because of its devastating impact on African peoples, societies, and economies. In closing, he urged increases in the scholarly community's involvement in HIV/AIDS prevention and in meeting the need for new approaches, strategies, and tactics that are based on in-depth knowledge of the affected social sectors and communities.

Session I: Driving Factors in Nigerian Communities

The first session introduced a number of issues and themes that would figure prominently throughout the seminar. Understanding HIV/AIDS within the socioeconomic and cultural contexts of Nigerian communities was repeatedly emphasised as a prerequisite to designing effective intervention strategies.

Professor Layi Erinosho of the Social Science Academy of Nigeria delivered a presentation on the 'Socioeconomic and Cultural Factors in the Spread of HIV/AIDS'. He divided the driving factors into three categories: macrosociological, microsociological, and cross-cutting. Macrosociological factors include poverty and such 'embedded' cultural practices as female genital mutilation, courtesanship, concubinage, wife hospitality exchange, widowhood rights, scarification, and prostitution. Microsociological factors, which Erinosho said were often the unintended consequences of rapid modernisation and urbanisation, include the sexual abuse of underage girls in overcrowded compounds; children working as street vendors who are vulnerable to sexual exploitation; needle sharing by drug users; trading in blood products; and medical 'quacks' who use unsterilised needles. He also pointed to new patterns of voluntary and involuntary migration, such as from Nigeria to the Niger Republic and Chad, partly in response to the social restraints that accompanied the imposition of Shari'a rule in Nigeria's northern states.

Exacerbating these tendencies, Erinosho contended, are cross-cutting factors such as low literacy levels, high unemployment and underemployment rates, the prevalence of commercial sex, erroneous beliefs about 'curative' sex with virgins and disabled persons, high rates of other sexually transmitted diseases (STDs), and weak health care-delivery systems.

In the face of these complex risk environments, Erinosho offered several specific recommendations. First and foremost is the need to combine AIDS prevention with more robust efforts to reduce poverty. Also important are policies to educate children via multiple entry points: parents, schools, nongovernmental organisations (NGOs), and religious groups. Public education campaigns must be conducted to eradicate harmful practices like female genital mutilation and widowhood rites. Preventative interventions must be designed for

groups that adopt risky lifestyles, such as young women in tertiary institutions and members of the Road Safety Corps. In his summary, Erinoshio emphasised that ten years of prevention advocacy, including the promotion of condom use, have had little demonstrable impact because preventive measures were not designed specifically for Nigeria's risk environments and group practices.

Professor Paul Nkwi, whose experience includes involvement in the Pan African Anthropological Association based in Yaoundé, Cameroon, elaborated on the cultural factors driving HIV infection in Africa, referring to extensive research conducted by the African Population Advisory Council (APAC) in Côte d'Ivoire, Cameroon, Kenya, Malawi, Togo, and Nigeria. Nkwi argued that reducing HIV infection rates in Nigeria, based on the evidence already collected, will require a deeper understanding of how specific cultural practices facilitate transmission of the disease and complicate prevention efforts. To be successful, this research must necessarily be multidisciplinary.

It is important, Nkwi stressed, to examine both positive and harmful cultural attributes. APAC research was designed to help communities better understand how certain sociocultural practices increased their HIV/AIDS risk and hindered their capacity to cope with the disease. By expanding awareness of cultural practices and their implication in HIV transmission, communities can make informed choices about behaviour modification.

Some of the positive cultural factors found in targeted communities include a strong extended-family system, male circumcision, the importance of virginity until marriage, adherence to sexual relations within polygynous families, and social solidarity. Negative practices, or those that raise the risk of infection, include early marriage, unequal gender relations, concubinage, widow inheritance, scarification with unsterilised equipment, group sex rituals, and beliefs in 'curative' sex. Some practices, such as initiation rites for young women, can have both positive and negative consequences: In some communities such rites may include sex education; in others, they may involve sex with older men. These factors need to be

carefully and dispassionately studied and their consequences discussed within the affected communities.

Among the key research strategies sketched in Nkwi's presentation was the engagement of 'cultural gatekeepers'—influential community leaders who are well informed about local practices. APAC research teams asked respondents to describe their attitudes toward these practices. In most cases, even with regard to those that facilitate transmission of the virus, these practices were shown to be deeply embedded in community structures and behavioural norms. This evidence reinforces the importance of paying attention to cultural norms

and sensitivities that shape behaviour, of involving communities in identifying solutions, and the need for cross-disciplinary research into why risky behaviours persist. In most instances, these practices were entrenched long before the AIDS era and often outlive the social and environmental factors that prompted their emergence.

Positive behaviour change, Nkwi contended, requires careful attention to both cultural practices and cultural norms. Mass public advocacy campaigns too often miss the mark. Community leaders must be mobilised to help translate exhortations into strategies relevant to their communities. The negative consequences of specific behaviours must be demonstrated in ways that do not imply an attack on deeply held community values. It is equally important

to recognise and strengthen positive cultural attributes. Nkwi concluded that Nigeria's behaviour-change communication strategy must be accompanied by improved understanding of cultural dynamics. He drew on his wide knowledge of cultural practices in West, Central, and East Africa to illustrate his argument and the challenge of helping communities distinguish between practices that sustain and those that endanger lives.

These informative presentations by seasoned researchers, one from Nigeria and the other from Cameroon, provoked many questions. How, it was asked, can impoverished people who engage in risky behaviour reach an economic level where they are able to abide by moral precepts? In a national culture that encourages the flaunting of wealth that provokes risky

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behaviour, how can abstinence and moderation be promoted? Young women in universities, for example, get drawn into commercial sex so they can afford clothing like that of their peers. Some questioners called attention to the rising use of alcohol and drugs by young people. Politicians and other policy makers often speak out against AIDS to please foreign interests while in their personal lives they engage in the same problematic behaviour that sustains the epidemic.

Session II: Advancing Prevention through Social Marketing of Condoms

Condoms are a crucial component of worldwide campaigns to reverse the AIDS pandemic. In Session II, Nigeria's social marketing of condoms was subjected to an intensive and often critical review.

'Social marketing' refers to the application of commercial techniques in the pursuit of public goals. It has been used to address such issues as energy conservation, smoking cessation, safe driving, family planning, and improved nutrition. The promotion of condom use provokes both negative and positive reactions from Nigerians. In his presentation on 'Advancing Prevention of HIV through Social Marketing of Condoms: The Nigerian Experience', **Mr Zach Akinyemi** of the Society for Family Health (SFH) began by emphasising that because sexual activity is the main mode of HIV transmission in Nigeria, the expanded and consistent use of condoms is key to halting spread of the disease.

SFH began the social marketing of condoms in Nigeria in 1985, and its efforts have progressed through four phases. The introductory phase coincided with a period of extreme sensitivity to the promotion of condoms. The initial aim of the social marketing campaign was to make Nigerians aware of the benefits of using condoms. The second phase was a radio, TV, and billboard message campaign that presented condoms as both a family planning tool and a means of preventing disease. In the third phase, SFH shifted its focus from condom sales and sales promotion to promoting healthy practices. It also altered its goals from expanding sales volume to changing the behaviour of vulnerable persons, especially the poor. This phase relied on behaviour-change communicators and the dissemination of behaviour-change models. The fourth phase, now under way, emphasises community mobilisation that combines community-level interventions with social marketing practices.

The Nigerian social marketing programme has grown in breadth and depth over the past twelve years, promoting delayed sexual activity among youth, reduction in the number of sexual partners, and condom use in nonmarital and non-cohabitating sexual relationships (including commercial sex). Despite these advances, a large portion of at-risk Nigerians still do not use condoms.

The campaign to increase condom use would benefit, according to Akinyemi, from targeted research. Factors that influence sexual behaviour include religion, economic status, pressure from partners and peers, and cultural norms; the relative importance of these factors, however, in determining behaviour is not known, nor is it clear which ones, if tackled by education and communication, would engender safer practices. Research could also inform marketing strategies that use multiple means of reaching the same audience. Finally, the issue of embarrassment at the point of condom purchase must be addressed and other distribution options identified.

Dr A. M. Sunmola of the University of Ibadan presented a paper on 'New Priorities for Condom Research in the Second Decade of AIDS in Nigeria'. Stressing that behaviour change is the primary key to preventing HIV transmission, he agreed with Akinyemi's assertion that condom use must be encouraged so long as heterosexual sex remains the primary mode of transmission in Nigeria. Risky behaviour at all levels of society takes many forms, including intergenerational sex, extramarital affairs, and nonmonogamous relationships; increasing the risk are commercial sex workers and 'bridge populations' — migrant workers, traders, military personnel and members of the Youth Service Corps — who have the potential to transfer the virus across wide areas. It is essential, according to Sunmola, that condoms are used consistently and correctly since transmission often occurs among regular partners.

Research is urgently needed to understand the gap between awareness of the value of condoms and their actual use. Many Nigerians cite diminished sexual satisfaction and the embarrassment of buying condoms in public as barriers to using them. Where gender relations are unequal, as is often the case in Nigeria, negotiations between sexual partners over condom use can be severely inhibited. Efforts to encourage consistent and correct condom use must therefore take these intersecting issues into consideration.

Sunmola also stressed that condom-promotion strategies that have been effective elsewhere must be put to the test in

Nigeria. He cited the case of Thailand, where the government mandated condom use by all commercial sex workers and used its authority to penalise brothel managers and proprietors who did not force compliance. Community-level studies of resistance to condom use would yield insights, Sunmola said, that could help shape campaigns that go beyond general exhortation and billboard advertising. He also recommended cognitive/behavioural studies that examine how Nigerians connect levels of risk with condom use.

In the discussion that followed, negotiation between sexual partners was mentioned as a crucial problem. What would it take to empower Nigerian women to ask their partners to use condoms, and how can men be made more amenable to their wishes? The female condom was suggested as a means for women to take control of their own protection, but, as discussants noted, it has so far been met with even more resistance than male condoms. Discussion then focussed on the differing attitudes of Nigeria's major religious groups and faith-based organisations toward condoms. Concerns about how the promotion of condom use may encourage promiscuity, for example, require thoughtful responses. Engaging religious groups from the perspective of their own belief systems, values, and sensitivities was recommended, especially in view of their high level of mobilisation and their strong influence on moral issues in Nigeria.

While agreeing that clergy and other religious leaders can provide useful interventions, some participants felt that any infusion of religion and morals into talk of HIV/AIDS risks further stigmatising people with the disease. The assistance of Nigerian researchers who can address these overlapping medical, social, ethical, and religious concerns is clearly needed.

Session III: Creating Effective Prevention Messages for the HIV-Negative and Untested Populations

Information on HIV/AIDS prevention reaches Nigerians via multiple channels including television, radio, newspapers, billboards, and speeches by political, religious, and community leaders. Seminar presentations and discussions emphasised the need for systematic evaluations of the impact of these diverse prevention messages and channels. The consensus of the participants was that the messages, and the methods by which they are transmitted, must be adjusted to accommodate the nature of the targeted groups.

Dr A. Ajuwon of the University of Ibadan has conducted a

survey of prevention messages in Nigeria. He observed that they usually reflect the 'ABCs': abstinence, faithfulness, and the use of condoms. Earlier messages employed 'scare tactics', using such phrases as 'AIDS Kills' and 'Beware of AIDS', and visuals like the skull and crossbones. Ajuwon described the downside of such messages, explaining that they promote fatalism, increase the stigmatisation of people living with HIV/AIDS (PLWHA), and may discourage AIDS testing. He also critiqued prevention messages that skirt the topic of limiting the number of sexual partners and minimise the importance of voluntary counselling and testing. In Ajuwon's view, messages often focus too heavily on condom use in contexts in which the burden is on women to negotiate their use. In addition, there is excessive concentration on urban locations. Prevention strategies tend to be implemented or discontinued without the benefit of research on their impact.

It is a tremendous challenge to craft messages about behaviour that is often secretive and difficult to change, especially in a country as diverse as Nigeria. From a methodological standpoint, sexual behaviour is not easily measured, and the outcomes of risky behaviour often take years to emerge. Even when risky behaviour is reduced, achieving consistency in what are usually regarded as individual choices often proves difficult. Ajuwon stressed that prevention messages would be improved by moving beyond the ABCs and considering a wider range — from A to Z — of Nigeria's needs, such as 'T' for testing. Also, targeted groups must be permitted to help formulate prevention messages; specific messages should be tailored for specific audiences; and text and visuals must be synchronised and all messages should be periodically evaluated.

Mr Akin Jimoh of Development Communications Network, a Lagos-based media resource and advocacy centre, echoed many of Ajuwon's arguments. Based on his extensive knowledge of prevention campaigns throughout Nigeria, he said that messages and interventions are largely unguided by research. In many cases, groups at risk do not see themselves in the messages. There are, for example, more than 300 NGOs in Lagos that work on some aspect of HIV/AIDS. While these grassroots organisations have the ability to interact with the population at the point of need, they must become better informed about the latest techniques and best practices.

It is important, Jimoh added, that the Nigerian mass media communicate accurate information. A single inaccurate report

can derail months of advocacy and sensitisation efforts. Even though greater media attention is now devoted to HIV/AIDS, attention alone is unlikely to change behaviours, in part because the media lack personal, interactive connections with society.

In order to improve the message and achieve behaviour change, Jimoh recommended conducting research on values, culture, language, beliefs, and social networks. For example, prevention messages should be formulated in local languages rather than simply translated from English. The cooperation of community-based entities such as churches, mosques, and associations of artisans and health workers should be enlisted. By using local authorities, prevention campaigns can be linked to community priorities. In addition, the involvement of such long-standing networks will enable follow-up after an intervention is completed.

Professor John Anarfi of the University of Ghana underscored the arguments made by Jimoh and Ajuwon, offering observations based on his own extensive research and publications. He stressed that generalised information has a limited impact; to reach the target audience, information must be culture-specific — provided in the local language and created with the participation of the local community. Anarfi concurred that the dispersal of inaccurate information must be prevented because of the lasting damage it causes.

While noting that messages advocating voluntary counselling and testing (VCT) are deficient in some respects, Anarfi favours scaling them up to coincide with the increasing availability of treatment. He cited Brazil as a success story, noting that rates of opportunistic infections, hospital admissions, and deaths from HIV/AIDS have decreased as a result of efforts that advance testing, treatment, and prevention simultaneously. Anarfi concluded by reminding seminar participants of some of the specific challenges that emerged from the World AIDS Conference in Bangkok in 2004: increase human capacity and global funding; ensure that prevention accompanies expanded treatment; and work toward national ownership of AIDS programming.

Anarfi's presentation was followed by discussion and debate over the design of messages that advocate voluntary

counselling and testing. Some participants questioned the value of scaling up VCT messages prior to increases in the availability of treatment. Some argued that now is the time to stress testing, as it benefits both HIV-positive and HIV-negative persons alike. Far from being limited to drugs, treatment also consists in reducing risky behaviours in all who are tested. Thus testing is itself an important prevention tool.

The issue of disaggregating target audiences was also discussed. Uneducated rural populations and minority communities should not be overlooked when prevention messages are designed. Sixty-five percent of Nigerians live in rural areas and are not reached by current prevention campaigns. How, it was asked, can the strength of oral tradition be better utilised in communications about AIDS? It is also important to distinguish awareness of a message from its impact.

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Session IV: Institutional Capacity and HIV Prevention

In view of Nigeria's declining health care resources and facilities, the seminar organisers consider institutional capacity building a central issue. Seminar participants concurred that HIV prevention efforts depend on the effectiveness of public and private institutions. Intervention efforts must tap the resources of underutilised and community-based institutions while creating incentives to strengthen existing formal institutions at state and local levels.

Professor I. Isuigo-Abanihe of the University of Ibadan began the session with an overview of official HIV prevention efforts in Nigeria and reflections on the meaning and importance of capacity building. Nigeria's National Action Committee on AIDS (NACA) and, under its direction, the HIV/AIDS Emergency Action Plan (HEAP) are charged with bringing together all the relevant sectors of government to coordinate interventions by organisations at community, state, and federal levels. HEAP seeks to create an enabling environment by removing barriers to prevention, care, and treatment while promoting community-based approaches.

Isuigo-Abanihe reviewed the extensive capacity needs of organisations involved in HIV/AIDS activities. These include



needs for relevant skills, accurate information, capacities to conduct monitoring and evaluation, research, advocacy, counselling, medical care, and the efficient use of funds. He emphasised that capacity building at the local level is often neglected despite the fact that community-level mobilisation brings about the greatest sense of ownership and participation. Isiugo-Abanihe pointed to the cautionary example of a foreign-funded capacity-building programme that failed because its top-down approach did not engage the targeted organisations in meaningful ways.

Dr Folarin Olowu of the Intellfit African Training Centre followed with a sweeping presentation on the shortcomings of public institutions in Nigeria, and enumerated the reasons for their poor performance. In Olowu's view, mediocrity has triumphed in many Nigerian public service institutions, low salaries and low expectations are the norm, and the talented have been forced out or have fled. The AIDS crisis cannot be separated from these declines since the affected institutions — hospitals, clinics, dispensaries — are now being called upon to respond to the epidemic.

Public-sector reform and the institutionalisation of HIV/AIDS prevention programming must be harmonised. If the Ministry of Education were to integrate HIV/AIDS training in the curriculum, new teachers would be able to accurately discuss these issues in their classrooms. Such training could be updated every few years. If the National Youth Service Corps were to train and send students to rural communities as HIV/AIDS educators, AIDS awareness in hard-to-reach communities would be increased. This, Olowu said, is how public institutions are supposed to work — by adapting to changing circumstances. Instead, a scattered approach is taken, with private sector institutions trying — and failing — to fill in for the state.

The private sector faces capacity challenges of its own. Olowu divided the NGOs active in HIV/AIDS work into three categories. There are the first-generation organisations, such as the Red Cross and Nigeria Planned Parenthood, that have existed since independence, usually with an international network and a nationwide presence. Second-generation organisations, such as Action Health and the Association for Reproductive Health, have acquired some credibility and are usually indigenous. Finally, third-generation organisations emerged in the late 1990s with limited operating capacity and sometimes opportunistic tendencies. The first-generation

entities have been slow to respond to HIV/AIDS. Their nationwide networks are potentially useful, even though their strength varies from region to region, and there are too many weak links to execute ambitious programming. The second-generation bodies have developed areas of competence but have not been able to project this strength nationwide and replicate successful interventions. Olowu recommends that strong second-generation NGOs mentor third-generation organisations that have similar missions but are too diffuse and ineffectual.

Olowu advanced several recommendations. Nigeria cannot improve AIDS programming without capacity building. He stressed that sustained technical assistance and operational autonomy are greatly needed at the level of the State Action Committees on AIDS (SACA). State-level AIDS responses have been caught up in politics, with funds going to pet NGOs and causes. More generally, merit must again be recognised in institutions, and professionals should be allowed to peak before being drawn into politics. Faith-based organisations have much to contribute, but their top leaders often need reorientation in their attitudes toward AIDS.

During the discussion, participants stressed that good policies on the books often fail to translate into strong programming. In Uganda, fifteen percent of national spending goes to fight HIV/AIDS, whereas in Nigeria it is three percent at the federal level and much lower at state levels. In addition, Nigerian AIDS programming frequently reflects a donor-driven agenda, because Nigeria does not know its own needs well enough to have them shape policy. Several participants supported Olowu and Isiugo-Abanihe's call for intensive capacity building at the state level and for grassroots NGOs. Offering an example, a professor from the University College Hospital described how its HIV/AIDS care unit refers to a list of partner NGOs to call upon when a patient needs legal representation, home-based care, or other services not available at the hospital. This kind of positive networking and division of labour should be encouraged.

Session V: Prevention in the Time of Expanded AIDS Treatment

The expanding availability of antiretroviral (ARV) treatment is altering the HIV/AIDS campaign globally and in Nigeria. While expanding treatment is vitally important, reducing infection rates must remain a central component of Nigeria's

national HIV/AIDS strategy. Explanations of the benefits and limitations of testing should be integrated into prevention messages and attention paid to achieving positive outcomes. Seminar participants identified several ways of updating prevention strategies to reflect the new treatment reality.

Dr B. O. Olley of the University of Ibadan began by observing that prevention interventions aimed at PLWHA have been few and far between, even though infected persons are likely to transmit HIV/AIDS and other sexually transmitted diseases if they have unprotected sex. As increasingly available ARV treatment prolongs the lives of infected persons, their chances of continuing or relapsing into risky behaviour also increase. As far as Olley is aware, little research has been conducted on this subject in Nigeria. Research is urgently needed to determine how the extensive poverty, strong tendency to stigmatise, and other factors specific to the Nigerian context affect the likelihood of PLWHA engaging in unprotected sex.

Olley named six strategies for improving prevention in an era of expanding treatment:

- 1** Strengthen the counselling available at VCT centres to encourage increased testing. The aim is not just to provide drugs but to encourage safer behaviours. These centres should seek to improve the low adherence rate among patients undergoing treatment.
- 2** Promote prevention efforts that pay greater attention to HIV-positive adolescents and young adults with psychological needs. At present, proven interventions are not available to help young people deal with their sexual relationships; issues of disclosure, anger, and depression; and ways of combatting stigmatisation.
- 3** Reduce emotional illnesses among the HIV-positive population. As with young adults, the general PLWHA population has great counselling needs. Psychological care will improve the well-being of HIV-positive persons while increasing their likelihood of practicing safer sex.
- 4** Address safer sex and disclosure as preventive measures for those testing HIV positive. In particular, the counselling that follows positive test results should urge condom use.

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- 5** Tackle stigmatisation and discrimination aggressively. While policy and legal reforms are important, they will have a limited impact if unaccompanied by general changes in social values and expectations. Community mobilisation and activism by PLWHA and their families and friends are valuable strategies. Along with creating a positive environment, reducing stigmatisation will increase testing rates, encourage disclosure, and allow for more objective discussions of the epidemic.
- 6** Empower existing support groups for PLWHA. Improving services for the HIV-positive population and encouraging safer behaviour require a better understanding of the experiences and priorities of these individuals.

In his remarks, **Dr T. A. Adewole** of the Nigerian Institute for Medical Research stressed that treatment must be understood in its proper context. The goals of treatment are to delay progression to AIDS, suppress viral replication, deny opportunistic infections, and reduce hospital stays. Access to such therapy remains extremely low. Currently, less than five percent of Nigerians who can benefit from ARV treatment have access to it. Even for those treated, serious problems persist, such as the still relatively high cost of drugs, toxicity, serious side effects, the high cost of monitoring, low adherence, and the fear of drug stocks running out (as they did in 2003).

The Nigerian government has initiated an ARV treatment programme that aims to provide treatment for 10,000 infected persons. Additional initiatives through the Global Fund, the private business sector, the U.S. Presidential Emergency Plan for AIDS Relief, and others will provide further access to ARV therapy.

In Adewole's view, prevention strategies must include

- developing new prevention strategies (e.g., microbicides);
- crafting prevention messages that are correct and balanced;
- creating an enabling infrastructure, maintained by government, to ensure that drugs are handled correctly by trained professionals, thereby reducing the risk of drug-resistant HIV strains.

The panel's discussant, **Ms Jennifer Cooke** of the Washington, D.C.-based Center for Strategic and International Studies, concurred that treatment must be fully integrated with prevention services. Too often, she stated, it is assumed that ARV drugs are a panacea for HIV-positive persons rather than one aspect of a larger effort to promote healthier lifestyles.

Prevention efforts are put at risk as increasing proportions of international funds for AIDS programmes are reallocated for treatment. These include the World Health Organisation's '3 by 5' Initiative, which aims to provide three million PLWHA in developing and middle income countries with antiretroviral treatment by the end of 2005, and President Bush's Emergency Plan for AIDS Relief (PEPFAR), which aims to bring 350,000 Nigerians into treatment by 2008. This shift in attention can be attributed to the political attractiveness of treatment, which sits outside the intense moral debate that often hampers prevention programming. Drug treatment has the ability to produce demonstrable, and often dramatic, results. A balance, however, between treatment and prevention must be urgently pursued. In fact, the increasing availability of treatment makes prevention more important today since, as in the United States, complacency and increased risky behaviour have followed the greater availability of ARV drugs.

Prevention must be defined beyond the traditional 'ABC' message and viewed not only in the 'operational' sense (condom distribution, prevention of mother-to-child transmission, peer counselling) but also in a 'structural' or longer-term way (building health infrastructure, training health workers, empowering women). Clearly, HIV interventions must be deployed even while the structural factors driving the disease — poverty, gender inequality, violence against women, among others — persist. A key role for researchers, particularly in the social sciences, is to identify the structural factors that directly contribute to the pandemic and the interventions that promise to have the most immediate impact.

During the discussion, **Mr Pat Matemilola**, national president of the Network of People Living with HIV in Nigeria, noted that of the approximately four million HIV-positive Nigerians, only a half million have been tested and know their status. There is a critical shortage of VCT clinics, Matemilola added, and while treatment is important, the pressing problems of poverty, stigmatisation, and discrimination must be urgently addressed. Because many of Nigeria's doctors, attracted by

higher salaries, choose to work in large Nigerian cities or abroad, special incentives must be created, as in the United States, for doctors based in rural areas.

Session VI: Improving Communication and Collaboration among Prevention Actors

While it is important to increase research on the factors driving the epidemic in Nigeria, it is equally important to communicate research findings to those who need the information. Meeting this challenge will require greater 'bridge building' among academics, policy makers, activists, local leaders, and other key persons.

Ms Toyin Afachung, representing Dr Ebun Delano, director of the Association for Reproductive and Family Health, began her presentation by identifying factors that exacerbate the spread of HIV in Nigeria, including sexual networking practices such as polygamy, the high prevalence of untreated STDs, low condom use, poverty, weak health systems, and the low status of women. However, Afachung credited the federal government, donors, and NGOs for stepping up efforts to address these challenges.

While the government's response to HIV/AIDS is crucial, NGOs and community organisations have the capacity to implement an even greater number of projects. Furthermore, society-wide AIDS awareness campaigns can draw on the strengths of these organisations, especially their wide reach and flexibility. Better communication, collaboration, and the sharing of skills and information among NGOs would help ensure that information becomes available and is put to use sooner. Afachung urged greater cooperation among prevention actors, especially between secular and faith-based organisations, and recommended their increased use of efficient and timely Internet-based communication.

Despite its potential, collaboration among NGOs can be difficult because these organisations often shift their focus, their agendas and beliefs may conflict, and they often must compete for the same resources. Yet there are ways to get around such obstacles. For example, an advocacy speaker who visits conservative religious institutions may not openly speak about condoms but could find opportunities to distribute them. Ways must also be found to avoid wasting resources through the duplication of efforts.

KEYNOTE ADDRESS:

'Bringing Prevention Back to the Forefront through Rethinking Prevention Strategies'

In his keynote address, **Professor Femi Soyinka** of the International Conference on AIDS and STDs in Africa (ICASA) and Nigerian Ethics, Law Against HIV/AIDS (NELA), stressed that prevention is still key despite important gains in treatment and care. While early prevention efforts focused on achieving awareness, strategies for achieving behaviour change must now come to the fore. Prevention that is socioculturally based and epidemiologically grounded can achieve positive results while also reducing stigmatisation. Over the years, a number of prevention approaches have been deployed, including improving blood safety, preventing mother-to-child transmission, creating workplace programmes, social marketing of condoms, targeting efforts at vulnerable and at-risk groups, advocating behaviour change through communications, and many others. Now that these approaches have been tried, it is time to assess which ones have worked and what combination best suits a given local environment.

In successful prevention programmes, the first step is to create a positive environment that enables people to make healthy behavioural choices. The efforts of policy makers are key here: AIDS policies and statements must be fully implemented and backed by legal reforms. Soyinka also emphasised that discussions of sexuality need not be clouded by moral debates. While communications should be culturally relevant, controversial steps, such as advocating condom use, must be accepted if they are needed to save lives. HIV/AIDS prevention must also be integrated into the existing health care system.

Prevention requires a long-term national strategy closely connected to grassroots efforts. Soyinka added that each country must determine how it can best structure its prevention response and not just adopt structures prescribed for developing countries. Both monocentric and multicentric approaches have their advantages. It seems that Nigeria has chosen the former, with NACA as the centrepiece, based on foreign directives and without considering the local

While early prevention efforts focused on achieving awareness, strategies for achieving behaviour change must now come to the fore.

implications. Soyinka also said that the Nigerian government lacks the economic motivation to tackle HIV/AIDS aggressively — a situation that stands in contrast to China's vigorous response to the SARS crisis as soon as business interests were jeopardized. Soyinka expects that the convening of ICASA in Nigeria in December 2005 will turn the spotlight on the HIV/AIDS crisis and how it is being tackled.

In the question-and-answer session, several members of the audience took up the issue of morality and its place in prevention interventions. 'How can we,' John Anarfi asked, 'rule out morality in dealing with something that kills' and

when many prevention measures — having fewer sex partners, refraining from coercive or commercial sex, improving dynamics between discordant couples — have moral dimensions. Better dialogue with faith-based organisations inevitably involves engaging their moral concerns. In contrast to Soyinka's stress on personal choice, several participants said that morality can be used to promote positive behaviours such as abstaining from sex, delaying sexual involvement until adulthood/marriage, and having fewer partners. They agreed, however, that if morality is brought in, it must be done without increasing the stigmatisation of infected persons.

One participant criticised the Nigerian federal government's handling of HIV/AIDS funding, noting that it is difficult for federal programmes and funds to be effective at the local primary-care level. State-level structures could be effective but lack the mandate to receive and direct the use of such funds. It is also a mistake to place population commissions under the President's Office. Another participant criticised the government's decision to pay for a significant portion of its HIV/AIDS activities through a World Bank credit that came with cumbersome procedures and a short time frame.

Following the keynote address, **Dr Katy Cissé Woné** of the Council for the Development of Social Science Research in Africa (CODESRIA) briefly explained how Senegal has been able to keep its HIV-infection rates from rising. She stressed that HIV remains a problem in Senegal, demanding constant vigilance. Factors in Senegal's success include its early

response, high-level political leadership, good dialogue with Muslim leaders, political stability, the traditional strength of NGOs in many sectors, cooperation between the medical and religious communities, legalised prostitution and regular medical checks of commercial sex workers, and a strong blood-safety system.

Session VII: Building Capacity for Policy-Relevant Research

Improving the design, execution, and impact of AIDS programmes requires increased local research and monitoring capacities. This in turn requires the training of Nigerians in order to ensure that research and recommendations are grounded in local realities. Participants in this session also suggested how the research community can expand its contributions to meet the challenges discussed in earlier sessions.

Professor Ogoh Alubo of the University of Jos began by describing recent progress in Nigeria. Official discussions, he noted, are more open; the ending of military rule in 1998 has fostered greater cooperation with international partners; media publicity has increased; and the overall amount of activity devoted to the epidemic has dramatically expanded at federal, state, and local levels. However, the focus in Nigeria remains overwhelmingly biomedical, resulting in the marginalisation or total neglect of psychological, social, and cultural interventions. Alubo urged that there be more research on the lives of infected persons, their families and communities, their economic responsibilities, and their social contexts. Two cross-cutting issues, he added, must feature prominently in research on HIV/AIDS in Nigeria: poverty and gender relations.

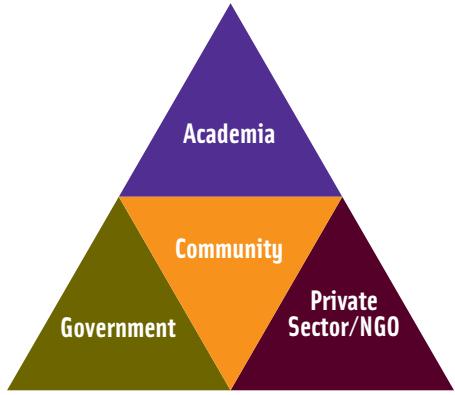
The agenda for policy-relevant research is extensive. Alubo advocates disaggregating the data on prevalence rates so that individual groups (for example, teachers, farmers, military personnel) can understand their vulnerability and contribute to designing interventions that pertain to them. Research gaps include nutritional guidelines for PLWHA that reflect local diets and low-cost care options. He also stressed the importance of better understanding the socioeconomic implications of several factors: rising infection rates, the number of funerals, increased care, orphans, and hard-hit professions. Similarly, conducting HIV/AIDS impact assessments for certain sectors would enable institutions to be better prepared and to scale up preventive measures.

Dr Oka Obono of the University of Ibadan compellingly analysed the role of policy-relevant research in academia and society and described how Nigeria's capacity to conduct research may be increased. Early in his presentation, Obono called for 'building capacity to build capacity'. In other words, indigenous organisations need skills and information to evaluate capacity-building programmes before deciding which are right for them. This is vital since such programmes often come about through intrusive interventions by external actors who have their own agendas. Endogenous will to achieve the intended outcomes — not just recognition of the need — must truly exist. Obono stressed that capacity building should be tied to specific functions so that improvements in performance can be tracked.

He also said that academics engaged in policy-relevant research have the responsibility of advancing their findings. If results are the goal, researchers must present their findings in ways that make them accessible to their communities. They should meet with local opinion leaders and take other measures to ensure that the maximum benefit is derived from their work; simply submitting bound copies of their reports is not enough. Moreover, to be able to advance AIDS prevention, the research involved would have to be transdisciplinary, integrate top-to-bottom and bottom-to-top approaches, and take the complexity of systems — including locally relevant research ethics — into account.

As illustrated by the 'synergy of energies' in Obono's 'capacity building triangle', government, NGOs, academia, the private sector, and local communities all have important roles to play. Each has different types of activities to which they are best suited, but they cannot remain separate from other key actors. For example, academics must consult regularly with all the other groups at the conceptualisation, implementation, and dissemination stages of their research. Government must help provide an enabling environment and allow research to inform policy making. NGOs and grassroots organisations should have opportunities to contribute to setting research agendas and to monitor the implementation of recommended policies and programmes. The community is often the 'mute partner' in research programmes when it should be a lead stakeholder, at the triangle's centre, in all stages of research, policy-making, and intervention processes.

In the discussion that followed, the university professors observed that the 'publish or perish' mindset often stands in



the way of conducting policy-relevant research. Appropriate training for policy-relevant work is also lacking. Several participants emphasised the importance of researchers focusing on policy implementation processes rather than just on policy making, which often remains rhetorical.

Concluding Remarks: The Road Ahead

In the final session, **Professor Richard Joseph** initiated discussion of plans for an international social science research programme that would advance HIV/AIDS prevention in Nigeria.

Based on the seminar proceedings, Joseph sketched a collaborative initiative that would be led by Northwestern University and the University of Ibadan, and whose initial phase would extend over three years, 2005–08. It would be cross-disciplinary and involve researchers from Northwestern, institutions across Nigeria, and other sources of expertise.

Research would begin with a baseline survey of selected communities that would include the following steps:

- Profile and evaluate existing prevention interventions.
- Identify authority structures and figures and gauge their current and potential involvement.
- Assess current modes of collaboration among relevant actors.
- Identify the community prevalence rates and assess the accuracy of the data.
- Disaggregate communities and identify at-risk groups in ways that do not contribute to stigmatisation.
- Determine the amount and quality of VCT services available and assess the current integration of prevention, treatment, and care services.

Based on the information gathered, researchers and the targeted communities would then jointly design projects.

To ensure the policy relevance of its research, the programme would do the following:

- Facilitate, monitor, and assess the implementation of its recommendations.
- Mobilise local, state, and national officials, the media, and other influential actors behind the findings and recommendations.
- Incorporate experts from a range of academic fields (law, business, journalism) and nonacademic professionals (activists, journalists, NGO activists) in the research teams to widen the pool of expertise.
- Include a training component in the research projects, thereby increasing the number and skills of researchers working on HIV/AIDS in Nigeria.

The programme would ‘brand’ itself by insisting on the highest level of commitment, cooperation, quality, transparency, and adherence to research ethics, and the production of usable and innovative findings.

Participants reacted positively to this outline and offered additional points, including perhaps the most critical: treating the community as a research partner. Community-based research inherently requires active participation by the community that is the subject of research. Programme researchers would need to think of offering incentives to garner positive and proactive participation by all segments of the local population. The research must benefit directly the targeted community, and this benefit should be clearly articulated. The norms of research ethics must be both international and locally relevant. Review boards at Northwestern and Ibadan should be sensitive to these issues.

While studying communities, researchers must avoid stigmatising high-risk groups. They must seek to identify local institutions, study how they perform, and determine the contributions they can make. Bridges with policy makers must be built and carefully maintained. The programme organisers will need to decide whether to target spatial communities such as a given town or collection of villages, nonspatial communities such as a certain profession or demographic group, or perhaps a combination of both. To create a sustainable partnership, other crucial issues include securing the commitment of university leadership, ensuring the flow of adequate financial resources, creating transparent operating procedures, and designing an explicit and shared agenda.

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