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COMMUNITY PERCEPTIONS OF PREVENTION OF MOTHER-TO- CHILD TRANSMISSION SERVICES AND SAFE MALE CIRCUMCISION IN SIX FOCAL STATES IN NIGERIA

AIDSTAR-One
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ACRONYMS

ANC	antenatal care
ARV	antiretroviral
BCC	behavior change communication
CADRE	Centre for AIDS Development, Research and Evaluation
FCT	Federal Capital Territory
FGD	focus group discussion
IDI	in-depth interview
MTCT	mother-to-child transmission
PMTCT	prevention of mother-to-child transmission
SMC	safe male circumcision
TBA	traditional birth attendant
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
VCT	voluntary counseling and testing
WHO	World Health Organization

EXECUTIVE SUMMARY

In Nigeria, only 28 percent of women and 39 percent of men know that the risk of an HIV-positive pregnant woman transmitting the HIV virus to her unborn child can be reduced by taking certain drugs during pregnancy (National Population Commission and ICF Macro 2009). About 58 percent of pregnant women receive antenatal care (ANC; United Nations Children’s Fund 2010) and the usage of prevention of mother-to-child transmission (PMTCT) services has only reached 12 percent. In addition, unsafe male circumcision practices taking place outside of health facilities are a major concern.

This study is undertaken to explore community perceptions of PMTCT and safe male circumcision (SMC) services and to identify barriers to uptake of services. In addition, the study explores attitudes and barriers regarding male partner involvement, which evidence suggests increases women’s participation in and adherence to PMTCT services, and improves infant health outcomes. The study will inform the development of behavior change communication messages to promote PMTCT and SMC at selected focal local government areas in a few states that can later be replicated across Nigeria. It will also identify key messages, the best communication channels for reaching target audiences, and delivering these messages.

The research took place in the states of Benue, Cross River, Sokoto, Bauchi, Lagos, and the Federal Capital Territory, in three local government areas per state. The study consisted of 50 key informant interviews (including male and female community leaders, religious leaders, ANC/PMTCT nurses/doctors, and PMTCT desk officers), 35 focus group discussions (including 16 groups of married men of reproductive age, 12 groups of married women of reproductive age, and 7 groups of women attending antenatal clinics), and individual in-depth interviews with 17 traditional birth attendants and 12 HIV-positive women.

Findings from the focus group discussions, in-depth interviews, and key informant interviews around PMTCT and pregnancy include the following:

- There was a strong desire for a “healthy pregnancy” among both women and men, as well as a good understanding of the importance of diet and regular prenatal checkups during pregnancy.
- Men perceive their role in the pregnancy as caring for the wife, financially supporting her, relieving her of some of the burden of domestic work, and making sure she gets to the clinic.
- Many of the men see no reason to accompany the wives to ANC. Barriers to men’s involvement include that men have to work, the perception that ANC is a woman’s affair, that it is not a regular occurrence in the culture, and that the man will be perceived as “weak” by his peers. Other barriers mentioned by the women include fear of being tested for HIV and not wanting to spend the money.
- ANC services need to be more “male-friendly” to encourage more men to attend with their spouses.
- Doctors and community leaders are best suited to engage men and women in discussions of pregnancy-related issues as they are the most trusted and respected sources of information. Religious leaders, heads of households, and leaders of community-based organizations had low

knowledge of PMTCT (Arulogun et al. 2007), therefore, for them to be effective as messengers for providing information, interventions need to be implemented to increase their level of knowledge.

- Fear of stigma and discrimination remain major obstacles to disclosure of HIV status.
- Awareness of PMTCT methods and services is high among women and men. Women receive information from ANC visits or radio broadcasts.
- Fear of stigmatization and “shame,” the husband’s attitude, confidentiality, lack of awareness, illiteracy, and poor attitude of hospital staff were mentioned as barriers to participating in PMTCT programs.
- Most men indicated that they would support their wives to take antiretroviral drugs to ensure that the baby is born free of HIV, especially if the drugs are at no cost.
- Offering encouragement such as nutritional aids and financial assistance could help keep women in PMTCT programs and adhere to treatment regimens, as well as forming support groups, home visits, and ensuring absolute patient confidentiality.
- Most women feel that husbands would be unsupportive and unhappy if their wives did not breastfeed.

The preliminary recommendations for PMTCT messages are:

1. HIV education programs should emphasize effectiveness of the interventions available for PMTCT.
2. Health workers and community leaders would be most effective at disseminating information to the target audience and educating women and men on PMTCT, as they are perceived as credible and trustworthy.
3. Interventions need to be implemented to increase the level of knowledge of community leaders to make them effective educators and advocates for PMTCT. All of the key informants interviewed (including religious leaders and male and female community leaders) expressed their willingness to relay accurate information to community members on PMTCT.
4. ANC services need to be made more male-friendly to encourage more men to attend with their spouses. The clinics should offer specific activities in which men can participate and try to adjust clinic hours to accommodate men’s schedules. Community leaders can help raise awareness among community members of the benefit of men participating in ANC with their spouses, along with radio messages.
5. PMTCT services should be available for all women who need it and should have a community outreach component to increase awareness and support.
6. Stigma has been identified as a major deterrent to the use of PMTCT services. Appropriate messages and other interventions must be developed and implemented nationwide to reduce stigma, thereby increasing uptake of PMTCT. Community sensitization is needed to help reduce stigma.
7. PMTCT services should be free and, where possible, women should be encouraged in various appropriate ways to adhere to the program.

8. Ensuring patient confidentiality is critical to overcome the mistrust of health workers that is serving as a deterrent for some women to participation in PMTCT.

Findings from the focus group discussions, in-depth interviews, and key informant interviews around male circumcision include the following:

- Overwhelmingly, participants said that the male child should be circumcised.
- The age at which circumcision is carried out varies according to ethnic background and religion. Age at circumcision ranges from immediately after the naming ceremony to seven years of age.
- Most participants in the study prefer to have doctors or nurses perform the circumcision in a hospital setting for health reasons. However, several participants in Bauchi and Sokoto prefer traditional *Wanzamai* in the home.
- The decision and arrangements regarding the son's circumcision is primarily the father's responsibility.
- While many of the participants indicated that they would most trust doctors and health workers for information on SMC, some of the men, particularly in the northern states, felt that the traditional leaders would be the best sources of information on SMC.

The preliminary recommendations for SMC messages are:

1. Nigerians are already circumcising their sons. The focus of behavior change communication messages should be on promoting earlier age for circumcision and safe medical male circumcision performed by a trained health care provider in a health facility.
2. It is important to respect the traditions of the communities who prefer *Wanzamai* while ensuring that procedures are medically safe. Traditional leaders need to be engaged in discussions. One option may be to incorporate some of the traditions that go along with the circumcision into the medical male circumcision in the health care facility, either before or after the surgery, or have the traditional circumciser present during the medical procedure. The *Wanzamai* should also be trained on safe medical procedures.
3. Fathers will be the primary audience in the strategy as they are the real decision makers in the family regarding the son's circumcision. Grandfathers and mothers will be secondary audiences. Doctors, health workers, traditional leaders, and community leaders will be best suited to deliver the messages on SMC.

BACKGROUND

In early 2011, the U.S. Agency for International Development (USAID)/Nigeria requested that AIDSTAR-One expand its scope to include the development of behavior change communication (BCC) messages to promote services for prevention of mother-to-child transmission (PMTCT) and safe male circumcision (SMC) to prevent the spread of HIV. The AIDSTAR-One team determined that formative qualitative research was needed to identify service gaps, key messages, and optimal channels for delivering messages to the target audiences.

The BCC messages to be developed aim to achieve two major goals: increased utilization of, and adherence to, PMTCT services, and safer practices related to male circumcision in focal northern states. Because evidence suggests that male partner involvement increases women's participation in and adherence to PMTCT services, and improves infant health outcomes, the communications messages will seek to increase men's engagement in antenatal care (ANC) and PMTCT services.

According to the United Nations Children's Fund (UNICEF), about 58 percent of pregnant women in Nigeria receive ANC (UNICEF 2010). According to the 2008 Demographic and Health Survey, only 28 percent of women and 39 percent of men in Nigeria know that the risk of an HIV-positive pregnant woman transmitting the HIV virus to her unborn child can be reduced by taking certain drugs during pregnancy (National Population Commission and ICF Macro 2009). In Nigeria, the usage of PMTCT services has only reached 12 percent. This study was designed to examine perceptions, attitudes, opportunities, and barriers related to PMTCT services. Results will inform the development of BCC messages to promote PMTCT at selected focal local government areas in a few states that can later be replicated across Nigeria.

PURPOSE

The purpose of this study is to explore community perceptions of PMTCT services, identify barriers to uptake of services, as well as attitudes and barriers regarding male partner involvement. In addition, the research conducted explored community perceptions of SMC. The rate of male circumcision is very high in Nigeria at 98 percent across all geopolitical zones (UNICEF 2010). However, unsafe practices in non-health facility-based circumcisions are a major concern. The research findings will be used in developing BCC messages to increase uptake of PMTCT services and in promoting SMC practices at selected local government areas in six focal states that can then be replicated across the country. The study also aimed to identify key messages needed to promote SMC as well as the best communication channels for reaching target audiences and the best channels for delivering these messages.

LITERATURE REVIEW

In February 2011, AIDSTAR-One conducted a literature review. The review consisted of a search for journal articles, recent research studies, and project reports from Nigerian stakeholders, as well as international agencies (e.g., the World Health Organization [WHO], the Joint United Nations Programme on HIV/AIDS [UNAIDS], and USAID), that could shed light on issues of participation in, and adherence to, community-based PMTCT in Nigeria, and in particular issues of male partner involvement. The literature review included 27 articles on both PMTCT- and SMC-related issues. The search was focused on Nigeria first, and then broadened to other sub-Saharan African countries where any studies had been conducted specifically on the role of male partner involvement in uptake of PMTCT and SMC. This section provides a brief synopsis of the literature review, organized by themes.

PREVENTION OF MOTHER-TO-CHILD TRANSMISSION

While the literature review revealed a number of interesting studies on PMTCT uptake, barriers, and adherence from other countries such as Tanzania and South Africa, very little was found for Nigeria.

BURDEN OF HIV IN WOMEN AND CHILDREN

Women and their children comprise about half of the global burden of HIV. Worldwide, approximately 39.5 million people are living with HIV, including an estimated 17.7 million women and 2.3 million children under the age of 15 (UNAIDS and WHO 2007). An estimated 430,000 children were newly infected with HIV in 2008, over 90 percent of them through mother-to-child transmission (MTCT). Without treatment, about half of these children will die before their second birthday. The majority of these infections are preventable. With specific interventions in non-breastfeeding populations, the risk of MTCT can be reduced to less than two percent, and in breastfeeding populations to five percent or less (WHO 2010). Without intervention, the risk of MTCT ranges from 20 to 45 percent.

In Nigeria, the estimated number of children under age 14 living with HIV is 360,000, and the estimated number of pregnant women living with HIV is 210,000 (National Agency for the Control of AIDS 2010). To prevent the transmission of HIV from mother to baby, WHO promotes a comprehensive approach which includes four components: primary prevention of HIV among women of childbearing age; preventing unintended pregnancies among women living with HIV; preventing HIV transmission from a woman living with HIV to her infant; and providing appropriate treatment, care, and support to mothers living with HIV and their children and families (WHO 2010).

BARRIERS TO UPTAKE OF SERVICES

In a review of social mobilization and communication in support of PMTCT in South Africa, barriers to PMTCT identified were classified into societal, social network, and individual barriers

(Centre for AIDS Development, Research and Evaluation [CADRE] and UNICEF 2009). The “societal barriers” (or systemic barriers) include poor health care worker attitudes, poor quality of counseling and information, shortage of skilled health staff, poverty, and poor referral links, among others. “Social network barriers” include social stigma, male partner involvement, and gender-related issues. “Individual barriers” refer to lack of awareness and knowledge, confusion around infant feeding options, and such psychological barriers as fear of HIV testing, denial, and shame (CADRE and UNICEF 2009).

According to a 2010 UNAIDS report, in the 25 countries with the greatest number of pregnant women living with HIV, the percentage receiving HIV testing and counseling varied greatly: more than 95 percent in South Africa and Zambia, 13 percent in Nigeria, and 6 percent in Chad (UNAIDS 2010).

According to UNICEF, only 58 percent of pregnant women received ANC and 39 percent were assisted by skilled birth attendants at delivery. These numbers reflect marked disparities in care according to wealth and residential status (UNICEF 2010).

Studies in Nigeria show that voluntary counseling and testing (VCT) resulted in high acceptance of HIV screening (Aboyeji, Fawole, and Ijaiya 2004). The majority of the women accepted antiretroviral (ARV) drugs and decided not to breastfeed to prevent MTCT as opposed to choosing caesarean section (Abiodun et al. 2008). Refusal of VCT was attributed to stigma associated with HIV, and male partner participation was an influential factor in the participants’ willingness to accept VCT.

In resource-limited settings, male partner involvement in antenatal VCT has been shown to increase uptake of interventions to reduce the risk of HIV transmission. The literature review found several studies in Tanzania highlighting the importance of men’s involvement. For example, in Tanzania despite achievement of PMTCT—a high acceptance rate of 85 percent—a number of challenges were identified that impact the effectiveness of the program. These include poor male partner involvement, low uptake of ARV prophylaxis, and poor community participation and support. In the study, 74.6 percent of the men were not willing to participate in PMTCT programs by accompanying their wives to antenatal clinics due to being too busy (25.2 percent), cultural reasons (21.4 percent), and lack of knowledge of the importance of the program (21.4 percent), and 15.5 percent perceived ANC services as women’s affairs (Boniphace 2010). In another study of male involvement in PMTCT services in Tanzania’s Mbeya region, although all the respondents generally accepted PMTCT interventions, barriers to involvement included lack of knowledge/information, no time, neglected importance, the services representing a “female responsibility,” or fear of HIV testing result (Theuring et al. 2009).

To be successful, PMTCT programs must include strategies to reduce stigma by engaging opinion leaders at the community level, normalizing HIV, and facilitating access to services by women living with HIV (WHO 2010). A number of studies have shown that a lack of awareness and understanding by communities is a major barrier to uptake of PMTCT services, and community leaders can play a key role in mobilizing members of their communities to access services (CADRE and UNICEF 2009). In a study on community gatekeepers’ awareness and perception of PMTCT services in Ibadan, Nigeria, it was reported that opinion leaders made up of religious leaders, heads of households, and leaders of community-based organizations had low knowledge of MTCT and PMTCT services, and community sensitization on the issue was inadequate (Arulogun et al. 2007).

SAFE MALE CIRCUMCISION

HIV remains an important public health problem in sub-Saharan Africa (UNAIDS and WHO 2007). Promoting effective interventions that prevent new infections and control the epidemic is a priority. Between 2005 and 2007, three randomized controlled trials conducted in Kenya, South Africa, and Uganda conclusively demonstrated dramatic reductions in HIV risk for men following voluntary medical male circumcision (Auvert et al. 2005). Based on these results, WHO and UNAIDS issued recommendations in 2007 for scaling up voluntary medical male circumcision in African countries with high HIV prevalence and low levels of male circumcision. Fourteen Eastern and Southern African countries were identified as high priority. These priority countries are at different stages of scaling up voluntary medical male circumcision as an additional, and important, strategy to prevent HIV transmission. In countries like Nigeria where traditional male circumcision has been practiced for centuries, safety of practices is a serious concern. In addition, male circumcision in a medical setting may not be acceptable to all communities in these countries (WHO and UNAIDS 2007b).

Male circumcision is the surgical removal of some or all of the foreskin (or prepuce) from the penis (Alanis and Lucici 2004; Doyle 2005). There is compelling evidence that male circumcision reduces the risk of heterosexually acquired HIV infection in men by approximately 60 percent (Auvert et al. 2005). As male circumcision provides only partial protection from HIV, WHO and UNAIDS recommend a minimum package of services to accompany the surgery, including HIV testing and counseling, sexually transmitted infection diagnosis and treatment, sex education and counseling, and condom promotion (WHO and UNAIDS 2007a). Circumcision, when conducted in medical settings with full adherence to medical ethics, is termed medical male circumcision.

Globally, 30 to 34 percent of men are circumcised (WHO and UNAIDS 2007b). Most circumcisions are performed for cultural or religious reasons during adolescence, outside the formal health care setting. In sub-Saharan Africa, circumcision rates vary from 15 to 80 percent of men (WHO and UNAIDS 2007b). When done in adolescence, circumcisions are typically rites of passage. The ceremonies test the adolescents' tolerance to pain. As observed by the author of this report, circumcisions are performed without anesthesia, without the use of sutures to prevent hemorrhages, and often using a single cutting instrument (of unknown sharpness and sterility) for multiple boys.

In Nigeria, neonatal circumcision is most common (WHO and UNAIDS 2007b). A survey carried out in Ibadan in western Nigeria showed that 80.7 percent of neonatal circumcisions were performed in hospitals. The remaining 19.3 percent were done at home. The surgeries were performed by nurses (55.9 percent), doctors (35.1 percent), and traditional circumcisers (9 percent). The survey found a 20.2 percent complication rate (Okeke and Asinobi 2006). Although the rate of circumcision across the country is very high, the northern zone performs circumcision rather late (age seven and older) in an unhygienic manner, generally at home rather than at a hospital, using one single knife for a group of boys by a traditional circumciser.

Male circumcision is a sensitive issue largely due to sociocultural and religious reasons. To preserve the sociocultural importance of the circumcision process, and improve safety and acceptability of the procedure, clinical providers need to engage community leaders, be mindful of the significance attached to traditional circumcision, and respond to leaders' concerns. For example, in the Bophelo Pele Project in Orange Farm, South Africa, traditional initiations were incorporated into the medical male circumcision program. The community agreed that the boys would have the safer medical procedure performed by a skilled doctor in a health facility, as long as it could be conducted in

groups with a traditional circumciser present, thereby preserving the cultural significance (Lissouba et al. 2010).

Safe medical male circumcision advocates must find ways to deliver appropriate resonant messages that will take into account prior perceptions and use the most appropriate means of communicating the value to different target audiences. Studies have shown that while acceptability of male circumcision is high in all geopolitical zones within the country, communication campaigns will be more effective when targeted to particular communities where it is done late (older than seven years) and in an unhygienic manner.

METHODOLOGY AND SAMPLE DESCRIPTION

The research study took place in the states of Benue, Cross River, Sokoto, Bauchi, Lagos, and the Federal Capital Territory (FCT), with three local government areas per state included. The first phase of the study began in February 2011 with 50 key informant interviews. The key informants included male and female community leaders, religious leaders (both Muslim and Christian), ANC/PMTCT nurses/doctors, and PMTCT desk officers. These groups were selected because they are knowledgeable about community activities and are closely linked to the target audiences. For the full report of the key informant interviews, see Appendix A.

The second part of the research study—with which this report is concerned—was conducted in September 2011. Following a training in Abuja for focus group discussion (FGD) moderators and note-takers, a total of 35 FGDs were conducted. The groups included 16 groups of married men of reproductive age, 12 groups of married women of reproductive age, and 7 groups of women attending antenatal clinics. The group discussions were held at church compounds, community centers, hospital premises, and local government offices. Groups were conducted by a trained moderator and note-taker using a topic guide. The topic guides for the different subgroups varied slightly (see Appendix B for sample topic guide). Participants were compensated for their time with snacks and drinks, as well as a stipend at the end of the discussion.

The research team determined that traditional birth attendants (TBAs) and HIV-positive women would not feel comfortable talking in the focus group setting. Therefore, individual in-depth interviews (IDIs) were selected as the more effective methodology for engaging TBAs and HIV-positive women. IDIs were conducted with 17 TBAs and 12 HIV-positive women (see Appendix C for schedule of FGDs and IDIs).

All groups and interviews were recorded, and informed consent was obtained from all participants.

ETHICAL CONSIDERATIONS

This study was reviewed and approved by the National Health Research Ethics Committee of Nigeria on August 5, 2011. The study design had confidentiality protections incorporated in its planning and implementation. All participants gave informed consent.

DATA ANALYSIS METHODS

Immediately following each FGD and IDI, the moderators and note-takers summarized the discussions, paying particular attention to any themes that emerged, and looked for similarities and differences within groups.

The tapes were transcribed as soon as possible after the FGD or interview. Analysis was done manually. Following the research questions as guides, every line, paragraph, or other section of text was coded for relevant themes or idea clusters. The researchers repeatedly read through the transcripts taking note of more detailed themes within larger themes, while highlighting the relevant quotes.

KEY FINDINGS ON PREVENTION OF MOTHER-TO-CHILD TRANSMISSION

A number of interesting themes related to pregnancy and PMTCT emerged during the FGDs and IDIs. The major importance given to a “healthy pregnancy” by both women and men was a consistent theme that will be discussed in this section. The supportive role that men play during their wives’ pregnancy was another consistent theme. Yet for many, this supportive role does not include accompanying wives to ANC, with ANC perceived as being for women only. While awareness of PMTCT and PMTCT services was high among women and men, accessing PMTCT services is often hampered by fear of shame and stigmatization. Men will support their wives in taking ARVs during pregnancy if it means the baby will be born healthy. The importance given to the health of the new baby, above all, was a consistent theme that emerged and will be discussed in this section.

KNOWLEDGE AND ATTITUDES REGARDING HEALTHY PREGNANCY AND PRENATAL CARE

For the vast majority of participants, pregnancy is a fulfillment of marriage. For all groups, healthy pregnancy is a priority. Most participants associate “healthy pregnancy” with eating the right foods (fruit is mentioned most often) and going to ANC for checkups. Some participants also mention personal hygiene and avoiding stress as being a part of healthy pregnancy.

“If my wife happens to be pregnant, my first thought is her health. Then secondly, I will pray for God to provide me with money so that I will provide her with food that will build her body.”

–Married man, FCT

“For me, if I am pregnant I’ll visit the hospital for checkup so that they will know if there is anything wrong with me.”

–Woman attending ANC, Sokoto

“Eating a balanced diet can help keep the baby healthy.”

–Married woman, Sokoto

MEN’S ROLE IN WIFE’S PREGNANCY AND ANTENATAL CARE

Most men viewed their role as one of offering support, “sympathy,” and care for their pregnant wife; making sure she goes to the clinic; and financially providing for her pregnancy-related needs

(e.g., food and medicine). The majority also saw their role as relieving the wife of “stress” and reducing the burden of household work during pregnancy.

“For me when my wife is in such stage, first of all I make sure that she has registered at the prenatal care clinic so that she will be checked at all time, and another thing is that I help her in the domestic work because of the big tummy she cannot bend down. I also have to make sure that my house is always filled with fruit.”

–Married man, Cross River

“You know when a woman is pregnant you make her minimize from the hard labor then you carry part of it. For instance breaking of firewood will now be your responsibility since the woman is now pregnant because once she is doing hard labor, she is likely wise to have a miscarriage because of the hard labor.”

–Married man, Benue

“One of the roles when the wife is pregnant in the house, he must take good care of her, give her money all she need if she wants shopping she can go shopping buy plenty of fruits because as a pregnant woman she is supposed to eat fine well, so that the joy of her feeding fine when people look her outside they will say the husband is really taking good care of her.”

–Married man, Cross River

MEN’S INVOLVEMENT IN ANTENATAL CARE: BARRIERS TO INVOLVEMENT AND MOTIVATING MEN TO ACCOMPANY WIVES

While the men in general agree on their supportive role in their wives’ pregnancy as stated previously, opinions vary on whether they should accompany their wives to ANC. In the Cross River and Benue regions, husbands felt it was important to accompany their wives to ANC to understand what care is needed and the financial obligations.

“It is important for the husband to follow the wife to hospital most especially those women who are not educated the man will be there to direct her on what to do and to go, even as the last speaker said he has to finance whatever, accept the bills.”

–Married man, Benue

In the Sokoto and Bauchi regions in the north, however, men saw no need to accompany their wives to ANC. The most common reasons for not accompanying the wife to ANC included not having time due to work, the perception that ANC is for women only, it’s “not in the culture” for men to go along, and that the man will be perceived as “weak” by his peers.

“It is not advisable to follow your wife to the antenatal clinic, since you may not be allowed in to see the doctor with your wife and you will be outside mingling with a lot of women, which is not equally advisable since this is against Islamic belief.”

–Married man, Sokoto

“Since the husband is the bread winner of the family, he cannot stay throughout the ANC with his wife because it takes long hours. Like myself, I only drop my wife and leave for work. When she is through she calls and I come to pick her.”

–Married man, Bauchi

“It is not in our culture. If you start following your wife for ANC, people will start saying, ‘look at this weak man following his wife everywhere,’ they will say the woman has hooked him completely.”

—Married man, Bauchi

Female participants gave other reasons for why husbands do not accompany their wives to ANC. Several women said that men fear they will be tested for HIV at the clinic. Others felt their husbands were unwilling to spend the money.

“Men do not usually want to accompany their wives for antenatal visits because they do not want to be tested in the hospital.”

—Married woman, Sokoto

When participants were asked what might convince husbands to accompany their wives to ANC, many of them—both women and men—said that men would be encouraged to go if their presence is requested specifically by the doctors. Several participants also mentioned that if the doctors would offer the men a medical checkup, they would be more motivated to attend ANC. A few participants felt that religious leaders could convince the men to accompany their wives.

“...Only if the doctor writes a directive and sends to the husband. Then he will go.”

—Woman attending ANC, Bauchi

“The only thing that can convince us is when they say if the doctor check the wife and also check the men then it will encourage men to go...but the situation where you go and you remain outside, maybe your wife undergoes the checking, you go without checking. What is the essence of you going?”

—Married man, Benue

“Religious leaders like Imams and Pastors should enlighten these men. It will help.”

—Married man, Bauchi

ENGAGING MEN AND WOMEN IN DISCUSSION OF PREGNANCY ISSUES

Most respondents felt that doctors and community/traditional leaders would be best suited to hold pregnancy-related discussions with both the men and women, as they are the most trusted and respected sources of information. Participants felt the best places to hold these discussions would be community gathering places like town halls, mosques, chief's palace, and schools.

“The doctors will be most trusted because they will be able to explain correctly.”

—TBA, FCT

“The most suitable person to do the enlightenment to the men should be the Yerima (prince) of the village.”

—TBA, Sokoto

ATTITUDES TOWARD HIV TESTING AND DISCLOSING HIV STATUS

Participants were asked why they would choose to be tested for HIV. The respondents who chose to be tested gave the following reasons:

- To know their status
- To enable them to seek treatment
- Engaging in risky behavior
- Reassurance of treatment that prevents death if they test positive
- To free them from the anxiety of not knowing their status.

“If you are tested positive that is not the end of your life, so there are still some other things to do, to be managed so that is why like some of us we were afraid but when we start hearing this message so we were encouraged to go for the counseling and testing.”

–Married man, Cross River

“If you do not know that the virus is in your body, it will keep eating you up. But if you have a test and you know, you can start taking drugs to keep you healthy.”

–Married man, Bauchi

Most of the respondents expressed unwillingness to disclose HIV status for fear of being stigmatized, discriminated against, and rejected.

“...Everybody will run away from that person because they will think that if they move near they will be infected.”

–Married man, Lagos

Many of the respondents described the treatment received by people living with HIV in the community as “rejection” and “abandonment” and avoiding contact with those infected. A few, however, said that those with strong spiritual beliefs would care for people living with HIV. Other felt that most people are more educated about HIV and are more caring toward those living with HIV.

“The only persons that can continue to having dealings with HIV patient are those with fear of God, who know that God decides on the affairs of men.”

–Married woman, Sokoto

“Well formerly when somebody had that disease people don’t even go close, but now because of the awareness they say make the patient happy, don’t go far away from the patient...even if he’s eating, you join hands and eat and make the patient feel at home.”

–Married man, Cross River

AWARENESS OF PREVENTION OF MOTHER-TO-CHILD TRANSMISSION AND SERVICES

Both men and women were asked what a pregnant woman can do to prevent HIV transmission to her baby. Among the women participating in the focus groups, awareness of PMTCT was high. Most female participants mentioned taking drugs to prevent transmission, as well as avoiding breastfeeding. A few women, however, believed that as HIV is “in the blood,” the baby could not be protected.

“Except with divine intervention, the baby must contact the virus since it is feeding from the infected mother regardless of the PMTCT program...as long as the pregnant woman is infected, there is no way she will not transfer it to the child because it’s in the blood.”

–Married woman, Sokoto

Most male participants were aware of drugs that the pregnant woman can take to prevent transmission to the baby. A few mentioned that when the woman is ready to give birth, she should go to the hospital and the doctors will know what to do so that she does not transmit the virus to the baby.

“We know that they give medications at the hospital that can prevent the child from getting infected. The best way out is for the mother to seek medical advice from experts who may tell her the way out.”

–Married man, Sokoto

“I think we have been listening to network news, there is an advert that before news end, they usually do it every day...There is a woman who said, I was pregnant and earlier went for HIV counseling and testing and was discovered HIV-positive...I started going to PMTC services, nine months later, I had my baby and the child was tested free, I’m born free and the child himself will say I’m born free...So you see, with those kind of advert, we should be able to encourage pregnant women to go to those counseling and testing center...So if you are tested positive, we encourage you to go for daily counseling or maybe ANC treatment and all that, so that transmission to your child can be prevented.”

–Married man, Cross River

“When you know is your time of giving birth is at hand then you go to the hospital so that they will know how to prevent the child from getting the HIV.”

–Married man, Benue

Most women learned of PMTCT services available in their community through health workers during an ANC visit or through the radio.

RESISTANCE TO ACCESSING PREVENTION OF MOTHER-TO-CHILD TRANSMISSION SERVICES

Participants were asked about what might prevent women from enrolling in PMTCT programs. A strong theme that emerged was “shame” and fear of stigmatization. Several respondents mentioned the husband’s attitude or rejection of the woman as an obstacle to her enrolling in a PMTCT program. A few respondents said that women do not attend PMTCT programs for fear of nurses and health workers breaching confidentiality and spreading gossip about the woman’s HIV status.

“Going to the hospital will invariably expose her to the mockery of the society. There is fear that the doctors and other health personnel who know her HIV status may divulge the information to others and this will make her uncomfortable in the presence of her friends.”

–Married woman, Sokoto

“When she goes maybe people will start saying ‘look at that woman, she has AIDS.’ So as a result they will decide to just stay at home so that nobody will know.”

–Married woman, Bauchi

“I think it’s stigma, the societal stigma against people that has HIV. They may be reluctant to go and say ‘I am HIV-positive’ If we can reduce the stigma, people will be encouraged to go to the clinic”

–Married man, Lagos

“She may not go because she doesn’t want her husband to know because he will divorce her.”

–Married man, Sokoto

“Some husbands will stop the woman from going because they don’t want people to know they have HIV.”

–Married woman, Bauchi

TAKING ANTIRETROVIRALS DURING PREGNANCY: HUSBANDS’ SUPPORT AND ADHERENCE ISSUES

The men, women, and TBAs were asked about adherence issues. When the men were asked if they would support their wives in taking medication during pregnancy to prevent transmission of HIV to her baby, a strong theme emerged. The men give great importance to the health of the new baby above all. Most of the men indicated that they would support their wives to take the drugs to ensure that the baby is born free of HIV, especially if the drugs are at no cost.

“If it will protect the baby I will support her...of course anything that will benefit her and the baby.”

–Married man, Bauchi

“The best option is for government to provide free medication to pregnant women that are HIV-positive. This will encourage men to support their wives. Nobody wants to discourage his wife from taking the ARV drugs. It is only lack of money, but when the medicine is free nothing will stop her from taking it.”

–Married man, Sokoto

A few of the male respondents felt that some men would not support the use of the drugs by their wives. The reasons varied from lack of awareness to poverty.

“Another reason why men would not support their wives is that some people make a lot of false allegations against antiviral drugs. Some will say it will kill you, people say words that will discourage the positive people to take it, especially those trado-medical people. Some of them are not well educated...”

–Married man, Lagos

“Lack of finance will be a reason for husbands not to support their wives. The poverty level in our society has made husbands not to follow their wives to the hospital. Most families cannot afford three square meals in a day, not to talk of money to buy drugs.”

–Married man, Sokoto

Female participants were asked if there were any reasons that prevent a pregnant woman from taking the drugs that help prevent HIV transmission to her baby. Reasons most frequently mentioned were family influence, lack of money, side effects, as well as a careless attitude.

“The elders of the house can prevent her from taking the drugs. Some don’t believe the hospitals. I know of a woman like that. She almost died before the elders in her house allowed her to be taken to the hospital.”

–Married woman, Bauchi

“It has a strong smell...it makes them to vomit.”

–Married woman, FCT

“The most probable reason for not taking the drugs is if you do not have the money to procure them.”

–Married woman, Sokoto

TBAs felt that adherence would improve if PMTCT programs offered incentives, such as nutritional aids and financial assistance.

“For me, I think the women should be helped with free can of milk to give their children. This will motivate them to stay in the program.”

–TBA, Bauchi

“If the women can be given small money to help them with transportation or other food items it will motivate them to remain in the program.”

–TBA, Bauchi

BREASTFEEDING AND THE HIV-POSITIVE MOTHER

The majority of women participating in the study felt that most husbands would be unsupportive, “unhappy,” and even ashamed if their wives did not breastfeed their baby, with several mentioning the high cost of buying milk for the baby.

“They asked us to breastfeed our babies at least for six months exclusively. The man will beat her.”

–Married woman, Lagos

“Some men will say they don’t have money for the milk. They will not like it.”

–Married woman, Bauchi

“The husband will not be happy with you if you do not breastfeed your child due to HIV virus...but there’s nothing he can do.”

–Married woman, Sokoto

A few women expressed the view that as the baby’s health was at stake, men would accept it if their wives did not breastfeed.

“He will accept it since he is after the child’s health.”

–Married woman, Bauchi

“Since the man has the awareness that the wife is positive to HIV...he would not want the wife to breastfeed the baby. He would not want the baby to die...the baby food will be bought by the husband.”

–Married woman, Lagos

KEY FINDINGS ON SAFE MALE CIRCUMCISION

A number of themes emerged from the discussions on SMC and will be discussed in this section. Participants consistently believe that the male child should be circumcised. Beliefs about who should perform the circumcision and where, however, seem to depend somewhat upon whether one lives in the north or south of the country. Trusted sources of information on SMC also varied from north to south, with those in the south most trusting of doctors and health workers and those in the north looking to their traditional leaders for this information. The father is the primary decision maker regarding the son's circumcision.

BELIEFS REGARDING REASONS FOR MALE CIRCUMCISION

Participants in the study were asked whether they would have their male child circumcised and to give reasons for their choice. Overwhelmingly, participants said that the male child should be circumcised, though the reasons given varied, with many naming religious and cultural traditions, others mentioning health and hygiene reasons, some mentioning to avoid shame, and a few mentioning sexual pleasure.

"...because the bible say that any male child must be circumcised at the age of eight."

–Married man, Benue

"Yes, I like it because it is our tradition...to keep the child very healthy. I want to circumcise my child because it is acceptable in our culture by everybody right from our forefathers...it's from God, God said that."

–Woman at ANC clinic, Sokoto

"Number one, this is Tiv land and in Tiv land here we always circumcise our male children. Number two, I assume that when you been circumcise you enjoy of sex more than somebody who is not circumcised. So these are two reasons."

–Married man, Benue

"For health reasons, because germs can hang on the foreskin...some children are unable to urinate well until they are circumcised."

–Woman at ANC clinic, Bauchi

PRACTICES: USUAL AGE FOR MALE CIRCUMCISION IN THE COMMUNITY

Participants in the study were asked about what age males in their community were usually circumcised. The responses varied, ranging from immediately after the naming ceremony (which is from birth to 28 days after birth for Igbo society and typically on the eighth day after birth for

Yoruba) to seven years of age depending on cultural and religious practices. One consistent theme that emerged was the biblical reference to circumcising on the eighth day.

“It differs, some at five or seven years, some immediately the child is born. It depends on the family. Some seven days after the baby’s naming ceremony.”

–Pregnant woman, Bauchi

“My own is done immediately after the naming ceremony. That time the pain will not be too much...the baby will not feel it too much.”

–Married woman, Lagos

“It depends, but for us Hausas, it’s between four to seven years.”

–Pregnant woman, Sokoto

“It is the eighth day.”

–Pregnant woman, Benue

“Eight days, that’s what the bible says.”

–TBA, Benue

“Before, till a child reaches the age of seven. But now it varies from two, three, to four years. They don’t have to reach seven years now. Sometimes it is done to avoid a particular kind of sickness.”

–TBA, Sokoto

PRACTICES: WHO SHOULD PERFORM MALE CIRCUMCISION AND WHERE?

When participants were asked whom they would prefer to perform circumcision for their child and where they would prefer to have it done, both male and female participants, particularly in Lagos, FCT, Cross River, and Benue, preferred to have doctors or nurses perform the circumcision in a hospital setting.

“I think the best place is in the approved hospital by the doctors, midwives, and senior midwives.”

–Married man, Lagos

“I will prefer a medical person because they are trained and they know how to carry it out better.”

–Married woman, Benue

However, several of the participants in Bauchi and Sokoto in the north of the country preferred the traditional circumcisers (or *Wanzamai*) performing the circumcision in the home environment, believing that it would be done better.

*“I believe that the reason why I prefer the *Wanzamai* is that most times the hospital makes it difficult to see the doctor and this greatly delays the process which may be harmful to the patient. But this is not so for the *Wanzamai*...the *Wanzamai* is the right person to circumcise my child because after two days the wound will be healed.”*

–Married man, Sokoto

“Wanzamai would do it at home while the doctors do it in the theater.”

–Married man, Bauchi

DECISION MAKING REGARDING MALE CIRCUMCISION

When participants were asked about who would make decisions and arrangements concerning their sons' circumcision, most women responded that either the father or grandfather would bear that responsibility. Male participants agreed that the father is the primary decision maker, with the mother making this decision only if the father was not around.

“The husband because woman did not know anything about circumcision because we Tiv we don't circumcise woman so they don't know something about circumcision.”

–Married woman, Benue

“It is the father. He is the one to give you the money for the circumcision.”

–Woman at ANC clinic, FCT

“...both can make the decision, but in the absence of the husband, the wife can still do that.”

–Married man, Cross River

TRUSTED SOURCES OF INFORMATION ON SAFE MALE CIRCUMCISION

The men in the study were asked who they would most trust to give them accurate information about SMC. While many said they would most trust doctors and health workers for information on SMC, some men, particularly in the northern states of Sokoto and Bauchi, felt that the traditional leaders would be the best source of information on SMC.

“The medical experts from the health center...the nearest to us is the health center.”

–Married man, Cross River

“I think traditional leaders and district heads are more respected around here. Anything they say will be trusted and accepted.”

–Married man, Bauchi

DISCUSSION

PREVENTION OF MOTHER-TO-CHILD TRANSMISSION

Findings from the FGDs and individual IDIs establish an important foundation for understanding why participation in and adherence to PMTCT programs is low in these communities, and for identifying the obstacles for male partners. The findings, when combined with the findings from the key informant interviews conducted during the first phase of the study (see Appendix A for full report) help to identify potential approaches, key messages, and the best messengers to improve participation, adherence, and male partner involvement.

1. There is a strong desire for a “healthy pregnancy” among both women and men, and a good understanding of the importance of diet and regular prenatal checkups during pregnancy.
2. Men perceive their role in the pregnancy as caring for the wife, supporting her, relieving her of some of the burden of domestic work, and making sure she gets to clinic. This is consistent with findings from the earlier key informant interviews, which found that the husband’s role was viewed as “taking care of the wife and providing for her needs.” It is viewed largely as a financial obligation to support wife and children.
3. Some men, particularly in the Cross River and Benue regions, also include accompanying the pregnant wife to ANC as part of their responsibility in order to understand first-hand from the doctor what care is needed and take care of financial obligations at the clinic. It is interesting to note that the report from the earlier key informant interviews states: “Respondents all said that the pregnant women go alone to their ANC appointments, or in some cases with the mother-in-law. The husbands only come when they have to donate blood” (see Appendix A).
4. Many of the men, particularly in Sokoto and Bauchi, see no reason to accompany the wives to ANC. The barriers to men’s involvement are that men have to work, the perception that ANC is a woman’s affair, that it is not a regular occurrence in the culture, and that the man will be perceived as “weak” by his peers. Other barriers mentioned by the women include fear of being tested for HIV and not wanting to spend the money. These findings are generally consistent with the findings from the key informant interviews conducted in February 2011, which found that men do not tend to go along with their wives to ANC mostly because it is not part of the culture and men are busy at work (see Appendix A). The men think of ANC as “the women’s thing.” Our findings are also consistent with the findings from the Tanzania study mentioned previously in the literature review, in which 74.6 percent of the men were not willing to participate in PMTCT programs by accompanying their wives to antenatal clinics. The reasons included being too busy (25.2 percent), cultural reasons (21.4 percent), and lack of knowledge of the importance of the program (21.4 percent), and 15.5 percent perceived ANC services as women’s affairs (Boniphace 2010).

5. Respondents suggested that if doctors specifically request the husbands' presence, it would motivate husbands to attend ANC. This is different than the findings from the earlier key informant interviews in which respondents said that men need to be made aware of the importance and benefits to the family of getting more involved (see Appendix A). A few key informants also mentioned that moving the clinic day to the weekend to accommodate work schedules might encourage men to attend ANC. In addition to this, some said if there is a guarantee that the doctors would conduct checkups for the men alongside with their wives, they will be encouraged to attend ANC. This implies that ANC services need to be more "male-friendly" to encourage more men to attend with their spouses.
6. Doctors and community leaders are best suited to engage men and women in discussions of pregnancy-related issues as they are the most trusted and respected sources of information. This is generally consistent with the earlier findings in which key informants said that the men would trust community leaders (village heads, ward heads), religious leaders, and medical personnel to relay information about pregnancy- and PMTCT-related issues. In a study on community gatekeepers' awareness and perception of PMTCT services in Ibadan, which was part of the literature review, it was discovered that opinion leaders made up of religious leaders, heads of households, and leaders of community-based organizations had low knowledge of MTCT and PMTCT services (Arulogun et al. 2007). Therefore, for them to be effective as messengers for providing information as desired, interventions need to be implemented to increase their level of knowledge.
7. Fear of stigma and discrimination remain major obstacles to disclosure of HIV status. This is consistent with findings from the literature review.
8. Awareness of PMTCT methods and services is high among women and men. Women receive information from ANC visits or radio broadcasts. This is consistent with findings from the earlier key informant interviews (see Appendix A).
9. Fear of stigmatization and "shame" are major barriers to participating in PMTCT programs. The husband's attitude can also be a barrier. Mistrust of nurses and health workers keeping confidentiality is also a factor. This is mostly consistent with findings from the earlier key informant interviews, which identified the main barriers to enrolling women in PMTCT programs as fear of social stigma and discrimination, lack of awareness, and illiteracy (see Appendix A). A few key informants also mentioned the poor attitude of hospital staff as being a barrier.
10. Men are very concerned about the health of a new baby. Most men indicated that they would support their wives to take ARVs to ensure that the baby is born free of HIV, especially if the drugs are at no cost. Similar findings were obtained in a study of male involvement in PMTCT services in Tanzania's Mbeya region where all of the respondents generally accepted PMTCT interventions (Theuring et al. 2009).
11. Offering encouragement such as nutritional aids and financial assistance could help keep women in the PMTCT program and adhering to the treatment regimen. The report from the key informant interviews pointed to several other ways of motivating women to stay in their PMTCT programs: forming support groups, home visits, and ensuring absolute patient confidentiality.
12. Most women feel that husbands would be unsupportive and unhappy if their wives did not breastfeed. These findings are consistent with studies done in other African countries.

PRELIMINARY RECOMMENDATIONS FOR PREVENTION OF MOTHER-TO-CHILD MESSAGES

1. HIV education programs should emphasize effectiveness of the interventions available for PMTCT.
2. Health workers and community leaders would be most effective at disseminating information to the target audience and educating women and men on PMTCT, as they are perceived as credible and trustworthy.
3. Interventions need to be implemented to increase the level of knowledge of community leaders to make them effective educators and advocates for PMTCT. All of the key informants interviewed (including religious leaders and male and female community leaders) expressed their willingness to relay accurate information to community members on PMTCT (see Appendix A).
4. ANC services need to be made more male-friendly to encourage more men to attend with their spouses. The clinics should offer specific activities in which men can participate and try to adjust clinic hours to accommodate men's schedules. Community leaders can help raise awareness among community members of the benefit of men participating in ANC with their spouses, along with radio messages.
5. PMTCT services should be available for all women who need it and should have a community outreach component to increase awareness and support.
6. Stigma has been identified as a major deterrent to the use of PMTCT services. Appropriate messages and other interventions must be developed and implemented nationwide to reduce stigma, thereby increasing uptake of PMTCT. Community sensitization is needed to help reduce stigma.
7. PMTCT services should be free and, where possible, women should be encouraged in various appropriate ways to adhere to the program.
8. Ensuring patient confidentiality is critical to overcome the mistrust of health workers that is serving as a deterrent for some women to participation in PMTCT.

SAFE MALE CIRCUMCISION

1. Overwhelmingly, participants said that the male child should be circumcised. Reasons for circumcision include religious and cultural traditions, health and hygiene, avoiding shame, and even sexual pleasure.
2. The age at which circumcision is carried out varies according to ethnic background and religion. Age at circumcision ranges from immediately after the naming ceremony (which takes place from birth to 28 days for Igbo society and typically on the eighth day after birth for Yoruba) to seven years of age. One common theme that emerged from discussions was the biblical reference to circumcising on the eighth day after birth. In the earlier key informant interviews, the majority of communities said that male circumcision is now done between eight days and three months after birth. In Bauchi, respondents said that traditionally boys were circumcised at seven years of age, but traditions are changing and families are circumcising boys within one week of birth.

3. Most participants in the study prefer to have doctors or nurses perform the circumcision in a hospital setting for health reasons. However, several participants in Bauchi and Sokoto prefer Wanzamai in the home, believing that it will be done better. This is consistent with earlier findings from key informants in which the majority of respondents said that circumcision should be done in a health facility, though a few said that it could be done traditionally if it is in a “clean” place (see Appendix A). To preserve the sociocultural importance of the circumcision process while improving safety and acceptability of the circumcision procedure and enhancing health education to the communities, clinical providers will need to collaborate with the community leaders. Such collaboration has been reported in Kenya.
4. The decision and arrangements regarding the son’s circumcision is primarily the father’s responsibility, with a few mentions of the grandfather. A few respondents mention the mother in cases where the father is not around.
5. While many of the participants indicated that they would most trust doctors and health workers for information on SMC, some of the men, particularly in the northern states, felt that the traditional leaders would be the best sources of information on SMC.

PRELIMINARY RECOMMENDATIONS FOR SAFE MALE CIRCUMCISION MESSAGES

1. Nigerians do not have to be convinced to circumcise their sons—they are already doing it. However, some are having their sons circumcised as young boys, when there is greater risk of complications, rather than as infants. Some families, particularly in the northern states, are choosing to use traditional circumcisers in the home setting, which can be unsafe. The focus of BCC messages should be on promoting earlier age for circumcision and safe medical male circumcision performed by a trained health care provider in a health facility.
2. It is important to respect the traditions of the communities who prefer Wanzamai while ensuring that procedures are medically safe. Discussions will need to be held early on with the traditional leaders in these communities to listen to their concerns and engage them in discussions as they may initially object to medical male circumcision. One option may be to incorporate some of the traditions that go along with the circumcision into the medical male circumcision in the health care facility, either before or after the surgery, or have the traditional circumciser present during the medical procedure. The Wanzamai should also be trained on safe medical procedures.
3. Fathers will be the primary audience in the strategy as they are the real decision makers in the family regarding the son’s circumcision. Grandfathers and mothers will be secondary audiences. Doctors, health workers, traditional leaders, and community leaders will be best suited to deliver the messages on SMC.

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APPENDIX A:

REPORT OF KEY INFORMANT INTERVIEWS

COMMUNITY PERCEPTIONS OF PREVENTION OF MOTHER-TO-CHILD TRANSMISSION SERVICES AND SAFE MALE CIRCUMCISION IN FIVE FOCAL STATES AND THE FEDERAL CAPITAL TERRITORY: WHAT CAN WE LEARN FROM KEY INFORMANT INTERVIEWS?

BACKGROUND

USAID/Nigeria requested that AIDSTAR-One expand its scope to include the development of a BCC strategy for promoting PMTCT services and SMC to prevent the spread of HIV and other blood-borne infections. AIDSTAR-One determined that formative, qualitative research was needed to inform this strategy by identifying gaps and key messages as well as best channels for communicating those messages to the target audiences. The BCC strategy aims to achieve the increased utilization of, and adherence to, PMTCT services and achieve safer practices related to SMC. As increasing evidence suggests that male partner involvement increases women's participation in and adherence to PMTCT services¹—improving the health outcome of the baby—the communications strategy also aims to increase male partner involvement in ANC and PMTCT services.

According to WHO and UNICEF, about 58 percent of pregnant women in Nigeria receive ANC. According to the 2008 Demographic and Health Survey, only 28 percent of women and 39 percent of men in Nigeria know that the risk of an HIV-positive pregnant woman transmitting the HIV virus to her unborn child can be reduced by taking prophylactic drugs during pregnancy. In Nigeria, usage of PMTCT services is at only 12 percent, thus the study was designed to find out from key stakeholders their perceptions, opportunities, and barriers/challenges related to PMTCT services to inform a communication strategy to promote PMTCT at selected focal local government areas in a few states that can later be replicated across Nigeria.

In February 2011, AIDSTAR-One conducted 50 key informant interviews in three local government areas of five states plus the FCT (8 in Cross River; 10 in Sokoto; 7 in the FCT; 8 in Lagos; 10 in

¹ Male partner involvement in PMTCT services reduced the risks of vertical transmission and infant mortality by more than 40 percent compared to no involvement according to Adam Aluisio and colleagues in a prospective cohort study undertaken between 1995 and 2005 in Nairobi, Kenya published in the January 1, 2011, edition of the *Journal of Acquired Immune Deficiency Syndromes*.

Bauchi; and 7 in Benue). The key informants were comprised of male and female community leaders, religious leaders (both Muslim and Christian), ANC/PMTCT nurses, and PMTCT desk officers. These particular categories were chosen as key informants for their first-hand knowledge of the topic and the target audiences, to help frame the focus group research, and to get their perspective and recommendations before speaking with the direct beneficiaries of the services. All of the key informants are involved in some capacity in helping to improve the well-being of community members. The key informant interviews were part of a larger research effort that also includes FGDs with men of reproductive age in the communities, women attending ANC services, and women in the community. In addition, individual IDIs are planned with TBAs and HIV-positive pregnant women.

The informants were asked about their awareness of where HIV testing could be done in their communities and whether it is common for husbands to accompany wives for HIV testing, their awareness of PMTCT services, observations of enrollment and adherence to PMTCT services, obstacles to enrollment, as well as men's participation in their wives' prenatal care. They were also asked about appropriate places to engage men and women in discussion about PMTCT, and their willingness to relay accurate information about PMTCT to community members. Finally, they were asked about male circumcision practices in their communities and where they believed that circumcision should take place.

EMERGING THEMES

HIV testing: All respondents were aware of where HIV testing could be conducted in their communities. According to respondents, men in these communities do not accompany their wives for HIV testing. Some of the reasons given were “men are afraid to check their status as they are usually unfaithful to their wives,” and “it is not really part of the culture for men to go with their wives.” The exception was in Bauchi, where respondents indicated that men in their communities sometimes do accompany their wives to go for HIV testing, especially when they want to marry another wife and the current wife wants to know the HIV status of the new wife first, and/or to know the husband's status.

ANC: Respondents all said that pregnant women go alone to their ANC appointments, or in some cases with the mother-in-law. The husbands only come when they have to donate blood. (The government hospitals in Nigeria are promoting blood donation by husbands in preparation for their wives' delivery.)

Men do not tend to go with their wives to the antenatal clinic mostly because it is not the culture and men are busy at work. As one respondent from Lagos put it, “If a man follows his wife all the time, people will look at him like a woman wrapper” (i.e., a man who has been made into a slave or zombie for his wife). The main reason given across the board was the culture and gender roles in the community. The men think of ANC as “the women's thing.” One of the ANC nurses mentioned that the health facilities have limited space and so they do not encourage the men to stay with their wives. Most of the respondents expressed that they thought that the husband should go with the wife to the clinic.

When asked what might encourage the men to be more involved in their wives' pregnancies and ANC, those interviewed said men need to be made aware of the importance and benefits to the family of becoming more involved. Most respondents felt that sensitization through the traditional leaders and education during meetings involving men would help. A few mentioned that moving the clinic day to the weekend might encourage men to attend ANC.

The husband's role during his wife's pregnancy seems to be viewed as "taking care of her and providing for her needs." It is viewed largely as a financial obligation to support wife and children.

PMTCT: Most of the respondents said they had heard of services and drugs available to help an HIV-positive pregnant woman reduce the chances of passing the virus to her baby, either from hearing it on the radio or from health workers. However, some of the respondents did not know where such services were offered.

The main barriers to enrolling women in PMTCT programs were identified by almost all of the interviewees as fear of social stigma and discrimination, lack of awareness, and illiteracy. A few also mentioned the poor attitude of hospital staff as being a barrier.

The main reasons why women drop out of PMTCT programs were lack of support, fear of discrimination, distance to the health facility, being misled to seek traditional medicine, and fear that health workers will not maintain confidentiality of their HIV status. The attitude of health staff was also mentioned by several respondents as very important in motivating women to stay in their PMTCT program. Others mentioned forming support groups, home visits, and ensuring absolute patient confidentiality as being important to help motivate women to stay in their PMTCT programs. A few of the ANC/PMTCT personnel said that adherence is usually high with the women who disclose their status to their husbands, and lower for those who conceal their status. In one facility in Lagos, it was noted that after giving birth, the women tend to drop out. The HIV-positive mothers remain in the program until they give birth because they want the best for their babies, but then they stop attending.

TRUSTED SOURCES AND BEST CHANNELS

Key informants were asked who the men in their communities would most tend to trust for accurate information on PMTCT issues. Most respondents said that the men would trust community leaders (village heads, ward heads, district heads), religious leaders, medical personnel, and the media to relay information about PMTCT services. Most respondents said that the women would trust health workers, older women/mothers in the community, and religious leaders.

Village meetings organized by ward heads, the market place, places of worship, and ANC clinics were all places suggested by respondents for engaging men and women in discussions on PMTCT issues. When asked what communication efforts would be needed to increase usage of services, respondents suggested intense and continuous community-level mobilization and wide media coverage. Several mentioned radio as being effective in informing people about PMTCT.

All of the key informants interviewed expressed their willingness to relay accurate information about PMTCT to the community, and some saw it as "their duty as leaders to educate people on staying healthy."

SAFE MALE CIRCUMCISION

The key informants were asked when male circumcision is normally done in their community. The majority of communities said that male circumcision is now done between eight days and three months of age. The exception was in the FCT, where respondents said that the time at which male circumcision is carried out varies according to their ethnic background and religion. Most are done at about eight days, but some are traditionally done at 7 to 10 years of age. In Bauchi, respondents said that traditionally it was done at about seven years, but now people are changing and having it done earlier, within one week of birth.

The majority of respondents said that circumcision should be done in a health facility, though a few said it could be done traditionally if it is in a “clean” place. Most of those interviewed said the procedure should be done by trained health workers. A few respondents in Sokoto said it should be done by the Wanzamai.

CONCLUSION

A number of important themes have emerged from the key informant interviews and should be further explored during the FGDs. For example, the men’s limited role during wives’ pregnancy and men’s perceptions of ANC should be explored during the FGDs with men. In addition, the suggested motivators (i.e., moving clinic day, making men aware of the benefits to the family from his involvement, etc.) should be discussed with the men’s groups. The barriers to women’s enrollment in PMTCT identified by the key informants should be explored further with the women’s FGDs, in particular whether attitudes of health staff are truly a barrier. The IDIs with HIV-positive pregnant women will provide a good opportunity for gaining a clearer understanding of why women drop out of PMTCT programs, and to explore the role that lack of support, fear of discrimination, attitude of health staff, and the other factors mentioned by key informants truly play in mothers’ decision to drop out. The significance of the traditional Wanzamai and circumcisers in male circumcision practices should also be explored further during the FGDs.

APPENDIX B:

TOPIC GUIDE FOR FOCUS GROUP WITH MARRIED MEN

TOPIC GUIDE FOR MARRIED MEN

Warm up and Explanation (10 minutes)

a. Introduction

Thanks so much for coming today. I am _____. I will be moderating this discussion. _____ will be recording the discussion and taking notes. We appreciate your willingness to share your time.

b. Purpose

We will be discussing healthy pregnancies, healthy babies, and services that help prevent pregnant mothers from giving HIV to their infants. I'm interested in all your ideas, comments, and suggestions. There are no right or wrong answers. Please feel free to disagree with one another. We would like to have many points of view.

c. Procedure

All comments are confidential and used for research purposes only.

I want this to be a group discussion, so you needn't wait for me to call on you, but please speak one at a time, so that the tape recorder can pick up everything.

We have a lot of ground to cover, so I may change the subject or move ahead. Please stop me if you want to add something. Our discussion should last about an hour to an hour and a half.

d. Self-Introductions

(Ask each participant to introduce himself.) Tell us your name and something about yourself—for example, how many children you have, what kind of work you do.

Topic 1: Pregnancy and prenatal care

- 1.1 (warm up question) Just to get us started, what's the first thing that pops into your head when I say "being a good husband"?
- 1.2 What do you see as the man's role during his wife's pregnancy? [alternative: What sorts of things can you do to make sure that your wife has a healthy pregnancy and delivers a healthy baby?]
- 1.3 Who normally goes along with your wife when she visits the antenatal clinic?

1.4 Why wouldn't men like you normally go with their wives to the antenatal clinic?
(probes: Why is that? Any other reasons?)

1.5 What might convince you, or husbands like you, to go along on the clinic visits?

Topic 2: Issues Related to HIV Counseling and Testing

2.1 How can people tell if someone is infected with HIV?

(Note if testing is mentioned)

2.2 (If testing is not mentioned) Has anyone heard of testing for HIV? What have you heard about it?

2.3 Where can couples go for HIV testing in this community?

2.4 Would you have an HIV test? Why or why not?

2.5 What would influence this decision?

2.6 Once you found out the results of the HIV test, who would you tell? Who would you not tell?

2.7 When someone in this community finds out that he is infected with HIV, how would his family react?

2.8 Would his family treat him differently? Why/why not?

Topic 3: Mother-to-Child Transmission of HIV Issues

Now let's talk about one way that HIV can be transmitted: from an infected mother to her infant.

3.1 Please describe what you think an HIV-positive pregnant woman can do so that she does not give the virus to her infant?

(Probe: Anything else?)

3.2 What have you heard about services being offered in this community to help the HIV-positive pregnant mother so she doesn't pass the virus to her new baby?

3.3 Where did you hear about these services?

(Probe: The radio, my wife, etc.)

3.4 Why do you suppose that more people in this community don't take advantage of these hospital services that help prevent HIV-positive pregnant women from passing the virus to the baby?

3.5 What have you heard about the use of some drugs to reduce the transmission of HIV from an infected mother to her child?

3.6 If your pregnant wife was told by the doctor to take a particular drug to prevent transmitting HIV to her baby, how do you think you might react? Would you support her in taking this medication? Why/why not?

3.7 Who would you most trust to give you accurate information on your wife's pregnancy and how to prevent giving the HIV virus to your baby?

(Probe: Health workers, media, religious leader, etc.)

Topic 4: Male Circumcision

Before we go, I just want to ask a few questions about male circumcision.

- 4.1 At what age would you have your male child circumcised?
- 4.2 Who would perform it, and where would you have it done?
- 4.3 Who in your family would make the decisions and arrangements about the baby's circumcision?
- 4.4 Who would you most trust to give you accurate information about safe male circumcision?
- 4.5 Is there anything else anyone would like to say about this topic (or the other topics we've discussed today)?

Notes to Moderator: Summarize the main issues that were brought up and ask for any additional comments. Thank the participants and let them know that their ideas have been a valuable contribution.

APPENDIX C:

SCHEDULE OF FOCUS GROUP DISCUSSIONS AND INDIVIDUAL INTERVIEWS

State	Local Government Areas	Focus Group Discussions	Interviews
Benue	Buruku	2 groups (1 male, 1 female)	1 traditional birth attendant (TBA)
	Vandeikya	2 groups (1 male, 1 female)	2 (1 TBA, 1 HIV-positive woman)
	Makurdi	3 groups (1 male, 1 female, 1 women attending antenatal care [ANC])	1 HIV-positive woman
Cross River	Abi	2 groups (1 male, 1 female)	2 (1 TBA, 1 HIV-positive woman)
	Boki	2 groups (1 male, 1 female)	1 TBA
	Ogoja	2 groups (1 male, 1 women attending ANC)	2 (1 TBA, 1 HIV-positive woman)
Sokoto	Gwadabawa	2 groups (1 male, 1 female)	1 TBA
	Rabah	0 groups	1 TBA
	Sokoto South	2 groups (1 male, 1 women attending ANC)	3 (1 TBA, 2 HIV-positive women)
Bauchi	Bauchi	2 groups (1 male, 1 women attending ANC)	3 (1 TBA, 2 HIV-positive women)
	Darazo	2 groups (1 female, 1 women attending ANC)	1 TBA
	Shira	1 group (male)	2 (1 TBA, 1 HIV-positive woman)
Lagos	Alimosho	2 groups (1 male, 1 female)	2 (1 TBA, 1 HIV-positive woman)
	Apapa	2 groups (1 male, 1 women attending ANC)	2 (1 TBA, 1 HIV-positive woman)
	Ibeju-Lekki	2 groups (1 male, 1 female)	1 TBA
Federal Capital Territory	Abuja Municipal Area Council	3 groups (1 male, 1 female, 1 women attending ANC)	2 (1 TBA, 1 HIV-positive woman)
	Bwari	2 groups (1 male, 1 female)	1 TBA
	Kwali	2 groups (1 male, 1 female)	1 TBA



National Health Research Ethics Committee of Nigeria (NHREC)

Promoting Highest Ethical and Scientific Standards
for Health Research in Nigeria



Federal Ministry of Health

NHREC Protocol Number NHREC/01/01/2007-15/06/2011
NHREC Approval Number NHREC/01/01/2007-02/08/2011
Date: August 5, 2011

Re: Community Perceptions of PMTCT and Safe Male Circumcision in Six Focal States

Health Research Ethics Committee (HREC) assigned number: NHREC/01/01/2007

Name of Co-Principal Investigator: Dr. Azeez Aderemi
Address of Principal Investigator: National AIDS and STI Control Program (NASCP)
Department of Public Health,
Federal Ministry of Health, Abuja

Date of receipt of valid application: 15-06-2011

Date when final determination of research was made: 02-08-2011

Notice of Expedited Review and Approval

This is to inform you that the research described in the submitted protocol the consent forms, advertisements and other participant information materials have been reviewed and *given expedited committee approval by the National Health Research Ethics Committee.*

This approval dates from 02/08/2011 to 01/08/2012. If there is delay in starting the research, please inform the HREC so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. *All informed consent forms used in this study must carry the HREC assigned number and duration of HREC approval of the study.* In multiyear research, endeavor to submit your annual report to the HREC early in order to obtain renewal of your approval and avoid disruption of your research.

The National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the HREC. No changes are permitted in the research without prior approval by the HREC except in circumstances outlined in the Code. The HREC reserves the right to conduct compliance visit your research site without previous notification.

Signed

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