

Nigeria's Mixed Epidemic

Balancing Prevention Priorities Between Populations



Sunset at Lagos beach popular with sex workers.

Aldo Spina

Away from the noisy, crowded streets of Lagos, the sun slowly sets over one of the city's many beautiful white sand beaches. Hundreds of plastic tables and chairs are scattered across the beach, awaiting the arrival of the Friday night crowd. One of the bars that line the beach turns up the music as the crowd of mainly young males slowly grows.

As darkness approaches, a steady stream of young women emerges from the huts behind the cafes and bars, hovering in the darkness at the shoreline. As the night progresses, hundreds of women appear, all for the same reason—to make money. The beach is one of the city's many outdoor hot spots for female sex workers.

What is not visible is just as significant. Do the young males fraternizing with the sex workers have girlfriends, wives, or other sex partners? The smell of marijuana wafts through the air, but are the men or women using other drugs, perhaps injecting them nearby? And what about men interested in having sex with other men? Although they may remain hidden to public gaze, they nevertheless manage to find each other.

During the daytime, it is an entirely different scene. The crowds of young men are gone. Instead, outreach workers from a local organization educate female sex workers about HIV and the correct use of condoms, and refer them to the nearby health clinic for HIV testing. Although the program focuses primarily on sex workers, all of the groups that appear at night—people who inject drugs (PWIDs), men who have sex with men (MSM), and clients of sex workers—as well as the larger community need prevention programs. This beach is a microcosm of the challenges of HIV prevention in Nigeria, which—with almost 3 million people living with HIV—has one of the largest HIV burdens in Africa.

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This publication was produced by the AIDS Support and Technical Assistance Resources (AIDSTAR-One) Project, Sector 1, Task Order 1.
USAID Contract # GHH-I-00-07-00059-00, funded January 31, 2008.

Disclaimer: The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

Knowing Your Epidemic

Each country confronts a different HIV epidemic, and many face a range of regional and local epidemics. The call for countries to “know their epidemic” has led to increasing recognition that in some places it is “mixed,” with epidemics occurring simultaneously among both members of the general population and members of most-at-risk populations (MARPs), including PWIDs, MSM, and sex workers, and often with significant geographical variations within the country, meaning that the populations at risk may vary from state to state and at the local level.

Until recently, many countries did not have sufficient data to determine whether or not their national epidemic was mixed; routine HIV surveillance activities often miss key at-risk populations, for whom targeted surveys are necessary. Countries must work with the data they have available to make difficult decisions about balancing resource allocation, carefully considering the unmet needs of MARPs and the needs of the general population and youth, as well as considering variations in the epidemic in geographical regions. Moreover, countries already deeply engaged in prevention programming sometimes find it difficult to expand their work with MARPs or divert prevention resources to them. Stigma and discrimination also drive many individuals to hide their practices (which in many countries are illegal) and not access services. This can leave governments reluctant to acknowledge or address their needs.

Nigeria’s Early Response

The first two cases of HIV in Nigeria were identified in 1985 and were reported at an international AIDS conference in 1986. Quickly, HIV prevalence rose from 1.8 percent in 1991 to 4.5 percent in 1996. By 2001, it peaked at 5.8 percent (National Agency for the Control of AIDS [NACA] 2010). The response



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A rural brothel visited by Winrock implementing partners.

to the epidemic throughout the 1990s has been characterized largely as a period of denial. The first policy statement on HIV was developed by the Federal Ministry of Health in 1997, but it was accompanied by limited public awareness and mobilization campaigns. It wasn’t until the restoration of democracy in 1999 that greater efforts were undertaken to respond to the epidemic, and the response moved from a health-centered response to a multisector response.

With a total population of over 153 million people, the HIV epidemic in Nigeria is complex, and rates of HIV and patterns of infection vary widely by region. While several states are experiencing epidemics in the general population, epidemics in other states are concentrated and driven by high-risk behaviors. It has previously been suggested that youth and young adults in Nigeria are particularly vulnerable to HIV, with young women at higher risk than young men. As a result, the first decade of HIV prevention programming tended to focus predominately on preventing transmission among young people and the general population.

Yet Nigeria’s experience is a good example of how research led to an increased understanding that the HIV epidemic was spreading among MARPs, as

well as the general population. This, in turn, led to a new emphasis on MARPs in the National Strategic Framework and, with the support of donors, an increase in programming for MARPs. Because much of the work with MARPs is still nascent, there are challenges in the coverage, intensity, and duration of interventions, as well as the extent to which geographic variations in the epidemic have been recognized and addressed.

Ongoing political and financial commitment to sustain activities is also required, particularly in light of competing HIV demands and the less than supportive cultural and legal environment. Even with these ongoing challenges, there are many valuable lessons from Nigeria's experience that can be shared with countries facing a more mixed epidemic among MARPs, other population groups, and the general community.

HIV Prevalence and State Variations

Adult HIV prevalence, based on a 2008 antenatal sentinel survey, is estimated at 4.6 percent, with variations across states ranging from 1 to 10.6 percent (NACA 2010). The survey found that Ekiti state in southwest Nigeria had one of the lowest prevalence rates at 1 percent, while Benue state in north central Nigeria had the highest prevalence rate at 10.6 percent. Benue, Nassarawa, Federal Capital Territory, Akwa-Ibom, Cross-rivers, and Rivers have the highest prevalence rates, all reporting above 7 percent.

Further differences were identified among women in urban and rural areas, with generally higher prevalence among urban women found within the six zones (geopolitical groupings of the states). For example, the north central zone had a higher urban prevalence of 6.2 percent compared to rural prevalence of 4.7 percent. In the south-south

zone, urban prevalence was 7.1 percent and rural prevalence was 4 percent.

These state variations in HIV prevalence highlight the complexity of responding to the epidemic in Nigeria. Decisions regarding resource allocation for HIV prevention requires not only balancing the needs of MARPs and general populations, but also requires giving consideration to geographic variations in the epidemic. These geographical variations have been recognized as important in a review of the national response that highlighted that high-risk behaviors vary in different communities and geographical settings within the country (NACA 2009a).

Researching Nigeria's Epidemic

A range of surveys are regularly conducted to monitor HIV trends in Nigeria. One is the biannual Integrated Biological and Behaviour Surveillance Survey (IBBSS), conducted by the Ministry of Health with support from a range of partners. First undertaken in 2000, the IBBSS focuses on groups whose behavior or occupation is thought to place them at higher risk of HIV, such as sex workers, transport workers, and members of the armed forces and police. In 2007, changes were made to the survey. For the first time, HIV and syphilis testing was included, and questions about risk behavior, knowledge, and beliefs were collected. MSM and PWIDs were also included for the first time because they were also likely to be groups at higher risk of HIV infection.

The 2007 survey was conducted across five states and the Federal Capital Territory, with a total sample size of 11,175 participants. Of these, 6,332 participants were police, transport workers, or in the armed forces. Of the remaining participants, 3,274 were sex workers, both brothel- and non-brothel-

MODES OF TRANSMISSION STUDIES

Modes of Transmission (MoT) studies aim to improve HIV prevention by better understanding the drivers of the epidemic and the allocation of prevention resources.

MoT methods include:

1. An epidemiological review to identify drivers of the epidemic
2. Incidence modeling using HIV prevalence and behavioral data to determine likely distribution of HIV infection based on MoT
3. Analysis of the scope and scale of prevention interventions
4. Analysis of the degree of alignment of national prevention resources with priorities.

(Joint U.N. Programme on HIV/AIDS 2007)

based. Smaller sample sizes were achieved with MSM (879) and PWIDs (690); recruitment of these populations was limited to only three states (Federal Ministry of Health 2007). (The small sample sizes of MSM and PWIDs, as well as the limited number of regions where the survey was conducted, have been acknowledged as limitations of the study to be addressed in subsequent surveys.)

The Impact of the Integrated Biological and Behaviour Surveillance Survey Findings

The IBBSS found that HIV prevalence among high-risk groups was significantly higher than the general population. The IBBSS found HIV prevalence to be 34 percent for female sex workers, 13.5 percent for MSM, and 5.6 percent for PWIDs (Federal Ministry of Health 2007). Lower levels of HIV prevalence were found among occupation groups: 3.7 percent for transport workers, 3.5 percent for police, and 3.1 percent for armed forces.

In many ways, this survey was an important turning point in the national response to HIV. It revealed that while Nigeria’s epidemic may be classified as generalized, the unequal distribution of HIV among different subpopulations means that the Nigerian epidemic also shares characteristics with the concentrated epidemics of other countries, indicating that the epidemic in Nigeria is more mixed than previously assumed.

While the IBBSS identified that MARPs have high HIV prevalence, it also found that knowledge about HIV and exposure to HIV interventions among MARPs were uniformly poor. This lack of knowledge as well as concern that MARPs can act as a “bridge” to the general population were factors considered in prioritizing MARPs for HIV interventions. For example, the survey revealed that a large proportion of MSM also had recent sex with women. Likewise, many of the clients of sex workers had other sexual partners, including wives and girlfriends.

Understanding of the Nigerian epidemic improved further with the 2009 Modes of Transmission (MoT) study, supported by the Joint U.N. Programme on HIV/AIDS (UNAIDS) and the World Bank. The

researchers used an MoT model recommended by the Reference Group on Estimates, Modelling and Projections of UNAIDS (UNAIDS 2007). The study estimated that MARPs (e.g., MSM, PWIDs, and sex workers) account for almost 23 percent of new infections, a figure that rises to 40 percent when the sexual partners of MARPs are included. The general population accounts for 42 percent of new infections, largely due to low levels of condom use and high levels of sexual networking (NACA 2010).

Making Most-at-Risk Populations a Priority in the National Policy Response

How have both of these studies informed the national policy response to HIV? In 2005, prior to the IBBSS, the National Strategic Framework for Action 2005–2009 was released to guide the national response (NACA 2009b). The framework was produced by NACA, which is mandated by the National Assembly to coordinate the national response to HIV. The framework recognized the importance of scaling up responses to “groups with special needs,” a broad definition that included 11 different groups, including PWIDs, sex workers, and MSM. Yet the strategy fell short of outlining major programmatic strategies to extend the reach of prevention activities to these groups.

In 2007, the National HIV/AIDS Prevention Plan 2007–2009 sharpened the focus on MARPs (NACA 2007). The plan acknowledged that interventions for the general population were important to sustain and called for specific prevention efforts for MARPs, which were identified as female sex workers, PWIDs, and MSM, as well as transport workers, the uniformed services, and youth both in and out of school. The latest National Strategic Framework 2010–2015

continues the focus on MARPs, but drops youth from the target groups. The document recognizes MARPs as key drivers of the epidemic and identifies a range of other key drivers, including low perception of risk, multiple concurrent partnerships, informal transactional and intergenerational sex, lack of effective services for sexually transmitted infections (STIs), and poor quality of health services (NACA 2009b).

A focus on MARPs is also evident in the National Policy on HIV/AIDS, October 2009 (NACA 2009c). It includes an explicit commitment to ensuring that MARPs have access to appropriate prevention interventions, as well as treatment, care, and support. The policy acknowledges the human rights and legal issues facing MARPs, while recognizing that efforts to reduce stigma and protect human rights “remain slow and hesitant.”

While accurately representing the nature of the epidemic is important in the national HIV policy response, Nigeria is a federation, which means ensuring a strong and appropriately targeted response at the state level is important. There has been recognition that political commitment needs to be improved at state and local government levels, as well as the response more generally strengthened (NACA 2010).

This acknowledgment of MARPs in national HIV policies represents a significant achievement for the Nigerian government, a step many other African countries have not yet taken. While these efforts should be applauded, prevention programming for MARPs has largely made progress because of donor support. The donor-dependent nature of the Nigerian response to HIV has meant that decisions regarding the allocation of resources have rested with donors. This raises an important question about the sustainability of prevention interventions for MARPs.

Culture, Religion, and the Legal Environment

Even with MARPs recognized as a national HIV priority, prevention programs encounter social factors that present a hostile environment for MARPs. Religious and cultural beliefs have led to widespread denial that certain sexual practices occur within Nigerian society. Homosexuality and sex work are prohibited. Illicit drug use is a criminal activity. Politically, there is often condemnation of and intolerance toward MARPs. The introduction of Sharia law in many states may have driven sex workers even further underground.

One immediate impact is that members of MARPs remain hidden for fear of legal and social repercussions, and even of their safety. Prevention programs have thus had to work hard to identify and reach hidden populations and to build trust and rapport. MARPs may be reluctant to disclose their sexual practices to service providers or even access health services for fear they will experience stigma and discrimination. The legal status of certain practices, such as homosexual sex, also impedes the sustainability of support organizations. Because these organizations are not formally recognized by the government, their ability to organize and advocate is limited.

Although HIV policy efforts in Nigeria increasingly acknowledge the needs of MARPs, there has been little legislative action to better protect the human rights of sexual minorities and other MARPs. As a result, advocacy has been recognized as an important component for many of the civil society organizations running prevention programs for MARPs. Since 1999, Alliance Rights Nigeria has advocated for the rights of sexual minorities and people living with HIV, and has played an important role in increasing awareness of the issues. In the meantime, with little substantial legal or political progress, programs have had to meet the

HIV prevention needs of MARPs while still working within the constraints of the environment.

Programming for Most-at-Risk Populations

With growing policy support, and despite the less than supportive cultural, religious, and legal environment, programming for MARPs has progressed in Nigeria. This has occurred in large part because of donor support and the efforts of civil society organizations that undertake prevention programs. Programming for sex workers has progressed furthest because of a long history of organizations working with this population. MSM prevention programming is more recent and still developing, while HIV prevention programming specifically targeted for PWIDs has not yet emerged.

How has programming developed? Pilot and small-scale interventions have demonstrated the feasibility of working with MARPs and point to future directions for scaled-up prevention programs. For example, Family Health International (FHI) ran a small-scale, time-limited men's health project in 2008 and 2009 that elucidated a great deal about working with MSM in Nigeria (FHI 2009). Such interventions are often accompanied by mapping of MARPs or by small-scale research to inform program design.

Who develops the programs? The hostile legal and political environment in Nigeria means MARPs often distrust government agencies. Civil society organizations are thus often better placed to provide programs for MARPs, but most require capacity building to do so. To do this, well-known international nongovernmental organizations experienced in working with MARPs, such as Heartland Alliance, Winrock International, and FHI, have supported civil society organizations to undertake this work by providing technical assistance, developing staff

knowledge about MARPs and the skills needed to work with them, and providing access to donor funds.

Where has programming developed?

To some extent, programming for MARPs has developed opportunistically in areas where donors already have implementing partners who are active in HIV prevention and are willing to expand their focus to include MARPs. Although this approach can enable fast scale-up by employing existing program presence, staff, and infrastructure, it may not ensure that services are located where they are needed most, in locations where MARPs tend to congregate or where risk behaviors are most likely to occur. To some extent, research efforts, such as the IBBSS, have helped determine where interventions for MARPs should be located. The next IBBSS, which will increase the number of survey regions from 6 to 10, will impact where programming for MARPs occurs. The successful Round 9 proposal to the Global Fund to Fight AIDS, Tuberculosis and Malaria

proposed that programming for MARPs be scaled-up in the same 10 survey regions.

What is the programming strategy? One overarching approach used by all HIV prevention programs in Nigeria is ensuring that a minimum package of services is delivered to the target audience. This became a priority when assessments of prevention efforts showed that single intervention approaches had not produced the desired behavior change required to prevent new infections (NACA 2007).

The minimum package approach requires implementing agencies to use a minimum of three interventions to reach a target audience. A range of interventions was outlined in the National HIV/AIDS Prevention Plan 2007–2009 (NACA 2007): a mixture of peer education, awareness raising, and STI management, among others. The combination of prevention interventions used may vary because implementing agencies choose the interventions

MEN’S HEALTH NETWORK

The Men’s Health Network (a project of the Center for the Right to Health, and Population Council Nigeria) works with men at higher risk, such as MSM, uniformed personnel, truck drivers, prisoners, and university students.

Because of concerns that an MSM-only intervention could increase stigmatization, the network adopted the broader approach of working with men at “high risk.”

“Man-friendly” clinics have been identified and supported to provide services to high-risk men. Social networks were geographically and ethnographically mapped.

Key opinion leaders have been trained to use social networking approaches to reach high-risk men to provide prevention messages and referral to the clinics and other services. They recruit by taking advantage of social networks—recruiting friends, acquaintances, and sexual partners—as well as using virtual and online social networks, such as chat rooms, websites, and text messaging services.



Media coverage of Men’s Health Network outreach to high-risk men.

most appropriate for their population. One reason different approaches are needed is because populations such as MSM cannot be assumed to be homogeneous.

The messaging developed will usually vary for each of the MARPs. For example, implementing agencies working with sex workers do not tend to emphasize abstinence or partner reduction messages but instead focus their efforts on condom use and regular HIV testing.

How is prevention for MARPs implemented? Even though the messages and combination of interventions may vary, there are many common approaches used by implementing agencies in their prevention efforts with MARPs in Nigeria.

These approaches include the following:

- *Peer involvement:* Members of MARPs are more likely to be able to reach their peers and be trusted by their peers. Peer educators are trained to provide formal and informal education sessions. There are plans to harmonize current peer education manuals to create one national manual.
- *Community mobilization:* Community mobilization aims to create a more supportive environment. Community mobilization has meant working with brothel owners and managers, health services, community leaders, state government, police, and other key stakeholders to ensure their support for HIV prevention efforts.
- *Access to HIV/STI clinics:* MSM, sex workers, and PWIDs may be uncomfortable disclosing their behaviors to clinic staff, fearing judgmental attitudes, lack of confidentiality, and discrimination. This reluctance to disclose means that clinics are unable to provide the most appropriate HIV/STI services and prevention messages for these MARPs. One way to address this is to train clinic staff to create clinic environments that are friendly to MARPs. Ongoing training and support will help clinics remain inviting to MARPs.
- *Education outreach and service delivery:* Outreach occurs at sites where MARPs are known to gather, including brothels, entertainment districts, beaches, or other sites. Outreach can involve HIV education, condom distribution, and referral to clinical services. Another way to improve access to health services is to take those services directly to MARPs. Mobile counseling and testing services have been shown to increase uptake of services among MARPs.
- *Advocacy:* Advocacy can create a more supportive environment for prevention programs. For implementing agencies, advocacy has meant working with local authorities to ensure support for prevention efforts, working with health services to ensure they are responsive to MARPs, and facilitating the participation of MARPs in local HIV responses.
- *Information and education materials:* For MSM and PWIDs, producing targeted resources is important because general education materials often do not make reference to the risk of HIV infection from anal intercourse or injecting drug use. This has left many MSM with the impression that anal sex is not a high-risk behavior for HIV transmission.
- *Innovative use of technology:* Technological advances can contribute to HIV prevention interventions. One reason to use technology is to protect client confidentiality and anonymity. These approaches are in their infancy in Nigeria and focus mainly on developing education websites for MSM.
- *Distribution of condoms and water-based lubricants:* Male condoms are widely available in Nigeria at affordable prices. Even so, implementing agencies that work with MARPs

provide condoms to participants during peer education sessions and outreach. Some programs also distribute water-based lubricant, even though it is expensive and not readily available. Female condoms are not widely available and are costly. However, when they are available, there has been some limited distribution of female condoms to female sex workers. A project is currently being planned to determine how to ensure reliable procurement and distribution of female condoms.

How effective is programming for MARPs? In Nigeria, it remains to be seen if the emphasis on MARPs generated by national policy and strategic plans will result in prevention programming with coverage, intensity, and duration sufficient to meet the needs of Nigeria's MARPs. The next IBBSS will provide more information about whether the scale-up of prevention programming for MARPs over recent years has resulted in increased exposure to prevention information, improved knowledge, and behavior change.

What Worked Well

After the critical first step of making MARPs a priority and increasing the level of programming for them, a number of successes have helped improve Nigeria's response to MARPs.

Research: Even within nations with highly generalized epidemics, there is increasing recognition that some groups are disproportionately affected by or uniquely vulnerable to HIV. Conducting qualitative and quantitative research with MARPs can help target prevention responses appropriately. Quantitative research with MARPs has been particularly important to the Nigerian response. Research findings that revealed the disproportionately high level of HIV prevalence among MARPs led to a re-examination of the epidemic and the recognition that it was more mixed than previously thought. This, in turn, led to a re-evaluation of national HIV prevention priorities. Since then, MARPs have become an important component of the national HIV prevention response.

It is, however, important to recognize that in a country as populous and diverse as Nigeria, further research is needed, in part because the epidemic in each of the 36 states and the capital territory are different. While the IBBSS has been informative, it was conducted only in five states and the capital territory, so the results have geographic limitations. In addition, while the IBBSS and MoT study provided valuable information, they offer little insight into the often hidden lives of

FORTRESS FOR WOMEN

Supported by the Global HIV/AIDS Initiative Nigeria Project and FHI, Fortress for Women trains female sex workers in Kano to become peer educators.

Street rallies have been held involving volunteers, peer educators, counselors, and other stakeholders to sensitize the public about HIV.

Peer educators, brothel owners, and managers meet regularly to discuss advocacy strategies. One outcome was an agreement to adopt a "no condom, no sex" policy in all brothels.

Key lessons learned include:

- The importance of building trust with sex workers
- The need for strong relationships with brothel owners and managers
- Coordination among HIV prevention programs to avoid duplication
- Advocacy with stakeholders to create a supportive environment
- The transient nature of sex work means education needs to be ongoing
- Working with sex workers is personally challenging but ultimately very rewarding.

MARPs. Qualitative research is important to see the full picture of the experiences and HIV prevention needs of MARPs. Small-scale qualitative research activities in Nigeria undertaken by FHI (funded by the U.S. President’s Emergency Plan for AIDS Relief through the U.S. Agency for International Development [USAID]) and the Center for the Right to Health (funded by the American Foundation for AIDS Research) have provided initial direction for prevention programs for MARPs.

Strategy and policy response: Even though there is strong evidence globally that MARPs nearly always have a higher burden of HIV infection, research in Nigeria made it possible to successfully argue that MARPs needed greater priority in the national response to HIV. It is a significant achievement that the new National Strategic Framework is committed to the scale-up of prevention among MARPs.

In addition, recognition of MARPs in the national HIV response helps break the silence and lift the taboos about these populations. In Nigeria, where HIV prevention relies heavily on donor support, recognition of MARPs in national policies and strategies is an important step to ensuring government ownership of the HIV response.

Including MARPs within the national response required strong leadership. For NACA, that meant balancing an evidence-informed public health response with competing political and religious views. An example of hostility that had to be overcome was when religious leaders threatened not to participate in the strategy consultation process when they learned that MSM would be included in the discussion.

Capacity building: Capacity building has meant supporting civil society organizations to undertake this work. This requires ensuring there is good knowledge about, understanding of, and empathy with MARPs, as well as developing skills in how best

to deliver and implement programs to MARPs. Civil society organizations are considered best placed to work with MARPs because they are capable of building trust and rapport with MARPs in a way that often is not possible for government agencies (particularly given the legal and political constraints). This capacity has largely been a result of donor financial support.

One approach to developing national capacity has been to work with organizations that may already be known to the target audience so that trust and rapport between the implementing agency and the target audience already exist. For example, FHI’s men’s health project in 2009 chose to work with Alliance Rights Nigeria and The Independent Project because of their familiarity with MSM. Even before MARPs became a national priority, some projects in Nigeria were already working with high-risk groups. One example is FHI’s USAID-funded IMPACT Project, which began in the late 1990s and targeted female sex workers.

Over time, the number of civil society organizations working with MARPs has steadily grown. In recent years, for example, USAID has progressed from having a few partners working with MARPs to having most of its partners, excluding faith-based partners, implementing programs for MARPs, particularly for female sex workers.

Improving access to services: In December 2009, a review of the national response identified an important challenge: HIV testing and counseling services were insufficiently targeted to MARPs (NACA 2009a). Even if individuals have access to a health service, they are unlikely to disclose their practices if they fear judgmental and discriminatory services. While all health care workers should provide confidential and non-judgmental services, in reality it will be a long time before such a standard is achieved across all services. In the meantime, the focus is on ensuring there are some existing health care services that meet these needs for MARPs.

This is a significant step in improving accessibility, but this may not always be easy to achieve because providers may not be able to expand services to MARPs without additional resources.

Health services that are willing to work with MARPs receive appropriate training and support to ensure they can meet the particular needs of MARPs. Prevention programs can then be confident in referring MARPs to such services. This has meant that these services are being developed in geographic locations with proximity to implementing agencies working with MARPs.

Challenges

Has the right balance of HIV prevention programs for the general population and MARPs been achieved? This remains an unanswered question. MARPs have been given greater national priority in recent years, with a corresponding increase in prevention programming for MARPs. However, one of the challenges is that such programs probably have not yet reached appropriate scale and intensity.

Getting better and broader research

results: One of the national strategic targets is to reach at least 80 percent of MARPs with specific interventions. Without estimates of the size of these populations, it is difficult to identify when this target has been met. Knowing this is critical to evaluating whether programs are reaching MARPs in sufficient numbers and intensity to have an impact on behavior change. However, undertaking robust size estimations of the population group is difficult. MARPs can often be hidden, difficult to reach, and highly mobile.

While there has been some good qualitative research done for MSM, more qualitative research is needed to better understand characteristics and behaviors of all MARPs in Nigeria. Understanding how MARPs perceive their own behavior and the value they ascribe to it can assist in developing interventions that

are culturally appropriate for these groups. As work with MARPs continues to expand, the other important research challenge will be to expand the evidence base about how to create effective programming for MARPs.

Greater scale-up: Nigeria's successful Round 9 proposal to the Global Fund to Fight AIDS, Tuberculosis and Malaria included a gap analysis that estimated that current MARP prevention programs reach only 5 percent of the target audience. Some stakeholders contest the reliability of this gap analysis (in fact, the proposal itself acknowledges that the number of MARPs in Nigeria is unknown); nevertheless, the analysis provides some indication that prevention programming for MARPs is not at sufficient scale.

Programming for MARPs is varied in scope, scale, and intensity. Prevention programming with sex workers has progressed the furthest because it has been implemented the longest. Prevention programming with MSM is nascent and covers only a handful of cities; USAID has only four partners conducting programming for MSM in Nigeria. One of the challenges to scaling up work with MSM is identifying how to expand the capacity of the few existing implementing agencies working in this area or to facilitate the involvement of additional agencies. For PWIDs, a limited number of organizations work under the National Drug Law Enforcement Agency, with a focus on reducing demand for drugs and on HIV and drug use. However, these services are thought to be underfunded and under-utilized. Finally, there is no public sector needle and syringe distribution program, although stakeholders report that syringes are widely available from pharmacies.

Recognize geographic variations: Nigeria has 36 states, a capital territory, and 774 local governments. In such a large and diverse nation, there is a need to recognize and address geographic variations in the HIV epidemic. While it is important

that MARPs are nationally recognized as a priority, this may not sufficiently reflect priorities at the state and local level. The challenges in identifying state and local priorities is exacerbated by the lack of specific research: for example, the IBBSS is only conducted in a small number of states. Each state and the capital territory will need to be responsive to the particular epidemic it faces and ensure that it balances priorities appropriately. Even within states, there may often be variations based on geographical location, such as urban compared to rural populations. Overall, the response and priorities in each state will need to vary while still working within the National Strategic Framework.

Avoiding further stigmatization: A key challenge is ensuring that prevention programs do not further stigmatize or put the physical safety of MARPs at risk. Homosexuality, sex work, and illicit drug use are prohibited behaviors. Fear of stigma and discrimination means MARPs will conceal their behaviors. Survey data show that less than 10 percent of MSM fully or partially disclose their sexual orientation to others (Federal Ministry of Health 2007).

Fear of stigmatization is one of the reasons the Men's Health Network, for example, works to ensure their services are not identified as MSM-only, but are for all high-risk men. Concerns about stigmatization also mean that intervention strategies that enable MSM to protect their confidentiality and remain anonymous are being explored, such as telephone information or support services, mobile messaging, and the Internet.

Advocacy and human rights: Even with the inclusion of MARPs in the national HIV response, the overall legal, political, and cultural environment remains largely unsupportive of and, in some cases, hostile to MARPs. As noted in the National Policy on HIV/AIDS, October 2009, progress is slow (NACA 2009c). This has a significant impact on

the ability of HIV prevention programs to reach and provide appropriate services to these groups.

When MARPs fear they will be subject to stigma, discrimination, public exposure, blackmail, or physical violence, and when their activities are criminalized, this affects their willingness to approach HIV prevention programs. Stakeholders report, for example, that the imposition of Sharia law often had the impact of driving sex workers underground, making HIV prevention programming for these women even harder to undertake. This is why advocacy to protect the human rights of marginalized groups is an important HIV issue.

Achieving legislative and cultural change will not happen overnight. Stakeholders often expressed a fear of a backlash among political, religious, and other community leaders against HIV prevention with MARPs. It is a legitimate fear, given developments in some African countries. This has meant that caution and wise political judgment are critical skills for those working with and advocating on behalf of MARPs.

Maintaining the focus on MARPs: In light of competing demands for treatment and prevention programs for the general population and young people, there is a legitimate concern that the focus on MARPs could waver. Maintaining the focus on MARPs and ensuring appropriate scale-up will continue to require strong political leadership, advocacy from civil society organizations, and continued support from donors. Research proved critical to driving the issue onto the national agenda, and further research on population size, resource gaps, and the effectiveness of programming can aid efforts to maintain the focus on MARPs.

Recommendations

Efforts in Nigeria to launch and expand prevention programming for MARPs are still in progress, and



Also Spina

Brothel signage.

how they will unfold over the coming years remains to be seen. However, there is cause for optimism that in mixed epidemics, the HIV prevention needs of the general population can be balanced with the need to ensure targeted programming for MARPs.

Do the research: Even though there is strong international evidence that MARPs have a higher HIV burden and significant HIV risk factors, this does not always act as a persuasive argument for their inclusion in the national response. Sometimes, there is a disbelief that such groups even exist within society. Country-level research estimating HIV prevalence and examining HIV risk factors for MARPs is critical. Such evidence can be used to argue that an effective public health response to HIV requires that MARPs be included in any national strategy.

Implement pilot projects: In an unsupportive environment, pilot projects can usefully demonstrate that it is possible to reach and implement programs with MARPs. Such projects can pave the way for the further scale-up of programs and demonstrate ways to strengthen later interventions.

Promote ownership: If the HIV response is largely donor-driven and donor-dependent, it becomes even more important to promote government ownership of the response. Ensuring that appropriate evidence is available can facilitate government ownership, as well as demonstrate the feasibility of working with MARPs through pilot projects. Despite the difficulties of promoting government ownership, particularly if there is political, social, and religious opposition, prevention efforts for MARPs may not be sustainable without support from government agencies.

Build the capacity of civil society: The criminalization of homosexuality, sex work, and illicit drug use in many countries means civil society organizations are normally best placed to work with MARPs. The role of government in providing health services is still important, but civil society organizations are often best placed to reach, educate, support, and advocate on behalf of MARPs. Currently, donors largely support the work of civil society organizations; in the long-term, the government needs to recognize and invest in the work of civil society.

Ensure coordination of multiple partners: Because there are often many civil society organizations active in HIV prevention, ensuring coordination of activities and areas of work is important to eliminate duplication of services and to provide high-quality services to all regions of importance.

Undertake advocacy: The legal, political, cultural, and religious environment has an enormous impact on the ability of HIV prevention programs to function effectively. This requires ensuring the human and civil rights of MARPs. In Nigeria, the immediate focus has successfully been on ensuring that issues related to MARPs are addressed in the HIV response, as well as on ensuring health services are provided to meet the needs of MARPs.

Future Programming

Future programming in Nigeria should build on the work that has occurred to date. While maintaining a focus on prevention for the general population and youth, Nigeria has proved that it is possible to introduce a much-needed focus on prevention for MARPs. NACA has taken ownership of the issue by giving priority to MARPs in national strategic plans and prevention frameworks. The response so far demonstrates that it is possible to introduce interventions with MARPs in a less than supportive political, cultural, and religious environment. Also importantly, while the focus on MARPs nationally remains important, state and local governments need to understand and be responsive to their local priorities, given there are significant geographic variations in the nature of the epidemic.

The focus on prevention for MARPs is beginning to result in a full range of program activities for MARPs implemented by agencies largely through the support of international donors. Many of the prevention activities for MARPs are relatively new and opportunistically take advantage of existing program activities. Future efforts should concentrate on settings where MARPs reside or congregate, and should also expand to ensure sufficient scale and intensity.

One of the challenges in scaling up programs is securing adequate financial resources and identifying implementing agencies with sufficient capacity and experience in this area. Funding of HIV prevention programs for MARPs is largely donor-dependent. Overall government funding of HIV prevention remains low, and prevention efforts for MARPs compete with those for the general population. This may pose challenges for the ongoing sustainability and ownership of the response to MARPs.

There will also need to be a focus on whether interventions are having the desired impact on

behavior. The next IBBSS should shed some light on whether prevention programs are reaching MARPs and have been successful in increasing their knowledge and improving behaviors. ■

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ACKNOWLEDGMENTS

The author would like to thank the U.S. Agency for International Development (USAID)/Nigeria for their assistance and support in undertaking this case study. Thanks go to a variety of stakeholders who shared their thoughts and experiences, including the Society

for Family Health; the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention Nigeria; the National Agency for the Control of AIDS; the Ministry of Health; the World Bank; Fortress for Women; Winrock; the Center for the Right to Health; FHI 360; Population Council; the Independent Project; Heartland Alliance; the National AIDS/STI Control Program; and members of the U.S. President's Emergency Plan for AIDS Relief General Population and Youth Prevention Technical Working Group.

RECOMMENDED CITATION

Spina, Aldo. 2010. *Nigeria's Mixed Epidemic: Balancing Prevention Priorities Between Populations*. Case Study Series. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

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