

COUNTRY CONTEXT

In Nigeria, while the overall adult HIV prevalence rate is 3.7%, rates vary greatly by region (from 2.0% in the South West to 7.0% in the South South) and by age group (from 2.9% in 40-44 year olds to 5.6% in 25-29 year olds). Sexual intercourse remains the most common mode of HIV transmission (80%), followed by mother-to-child transmission (10%), and infected blood and blood products (10%). The majority (62%) of new infections occur among the general population and 38% among high-risk populations, e.g. injecting drug users, female sex workers and men who have sex with men (NACA 2007).

In 1999, the *National Agency for the Control of AIDS* (NACA) was created together with a *State AIDS Control Agency* (SACA) in each state. The second *National Strategic Framework for AIDS (2010-2015)* includes ambitious targets for 2015: to reach 80% of sexually active adults and 80% of most at-risk populations with HIV counseling and testing; to ensure 80% of eligible adults and 100% of eligible children are receiving anti-retroviral therapy (ART); and to improve access to quality care and support services to at least 50% of people living with HIV (PLHIV).

Civil society organizations (CSOs) have emerged as a vital part of the HIV and AIDS response in Nigeria, especially community-based organizations (CBOs) operating at a local level. In addition to providing services in their communities, CSOs have become a key partner of the Nigerian government in developing, implementing, and monitoring the national response to AIDS. The Civil Society Consultative Group on HIV/AIDS in Nigeria (CICGHAN) established in 2002 is platform for CBOs to participate in policy formulation.

STUDY FOCUS

The objective of the community response evaluation in Nigeria's is to assess the impact of the community response on the following indicators:

- *HIV and AIDS-related results*: knowledge of HIV prevention strategies, sexual risk behaviour, AIDS-related morbidity and mortality
- *Utilization of HIV and AIDS-related services*: use of key HIV-related services
- *Social transformation results*: gender attitudes, HIV-related stigma, knowledge of OVC rights, social capital

The evaluation study seeks to enhance our understanding of the contribution of CBOs to important AIDS-related and social outcomes in order to inform future action by communities and approaches to community engagement in the wider health and development arenas.

NIGERIA AT A GLANCE

Region	West Africa
Capital	Abuja
Population (millions)	154.73
GDP (US\$ billions)	173.00
Life expectancy at birth (total years)	48
Primary completion rate (total %relevant age group)	80 (2005)
Number of people living with HIV	3,300,000 [2,900,000-3,600,000]
Adult prevalence rate (age 15-49)	3.6% [3.3%-4%]
Adults living with HIV (aged 15 and up)	2,900,000 [2,600,000-3,200,000]
Women living with HIV (age 15 and up)	1,700,000 [1,500,000-1,900,000]
Children living with HIV (age 0-14)	360,000 [180,000-520,000]
Deaths due to AIDS	220,000 [170,000-260,000]
Orphans due to AIDS (age 0-17)	2,500,000 [1,800,000-3,100,000]
National Policy: <i>National Strategic Framework 2005-2009</i>	
National Coordinating Body: <i>National Agency for the Control of AIDS (NACA)</i>	

Source: UNAIDS 2010 & World Bank 2011

Community Evaluation in Nigeria

Communities

The specific definition of community used in this evaluation follows the definition used in Nigeria: communities are a collection of household units brought together by common interests, and/or made up of at least 5,000 people (or 100 households) living in the same geographical area. These villages are mainly administered under a chief based at the location level. A collection of villages forms a sub-location, which together to form a location. A community would share, therefore, similar culture, social practices, beliefs, and value systems.

Community response

Ideally, the strength of a community response would be measured by the scope and intensity of HIV and AIDS-related interventions, activities and programs implemented by CBOs. As this data was not available, the strength of a community response was measured by the number of CBOs. Data collected during the survey was used to verify the initial community assignment.

STUDY METHODS

Utilizing a quasi-experimental design, data was collected through:

1. a household survey in 28 communities
2. qualitative data collected from 69 CBOs and 66 key informants: 23 health officials including Local AIDS Action Committees (LACAs), 20 community leaders, 11 religious leaders, and 12 principals or teachers from local schools
3. a funding allocation study: 35 CBOs in the study group and 19 CBOs in the comparison group

Twenty-eight communities were selected across six states which represent the geopolitical zones of Nigeria and have the highest HIV-prevalence in their respective geopolitical zone. HIV-prevalence varied substantially in the included communities, ranging from 3% in Nsukka to 22% in Bwari. Communities were paired, so that there was an urban-rural pair in each state. Within each pair, the community with the higher number of CBOs relative to population was considered to have a stronger community response and assigned to the study group; the community with the lower number of CBOs relative to population was assigned to the comparison group.

STUDY FINDINGS

CBO activities: CBOs in the study group had been present for a longer time (on average 11 years versus 7 years for CBOs in the comparison group, and tended to be larger (on average 52 volunteers and 11 full-time staff members versus 33 volunteers and 4 staff members in the comparison group).

The interviewed CBOs focused on prevention activities: 77% engaged in some type of prevention efforts, 39% in providing treatment and care, of which only a few provided HIV treatment including ART (17%), 42% in support for OVC and 17% in impact mitigation.

None of the interviewed CBOs conducted a systematic community needs assessment to inform their activities. This is likely related to the scarcity of financial and human resources at their disposal, though it would be a good means to focus their limited resources to where the need is highest and thus achieve the best return for investment.

Do community members in communities with a stronger community-based response demonstrate better HIV and AIDS-related results?

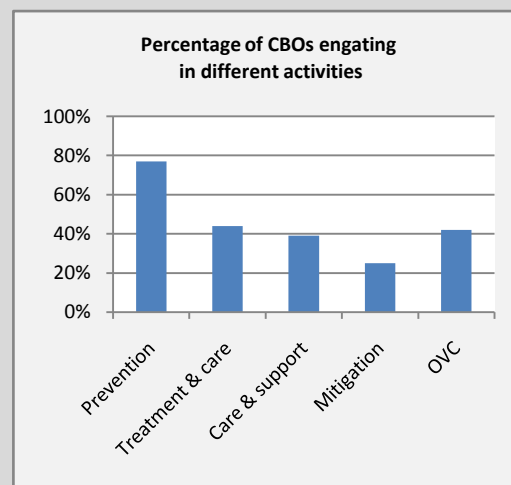
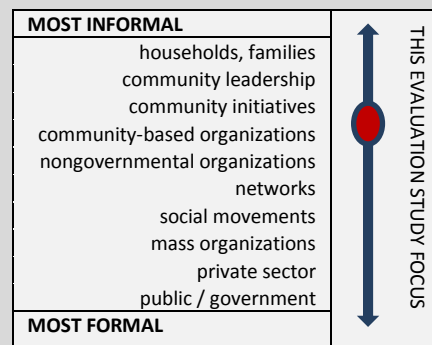
Knowledge of HIV-prevention strategies: The strength of CBO engagement was not associated with HIV/AIDS-related knowledge; respondents' demographic characteristics were better predictors of knowledge.

Sexual risk behavior: The number of CBOs per 100,000 inhabitants was not associated with condom use or the number of sex partners (past 12 months).

AIDS-related morbidity and mortality: The number of CBOs per 100,000 inhabitants was not associated with the number of sick or the number of deceased household members. The study group had higher overall mortality than the comparison group. The leading cause of illness and death was reported by household members to be malaria. Wealthier households had fewer deaths and cases of illness in the past 12 months than poorer households and reported mortality was higher in urban than in rural areas.

Civil society organization (CSO): is a generic term, inclusive of all community-based initiatives and organizations (e.g. CBOs, NGOs, FBOs, networks, as well as local initiatives).

This evaluation study is focused on: AIDS-engaged community-based organizations (CBOs) in Nigeria



Do community members in communities with a stronger community-based response demonstrate better use of AIDS and HIV-related services?

Use of AIDS and HIV-related services: CBOs had a much greater impact in rural areas than in urban areas. An increase of 1 in the number of CBOs per 100,000 inhabitants was associated with more than 2-fold increase in the likelihood that a respondent would report using prevention services; 64% increase in the likelihood of reporting use of treatment, respectively; and 41% increase in the odds that an OVC received emotional or psychological support. In Urban areas the association between CBOs and service utilization was either weaker (prevention), as or was the case with treatment services and services provided to OVC, not statistically significant.

Do community members in communities with a stronger community-based response demonstrate better social outcome?

Gender attitudes: The strength of CBO engagement was not associated with the selected indicators of gender equality. A majority of key informants (KIs) reported an increase in women’s capacity to decide how household money is spent which was mostly attributed to increased education and empowerment of women (in the past five years).

HIV-related stigma: The strength of CBO engagement was not associated with reported attitudes towards PLHIV. However, almost three quarters of all KIs said that CBOs affected the way that PLHIV were treated in the community, with more KI in the comparison group holding this opinion.

Knowledge of OVC rights: The strength of CBO engagement was not associated with the selected indicators of children’s rights.

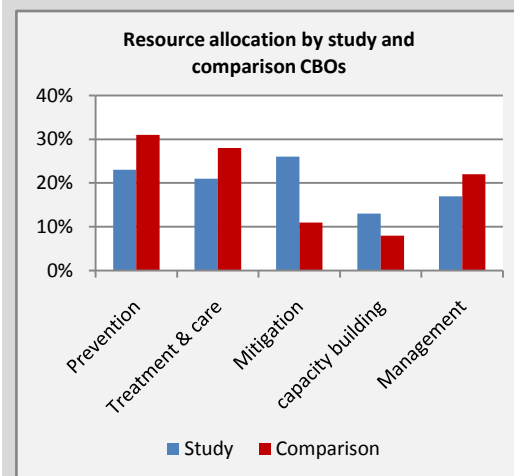
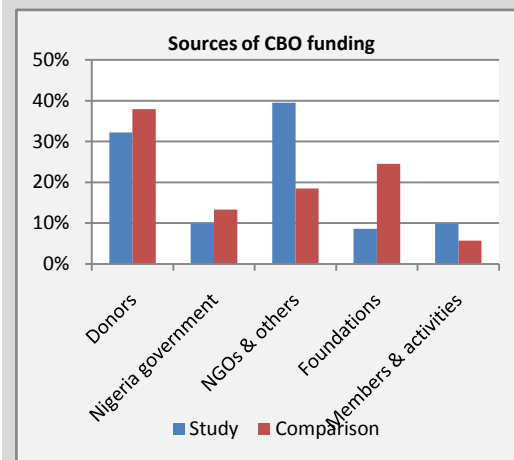
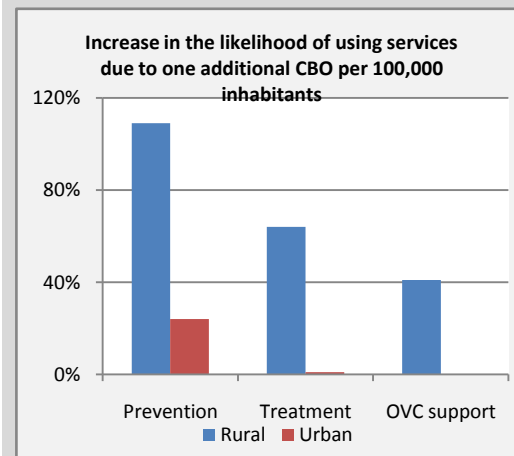
Social capital (interpersonal trust, cooperation, civic engagement): The number of CBOs per 100,000 inhabitants was not associated with any of the selected social capital indicators. Also, there were no significant differences between the study and comparison groups.

How is CBO funding used to support community-based activities for prevention, treatment, care, and mitigation?

CBOs spent most on prevention services (25% of total expenditures) and socio-economic impact mitigation (including support services for PLHIV and OVC) (23% of total expenditures). Study CBOs devoted proportionally more resources to socio-economic impact activities and capacity-building; comparison CBOs devoted proportionately more resources to HIV prevention, treatment and care services. Average annual funding levels were US \$22,491 across organizations in the study group and US \$6,219 in the comparison group.

There are substantive differences in funding streams. CBOs in the study communities reported receiving most of their funds from NGOs and others (which include funding from professional associations and religious organizations) (39.5%). In the comparison communities, CBOs indicated that they received most of their funding from international donors (37.5%) and foundations (24.5%).

Average annual funding was US\$22,500 per CBO in the study group and US\$6,200 in the comparison group. The average number of volunteers was higher in the study group than in the comparison group (69 and 38, respectively). These volunteers represented a substantial resource for CBOs.



The allocation of expenditures by CBOs was substantially different from the use of funds at national level. Expenditures recorded in the National AIDS Spending Assessment (NASA, 2008) indicated that most of the funds of the national AIDS response were spent on treatment and care (47%) and very little on impact mitigation and OVC support (2.5%). In contrast the interviewed CBOs reported a much more equal allocation of funds between prevention, treatment and care and impact mitigation.

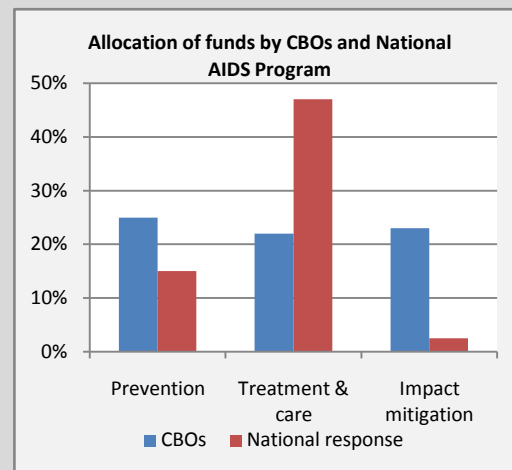
CONCLUSIONS

The findings suggest that CBO engagement adds value to the national HIV response. The strength of CBO engagement was associated with increased service utilization, especially in rural areas. These findings are particularly encouraging as the availability of services by other types of organizations or the government is often limited in these locations. Consequently, further investment (i.e., funding, capacity-building) in CBOs is needed, with an increased emphasis on those operating in rural areas.

As there were already very high levels of knowledge and acceptance of PLHIV, and low levels of reported stigma, no association was noted between the strength of CBO engagement and these indicators.

Strength of CBO engagement was not associated with reduced sexual risk behaviors. One reason may be that interviewed CBOs focused on education and information campaigns and only a few reported engaging in targeted behavior change communication programs.

The strength of CBO engagement was not associated with the indicators of community transformation (social capital and gender norms). The lack of differences in these indicators between study and comparison communities most likely is due to the fact that the CBOs did not concentrate on activities aimed at changing these factors.



REFERENCES

- NACA** (2007) HIV/STI Integrated Biological and Behavioural Surveillance Survey. Abuja: National Agency for the Control of AIDS
- Rodriguez-Garcia R et al** (2011) *Analyzing community responses to HIV and AIDS: Operational framework and typology*. Washington: World Bank: Policy Research WP 5532 (January)
- UNAIDS** (2005). *Civil Society and the 'Three Ones'*, International HIV/AIDS Alliance and International Council of AIDS Service Organizations, May 2005, Geneva: Joint United Nations Programme on HIV/AIDS
- UNAIDS** (2010) *UNAIDS report on the global AIDS epidemic 2010*, Geneva: Joint United Nations Programme on HIV/AIDS
- World Bank** (2011) *World Development Report and Indicators 2011*. Washington, DC: The World Bank

EVALUATION OF THE COMMUNITY RESPONSE TO HIV AND AIDS

The World Bank in collaboration with DFID and the UK Consortium on AIDS and International Development launched an evaluation exercise in 2009 to assess the results achieved by community responses to HIV and AIDS. The primary objective of this effort is to build a more robust pool of evidence on the impact and added value of community-based activities and actions. This brief is part of a series summarizing the findings from studies conducted in Burkina Faso, India, Kenya, Lesotho, Nigeria, Senegal, South Africa and Zimbabwe.

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EVALUATION PARTNERS IN NIGERIA

This brief is based on the evaluation report entitled "Effects of the Community Response to HIV and AIDS in Nigeria" prepared by ICF Macro. The field research was conducted by ICF Macro and the Nigerian National Population Commission (NPC). Oversight was provided by the National Agency for the Control of AIDS (NACA), the UK Department for International Development (DFID) and the World Bank.

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