



The Benefit of HIV Voluntary Counseling and Testing (HVCT) in Abuja, Nigeria

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HIV/AIDS present a major crisis that is increasingly affecting the most productive segments of the population across the development sectors in Nigeria. HIV voluntary counselling and testing (HVCT) has demonstrated its ability to increase number of people coming for testing because its free, the use of care and support services among adults, has contributed to viable strategies of HIV interventions. HIV antibody rapid testing has emerged as a key component of its prevention strategies world wide. Despite its importance in reducing HIV risk behavior and linking people to care and treatment, the actual HIV antibodies testing is still relatively low. Some rural areas in three out of six area councils in the Federal Capital Territory, Abuja were visited from November 2006 to January 2007. One thousand six hundred and seventy (1670) people were voluntarily counselled and tested in these areas. Serial algorithm was performed using Determine HIV1&2 (Abbott Japan Co., LTD. Minato-ku, Tokyo, Japan.), Stat pakTM HIV1&2 (Chembio diagnostic system, Inc. 3661 Horseblock road Medford, NY 11763, USA.) and Genie II HIV-1/HIV-2 (Bio-Rad, 3 boulevard Raymond Poincare 92430 Marnes LA Coquette- France). 734 (43.95%) were male and 936 (56.05%) were female. 115 (6.89%) people were positive for HIV antibodies, 1392 (83.35%) were negative for HIV antibodies and 163 (9.76%) defaulted. 1587 (95%) had never tested their HIV status benefitted from these programme. It is necessary to continue HVCT awareness in rural areas to avail more opportunity to benefit from these services to reduce HIV/AIDS infection.

Keywords: HVCT, HIV, Determine, Stat pakTM, Genie II, Rural areas

Introduction

HIV/AIDS infection continues to pose a major threat to many people in Nigeria. It is now apparent that HIV/AIDS epidemic is a national disaster and therefore, everyone's problem and that is the reason why our government responded to the expressed and unexpressed needs of the research institute, non governmental organizations (NGOs), university community and the needs of its broader external community. Various activities undertaken have demonstrated the need for a concerted intervention requiring creative, well-informed leadership from a section potentially well-resourced to shape institutional and inter-institutional responses.

Since 1985, when a test for HIV antibodies first became available [5, 9], issues pertaining to HIV testing behaviour have been of considerable interest to research. Some of the issues raised in previous studies are the benefits of testing for HIV antibodies. One of the benefits is the reduction of risky sexual behaviour [8, 10] and allowing early access to clinical care [3, 4].

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HIV voluntary counselling and testing (HVCT) is the process by which a person undergoes counselling enabling him or her to cope with stress and make informed choices about HIV testing. HVCT programs have demonstrated their ability to increase safe sexual behavior and use of care and support services among adults [2]. By helping clients learn their HIV sero status and creating a personalized HIV risk reduction plan, HVCT can provide the information and support necessary to change risky behaviors that could lead to HIV infection or transmission [1]. Pre counselling of subjects, post counselling of subjects and a risk reduction plan are the key features that distinguish HVCT from other HIV testing services.

HVCT has become a widely advocated HIV/AIDS prevention strategy among adults. Most clients of HVCT have become advocates for HIV/AIDS prevention strategy. Sixty percent of all new HIV infections in sub-Saharan Africa, however, occur among young people between the ages of 10 to 24 [11].

The focus of this study is to ascertain the relevance and benefit of HIV voluntary counselling and testing (HVCT) in rural areas of Abuja, Nigeria. We chose rural areas because of the profound effects of HIV/AIDS and lack of awareness in this setting.

Methods

This study was cross-sectionally designed and conducted in the Federal Capital Territory (FCT) Abuja. Abuja is the developing Federal Capital City of Nigeria. It is located at the centre of the country with a land area of 8,000 square meters. It has boundary with the Kaduna state on the North, Plateau State in the East and South East, Kogi State to South West and Niger State to the West. It is divided into six area councils; Abaji, Gwagwalada, Kuje, Municipal, Bwari and Kwali. It was a purposely built capital city to replace Lagos, and it officially replaced Lagos in December 1991, after 15 years of planning. This research work was funded by FCT Action Committee on AIDS (FACA), Abuja, from November, 2006 to January, 2007 in three out of a total of six Area councils. The research instrument, originally constructed in English, was translated into Hausa (Language spoken widely in Abuja, FCT) and then back-translated into English to ensure validity of questions. The participants gave their consent prior to the study; however consent was gotten on behalf of those below 18 years from their parents or guardians.

One thousand six hundred and seventy (1670) people were voluntarily counselled and tested in these rural areas. The HIV rapid testing was performed in line with the national algorithm using Determine HIV1&2 (Abbott Japan Co.), Stat pak™ HIV 1 & 2 (Chembio diagnostic system, Inc) and Genie II HIV-1/HIV-2 (Bio-Rad, 3 Boulevard Raymond Poincare 92430 Marnes LA Coquette- France) on-site and test results were offered to the clients the same day. A client was considered to be HIV positive if he/she had two positive rapid HIV test or positive tie breaker (Genie 11 HIV1/HIV2) in cases where rapid test results were ambiguous or discordant.

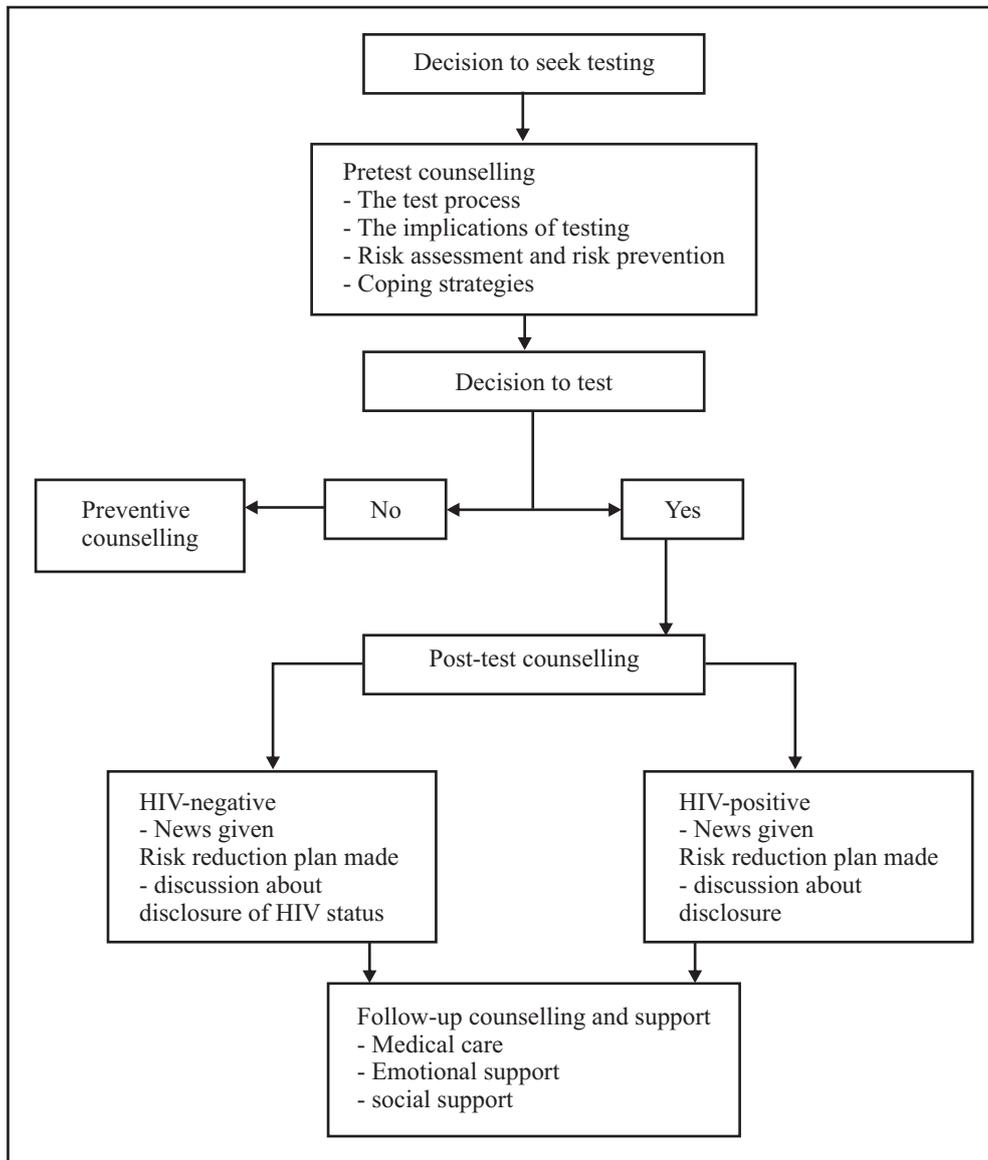


Figure 1: HVCT MODEL [6]

Results

One thousand six hundred and seventy (1,670) subjects were counseled and tested for HIV antibodies. 734 (43.95%) were male and 936 (56.05%) were female with mean age of 34. 115 (6.89%) were positive for HIV antibodies, 1392 (83.35%) were negative. 163 (9.76%) declined testing despite the counselling. One thousand five hundred and eighty-seven (1,587) had never known their HIV status before (Table 1). The results of One thousand Five hundred and Seven(1507) clients screened for HIV shows that Seven (7.6%) were positive for HIV. Twenty nine (1.9%) were males and Eighty six (5.7%) were females. It is seen that highest prevalence of HIV was obtained amongst the age bracket (26-30) and followed by age bracket (31- 35) as shown in figure 2.

Table 1: Sociodemographic characteristics of studied population

Sociodemographic	No. of Clients	Percentage (%)
Sex		
Male	734	44
Female	936	56
Currently in school		
Yes	1106	66
No	564	34
Marital status		
Single	856	51
Married	726	44
Divorced	88	5
Ever had sex		
Yes	1414	85
No	256	15
HIV testing previous		
Yes	83	5
No	1587	95
HVCT		
Yes	1507	90
No	163	10

Note: Percentage may not add up to 100% since percentage were rounded to nearest whole.

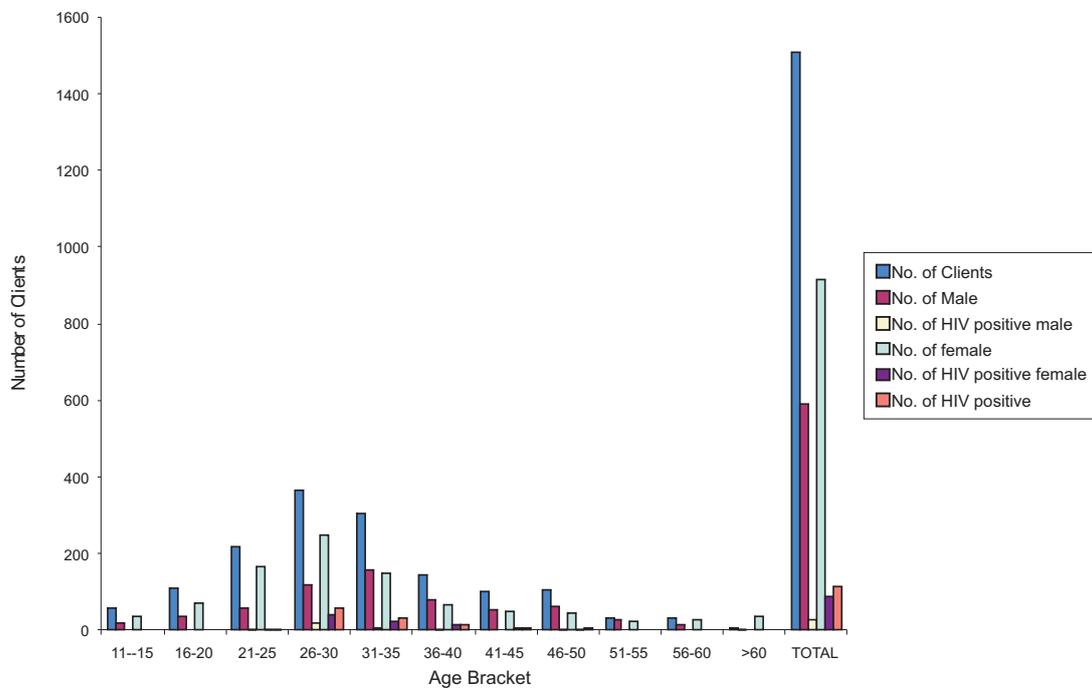


Figure 2: The Prevalence of HIV infection in Abuja, Nigeria.

Discussion and Conclusion

The results obtained were quite interesting. A staggering 95% (1,587) of the selected population did not know their HIV status. Of this population studied 163(9.76%) of the population studied declined testing despite counselling (Table 1). Reasons given ranged from ignorance of the benefits of knowing their HIV status, fear of alienation and stigmatization. 3.52% refused testing at first but returned a few days after counselling for testing. This further stresses the need to continue awareness programmes for individuals in rural areas to know their HIV serostatus. This benefit would create an HIV risk reduction plan, since individuals migrate from rural to urban and vice versa for survival.

Sexually active age group is a factor that predisposes people to HIV infection and high rate of infection is expected in such groups. Age group with the highest infection was among both males and female of age bracket 26-30 and 31-35 years with 18, 7 persons infected with HIV respectively while that of females was at age bracket of 26-30 and 31-35 years had 39,23 cases. Data showed an increase in infection with age and peaked at the age bracket 26-30 after which a decrease followed and no infection was observed in people higher than 51 years.

Barriers to accessing HVCT services include stigmatization, geographic accessibility, lack of social promotion, inefficient counselling and testing practices, and cost [12]. These studies have demonstrated that a period of HVCT significantly increased the number of persons testing per day and enhances cost-effectiveness of HVCT when offered as an integrated program within an existing AIDS service-oriented non governmental organization. While HIV testing behaviour and associated characteristics has been studied in the general population, sector specific information is largely lacking. As articulated by the International Labour Organization, studies that contribute specifically to the multilateral effort to combat HIV/AIDS at workplaces are needed [7].

Therefore, integration of this HVCT program within a volunteer-based AIDS service organization should also be encouraged.

Acknowledgment

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