Plateau State HIV and AIDS Epidemiology and Impact
Map of Nigeria showing Plateau State
Introduction

• Plateau state is situated in the North Central Region with about 21,000 sq. km and have a projected population of 3,933,822 (2006 Census) with 196,691 pregnant women 865,440 of child bearing age

• It has three senatorial districts with 17 LGA. The State has been classified among the “hot zones “of HIV infections

• There are about 1,109 health facilities in the state, 828 are publicly owned health facilities while about 486 are private health facilities.
Purpose and Objectives

Rationale

• Detailed assessment of trends and magnitude of HIV & AIDS burden enhances understanding of the disease and the impact of the different interventions, areas of gaps and policy measures
• This is of immense benefit to the national health programs in areas of planning and prioritization, funds allocation and funding applications as necessary

Objectives

• To review trends of the epidemic through available epidemiological data (disease incidence, prevalence, morbidity and mortality) at the National, State and local Government levels and among sub populations (e.g. MARPs, Vulnerable groups)
• To identify and provide plausible explanations for the variations in geographic areas and communities with changing or static HIV prevalence or risk factors
• To examine the relationship between epidemiological data and programmatic interventions (prevention, diagnosis, treatment) including financing.
• To estimate where possible the number of lives saved and infections averted by modelling of interventions using three different scenarios (maintenance of status quo, scaling up support to meet targets on National plans and scaling up support to meet universal access targets)
Methodology

• The study methodology involved
• Process understanding
• Tools development and training (National & Zonal)
• Data collection
  ✓ Desk review
  ✓ Secondary data analysis and synthesis
  ✓ Impact analysis and modeling
  ✓ Critical Assumptions
• Limitations
The prevalence of HIV has been on the decline since 2001 until 2010 when it was 7.7%, the security challenges in the State, low condom use among the population were some of the factors fueling the epidemic.
There was consistent increase in HIV prevalence in the urban areas compared with the rural areas over the years. This could be explained by persistence rural-urban migration and lack of focused intervention among the vulnerable population in rural areas.
The proxy prevalence from FCT was highest among the MSM and least among the armed forces in the key population over the years. The FSW when combined was 56.0%. This is because sex workers and MSM are not in the formal sector and structured programmes were not implemented for them. There is need for concerted effort to put in place appropriate intervention for the key populations particularly the MSM and FSW.
The prevalence of STI has been on the increase over the years. There is need for robust STI prevention interventions.
The trends of new infection in the population were similar across the age categories except for the gradual decline observed among individuals between the ages of 25-49 years.
The trend of incidence of HIV was the same in both males and females and on the decline. However more females were infected compared with males. This could be due to the biology of female and the socio-economic context in our society.
The trend of new HIV infection among key populations progressively declined over the years. There is need for sustained efforts to avert HIV transmission in the State.
The trend of new infection among children born to HIV-infected pregnant mothers was similar in both gender. The persistent security challenges could be responsible for the fluctuations between 2008 and 2013.
There was marginal increase in number of deaths except for 25-49 years which had increased over the years; however there was data gap in number of deaths recorded in the State. There is need to institutionalize the mortality records in the State.
There was progressive decline in HIV deaths resulting from TB complications over the years. This could be due to improvement in management in terms of diagnosis, availability of drugs and treatment. However, there is need to sustain the efforts.
The trend of TB and HIV co-infection has been stable over the years until 2013 when a sharp decrease was observed. This could be due to improved access to health care services.
Tb mortality among HIV patients reduced from 2002, similarly, the incidence of TB was also on the decline. However, the number of people with HIV and TB co-infection on ART increased slightly. The increase could be due to accumulation of both new and old cases on ART services.
The risk perception was low for HIV and AIDS among the key populations. The available data was limited to informal groups of the key populations for HIV transmission. There were data gaps for the formal groups (Armed Forces, Police, and Transport workers) and other years. Therefore, there is need for survey among other drivers of epidemic.
More males (24.2%) engaged in higher-risk sexual intercourse compared with females (3.8%). The socio-economic context favors males compared with females.
More males used condom during higher-risk sexual intercourse compared with females. The low knowledge and socio-economic context limited sexual bargaining of females.
More females discriminated against HIV infected people compared with males. Gender focused HIV stigma reduction is required in the State.
The males had good knowledge of HIV prevention methods compared with females. This explained the increased burden of HIV among females.
Males (40.4%) had more comprehensive knowledge of HIV and AIDS compared with females.
Majority of males (99.1%) were circumcised. This was because the cultural practices support male circumcision.
The prevalence of STI was more among male respondents. This could be due to the fact that STI symptoms manifest early in males compared with females.
More males engaged in early sexual intercourse compared with females and more of them used condom. The increased knowledge of males could be the reason for increased condom use.
There was increased number of females screened compared with males. This was because more females were screened during antenatal clinic visits.
More females tested positive compared with males. This was similar to pattern of HIV infection in the State.
Majority of clients on 1st line ARV were 15 years and above. This was because more of them were on treatment.
The 15-19 years clients were more on the 2nd line regimen compared with 0-14 age group; however there was lack of data for other age categories. The data gaps observed could be due to absence of data tools that disaggregated into various age structures.
The proportion of females on 2\textsuperscript{nd} line regimen was more than males, however there was significant reduction in 2013 compared with 2012. The observed reduction could be due to lost to follow-up or lack of defaulter tracing.
More males and females clients aged 15 years and above were lost to follow up compared with others.
There were more HIV positive pregnant women on ARV compared with infant tested positive. There was no data on key populations provided with MPPI and people living with HIV/AIDS who received adherence support 2013 in Plateau State.
More people were currently on ART than those that were newly enrolled. However, there was a significant increase in the number of newly enrolled clients in 2013. The gaps in available data should be improved by strengthening the M&E system.
The females were more on ART than males. This was because females were more among people infected by HIV.
The clients in the age group 15-19 years were more on ART in both 2012 and 2013. This reflected the majority of people on treatment.
The only available data (2012 and 2013), showed that number of clients attended ANC were more than those tested. Efforts should be made to screen all pregnant women during ANC visit.
The number of pregnant women on ART was less than those that are actually HIV positive. This was because some did not qualify for inclusion in the treatment group.
The year 2013 recorded significant increase in the number of clients (25-29 and 0-14) who were counseled, tested and received results. This revealed increased service coverage.
There was significant increase in ART coverage especially among females in year 2013 compared with 2012.
There were more female orphans provided with social services compared with males. There were data gaps on services provided for orphans in the State. Data collection and management should be given priority.
Plateau State treatment Coverage for HIV Pregnant Women (PLACA)

The treatment coverage for HIV pregnant women significantly increased in 2013.
All ART and PMTCT service providers were trained; however, the HCT service providers were more than those trained. Capacity building in HCT should be done for quality service delivery.
There was progressive increase in Plateau State financial investment in HIV in the years under review. This should be sustained and effectively monitored.
The Ministry of Local Government Affairs and that of Education attracted more funds from State HIV compared with other line ministries. The fund disbursed to Ministry of Health was lower than expected because it is in the domain of health sector response. There were data gaps for other years.
There was progressive increase in the fund released by the World Bank to the State HIV programme since 2011. There was no fund released in 2009 and 2010. This may be because the State could not release the counterpart fund since it is a conditional grant from the World Bank.
There were women in SACA, but not in other HIV programmes. There is need for gender mainstreaming in all HIV programmes.
The proportion of women in SACA declined in 2010 till 2013 and women were involved in other components of HIV programmes. There is a need to improve on this.
Monitoring and Evaluation meeting was held every month in 2013, and 9 times in 2012. All LGAs submitted data in 2012 and 2013. However, timeliness and completeness of data submission was poor. The persistent security challenges in the State were responsible for late data submission.
Prior to 2012, there was poor data use in HIV programme management in Plateau State. This has improved significantly in 2013 as newsletter and other advocacy kits were produced based on available data.
Over the years, public facilities were the major providers of HCT services. However, between 2012 and 2013, the number of HCT services increased in private and NGO outlets. There is need for increased collaboration among stakeholders so that more of HCT services are provided in non public health institutions.
All the ART service sites used CD4 monitoring, and the number increased significantly between 2010 and 2013. This could be because CD4 monitoring machines were available in small number before 2010. This initiative should be sustained in order to improve service delivery.
The public facilities were the major providers of PMTCT services among health institutions. However, between 2010 and 2013, the number of PMTCT service outlets significantly increased. There is need for increase collaboration among private and NGO this is because private health institutions provided more than two-thirds of health services to the population.
The available youth friendly service outlets in the State were integrated. However, the number of the outlets has reduced drastically since 2009. The persistent security challenges have affected the expansion of youth friendly services.
There was gradual increase in number of facilities providing integrated HIV and SRH services. These should be maintained or improved upon in order to reduce drivers of HIV epidemic in the State.
In 2013, 456 infections were averted as a result of PMTCT services in Plateau State. Similarly 126 deaths were averted. This demonstrated the effectiveness of PMTCT services.
There were about 19,000 adults clients who needed ART but were not reached in 2013. Similarly, about 4,000 children could not access treatment of HIV. The security challenges, narrow scope of interventions could be adduced for this. There is need to expand service coverage to reach more clients in need.
The number of those needed PMTCT services was far more than those who received it over the years, except in 2013 when an improvement in the service provision was achieved leading to reduction in new children infection due to MTCT.
Conclusion

• There was no data or information on FLHE activities in the State for the years under review. There were data gaps in HIV intervention services in Plateau State.

• The low capacity, persistent security challenges, lack of appropriate data tools could be adduced for this.
Recommendation

• The key populations were significant drivers of HIV epidemic in Plateau State.
• There is need for specific intervention programmes including behavioural re-orientation and condom programing for the key populations and particularly the female sex workers to avert the tide of HIV epidemic.
• The existing data collection mechanism should be improved and strengthened by designing and providing appropriate data tools and forms to capture information that will guide programme direction and facilitate data analysis and comparison.
• Stakeholders at national level should monitor data collection and provide timely feedback to the lower levels.