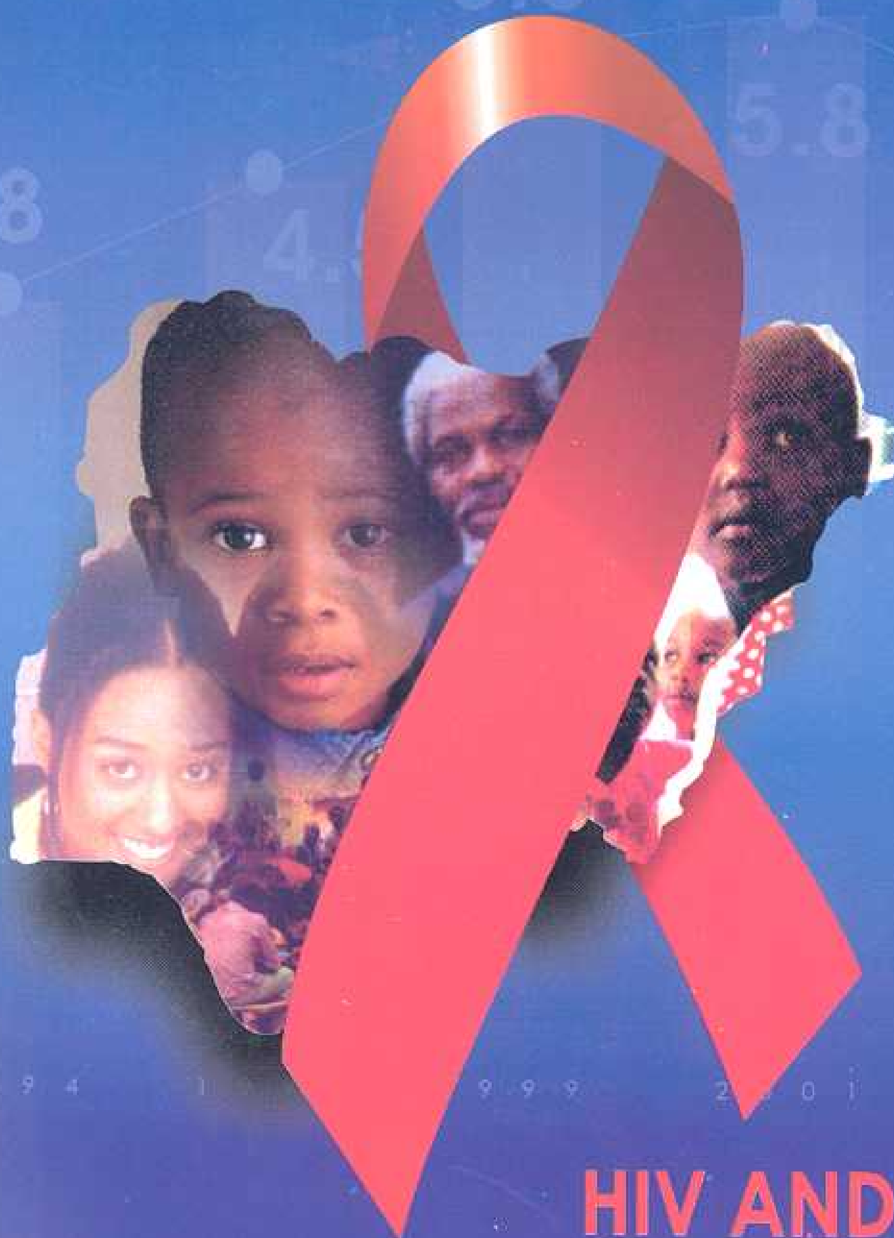
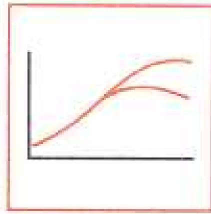
HUMAN DEVELOPMENT REPORT

NIGERIA 2004



HIV AND AIDS:

A CHALLENGE TO SUSTAINABLE HUMAN DEVELOPMENT



HIV and AIDS: A Challenge to Sustainable Human Development

The analysis and policy recommendations of this report do not necessarily reflect the views of the United Nations Development Programme, its Executive Board or its Member States. The Report is an independent publication commissioned by UNDP Nigeria. It is the fruit of a collaborative effort by a team of eminent consultants and advisors.

Foreword

This report takes an in-depth look at HIV and AIDS in Nigeria and its effect on the dimensions of human development including the capacity for people to lead long and healthy lives, to be knowledgeable and to have a decent standard of living. The Millennium Development Goals address vital aspects of human development in relation to eradicating extreme poverty and hunger; achieving universal primary education; gender equality and women's empowerment; reducing childhood mortality; improving maternal health; combating HIV and AIDS, malaria and other diseases and ensuring environmental sustainability. HIV and AIDS has begun to take a definite toll on human development in Nigeria exacerbating the problems of poverty, malnutrition, low educational attainment, and gender disparities, which threaten the attainment of the MDGs.

The HIV and AIDS epidemic is a word-wide phenomenon, however, sub-Saharan Africa with only 10% of the world's population has over two thirds of the people living with HIV (25 million people). It is estimated that 3.2 to 3.8 million people are living with HIV in Nigeria, which implies that 1 in 7 African living with HIV is a Nigerian. On the whole, although the overall percentage of adults infected seems to have remained stable over the last few years the number of people living with HIV is still growing. The poor, women and children bear the brunt of the disease, which affects health, productivity and incomes thus exacerbating poverty. In sub-Saharan Africa, 57% of adults infected are women and 75% of the young people infected are women and girls.

Based on the available literature on HIV and AIDS in Nigeria, this report finds that there is a generalized epidemic. This means that HIV is spreading throughout the general population rather than being confined to populations at higher risk, such as sex workers and their clients, men who have sex with men and injecting drug users. There are large regional variations in HIV prevalence with an alarming increase in prevalence in formerly low prevalence areas. The report notes that while the primary effects of the disease are devastating to the individual, family and nation, the secondary effects of the disease are equally important including the needs of millions of orphans requiring care and support from ageing relations. Children represent the future, lack of attention to quality healthcare and education imperils the future growth of the nation. The stigma associated with people living with HIV and AIDS and those affected by AIDS leads to further isolation and mental hardship. Losses in productivity created by deaths and illnesses associated with HIV and AIDS can result in slowing down of growth and other development objectives.

Nigeria is a signatory to the Millennium Declaration as well as other international commitments including the Declaration of Commitment adopted at the UN General Assembly Special Session on HIV and AIDS (UNGASS) in 2001 which articulate measurable goals and targets to reverse the epidemic, including targets in several key areas, and call for resources commensurate with the challenge and specified follow-up at national regional, and global levels. This report has examined both achievements and constraints to the country's response to HIV and AIDS and come up with powerful recommendations on what needs to be done, offering concrete policy messages that promote a comprehensive approach and mobilize actors and institutions well beyond the health sector. The scale of the problem demands a stepped up campaign to prevent infection and a much more concerted effort at the three tiers of government with concrete action at the community, household and individual levels to promote prevention as well as care and support of those infected and affected by the virus.

The report highlights issues to be taken into account in promoting a sustained proactive multi-sectoral approach towards prevention and mitigation of HIV and AIDS, to stop and begin

to reverse its impacts on human development in Nigeria. Key areas of intervention include integration of HIV and AIDS programs into the strategic plans of all sectors; promotion of voluntary counseling and testing as a gateway to care and support and reduction of stigma and discrimination; expansion of access to treatment; capacity building for the large number of community-based and non-governmental organizations involved in HIV and AIDS programmes; dealing with social stigma and the violation of human rights; empowering women to negotiate safe sex and encouraging the use of condoms; promotion of community-oriented and home based care and social support systems; harnessing the contribution of the private sector; the establishment of effective monitoring and evaluation of HIV and AIDS programmes; dissemination of best practices from existing interventions and more in-depth studies on the drivers and socio-economic impact of HIV and AIDS at the state and regional levels.

In 2004, UNAIDS, the United Kingdom and the United States co-hosted a high-level meeting at which key donors reaffirmed their commitment to strengthening national AIDS responses led by the affected countries themselves. They endorsed the "Three Ones" principles, to achieve the most effective and efficient use of resources, and to ensure rapid action and results-based management. The principles for the coordination of national AIDS responses include one agreed HIV and AIDS Action Framework that provides the basis for coordinating the work of all partners, one National AIDS Coordinating Authority, with a broad-based multi-sectoral mandate and one agreed country-level Monitoring and Evaluation System. The UN Country Team in Nigeria coordinates a Thematic Group on HIV and AIDS, a joint effort by the UN system and development partners in Nigeria to support the national response. This National Human Development Report, prepared in collaboration with the UN Theme Group on HIV and AIDS, like its predecessors aims to contribute to this framework of action by providing independent analysis and focusing attention on the broad-based monitoring and evaluation of the progress towards the achievement of internationally agreed goals and targets.

Tegegnework Gettu
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Acknowledgements

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Special acknowledgement should go to Prof. B. Osotimehin and members of the National Action Committee on AIDS (NACA), Prof. Eyitayo Lambo (the Minister of Health), Prof. Odeh Ojowu (Chief Economic Advisor to the President), the Permanent Secretary and staff of the National Planning Commission (NPC), the UN Country Team and Representatives, and above all the staff of UNDP for their support and commitment. The steering committee composed of representatives of UNDP, NACA, and two umbrella civil society organizations Civil Society consultative Group of HIV and AIDS in Nigeria (CISGHAN) and Network of People Living with HIV and AIDS in Nigeria (NEPWHAN) reviewed and directed the work of the five contributing authors. The committee included Dr. I. Atta, Chief E. Ativie, Mr. S. Harbor, Dr. J. Landi, Dr. A. Lusigi, Prof. E. Oladipo, Dr. D. Omoweh, Dr. K. Oyegbile, and Dr. P. Matemilola. The five contributing authors included Dr. W. Daini, Prof. L. Erinosho, Prof. J. Idoko, Dr. A. Ikpeazu, and Dr. M. Lecky. In addition, a number of UNDP Nigeria staff also provided useful comments, suggestions and inputs during the drafting of the report.

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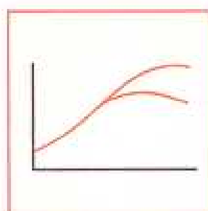
The insightful comments from international reviewers have also enriched the final document including input from V. Robinson and S. Burd-Sharps. We are also indebted to the editor, P. Edebor, and various readers who did substantial work to ensure that the language of the document makes it accessible to a wide audience.



Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-retroviral
ANC	Ante Natal Care
APIN	AIDS Prevention Initiative in Nigeria
AED	Academy for Educational Development
CACA	Catholic Action Committee on AIDS
C&S	Care & Support
CSW	Commercial Sex Workers
CEDPA	Center for Development and Populations Activities
CSO	Civil Society Organization
CHBC	Community Home Based Care
CiSCGHAN	Civil Society Consultative Group on HIV and AIDS in Nigeria
DFID	Department for International Development
DOTs	Directly Observed Therapy Scheme
FBO	Faith Based Organization
FHI	Family Health International
FGN	Federal Government of Nigeria
FMOH	Federal Ministry of Health
FACA	Family Action Committee on AIDS
GIPA	Greater Involvement of People with AIDS
HIV	Human Immune-deficiency Virus
HAART	Highly Active Anti-retroviral Therapy
LACA	Local Government Action Committee on AIDS
MSM	Men having Sex with Men
NEPWHAN	Network of People Living with HIV and AIDS in Nigeria
NACA	National Action Committee on AIDS
NGO	Non-Governmental Organizations
NLC	Nigeria Labour Congress
OVC	Orphans and Vulnerable Children
ORIDs	Other Related Infectious Diseases
OIs	Opportunistic Infections
PLWHA	People Living With HIV and AIDS
PABA	People Affected by AIDS
PCA	Presidential Committee on AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PCP	Pneumocystis Carinii Pneumonia
PHC	Primary Health Care
PID	Pelvic Inflammatory Diseases
STIs	Sexually Transmitted Infections
SM	Syndromic Management
TB	Tuberculosis
TBPT	Tuberculosis Preventive Therapy
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly
UNICEF	United Nations Children Fund
UNAIDS	United Nations Joint Programme on HIV and AIDS
USAID	United States Agency for International Development
VCT	Voluntary Counselling & Testing

Note on Data

This National Human Development Report on HIV and AIDS relies heavily on Statistics from three major sources: (i) *AIDS Epidemic Update, December 2003*, UNAIDS and WHO; (ii) *Report on the Global HIV/AIDS Epidemic*, July 2002, UNAIDS; and (iii) *Technical Report on the 2003 National HIV Sero-prevalance Sentinel Survey*, April 2004.

The AIDS Epidemic Update, 2003 provides new estimates that show increasing numbers of people living with HIV and AIDS especially in Sub-Saharan Africa as well as Asia and the Pacific, and Eastern Europe and Central Asia. The Update provides *global* and *regional* estimates of (i) the number of people living with HIV and AIDS; (ii) people newly infected with HIV in 2003 and (iii) AIDS deaths in 2003. Out of the estimated 40 million people living with HIV and AIDS, 26.6 million are in Sub-Saharan Africa, which also had 3.2 million of the new infections (5 million globally) and 2.3 million deaths due to AIDS in 2003 (3 million globally).

The 2002 Report on Global HIV and AIDS Epidemic provides the most comprehensive view of the HIV/AIDS epidemic worldwide and includes *global, regional* and *country by country* estimates of (i) estimated number of people living with HIV and AIDS; (ii) Children orphaned by AIDS; (iii) AIDS deaths; (iv) HIV prevalence rates; (v) knowledge and behavior indicators. Since the first clinical evidence of HIV and AIDS was reported in 1981, the report estimated that globally, more that 20 million people had died from AIDS by 2001, 40 million people were living with HIV and AIDS, and 5 million people became infected in 2001 (including 800,000 children). Sub-Saharan Africa (SSA) accounted for 3.5 million of the new infections bringing the total number of

people living with HIV and AIDS in the region to 28.5 million. Fewer than 30,000 people were estimated to be benefiting from antiretroviral drugs by the end of 2001 with an estimated 1.1 million children orphaned by AIDS.

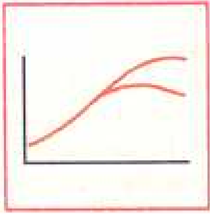
The UNAIDS report notes that prevalence levels should be treated with caution since these do not reflect that actual risk of acquiring the virus. Prevalence rates may be higher in specific age groups, the example is provided of Botswana that had a median prevalence rate of 44.9% among pregnant women between 15 24 years while the median prevalence among older pregnant women between 25-29 years was 55.6%. For Nigeria the continued high prevalence rates among women and youth is major challenge.

The Technical Report on The 2003 National HIV Sero-prevalence Sentinel Survey is the sixth in a series of HIV/Syphilis sero-prevalence surveys that began in 1991 and were conducted in 1993, 1995, 1999 and 2001. The report on the 2003 survey highlights the prevalence of HIV infection among the adult population of 15 49 years using pregnant women attending antenatal clinics in public health facilities in selected sites in all states of the Federation as a proxy. The series of surveys reveal an alarming increase in median prevalence rates from 1.8% in 1991's survey of 9 states to 3.8% in 1993 (17 States), 4.5% in 1995 (21 states), 4.5% in 1999 (36 States and FCT) to 5.8% in 2001 (36 States and FCT). The national median prevalence for the 2003 survey was 5.0%. However, although the national prevalence is perceived to be lower,

there are wide variations between states and between urban and rural areas across the country. *The report therefore notes that it is not sufficient to conclude that the epidemic has stabilized or is on a downward trend ant it would be most inappropriate to relax nterventionefforts based on these observations alone.*

UNAIDS Cosponsors include UNICEF, UNDP, UNFPA, UNDCP, ILO, UNESCO, WHO and the World Bank

[2] supported by the Federal Ministry of Health, National Action Committee on HIV/AIDS (NACA), US Center for Disease Control and Prevention (CDC), USAID, WHO, Policy Project of the Futures Group International, and the Joint United Nations Programme of HIV/AIDS (UNAIDS).



Executive Summary

THE has frst cases of HIV and AIDS were reported in 1981 and two decades later the disease infected 40 million people worldwide 28.5 million (or 75 per cent) of which reside in Africa. As the most populous country in Africa, Nigeria is responsible for 20 per cent of Africa's total AIDS fgure and 10 per cent of the world's.

With an offcial prevalence rate of 3.5 million PLWHA and 1.5 million AIDS orphans, and 300,000 deaths annually, HIV and AIDS has become a "generalized epidemic" in Nigeria and current evidence suggests that the epidemic is yet emerging; it is still far from maturing. Already, all the geo-political zones are affected, and the prevalence gap between the urban and rural areas of the country has narrowed down signifcantly. The burden of infection continues to be borne by young people with more females than males infected.

Also, since the majority of Nigerians are youths (over 60 per cent, 44 per cent of which are 15-year-olds or under) and, as the most sexually active (25 per cent of which initiate sex at age 15 and 50 per cent at age 18), they constitute the most vulnerable group. It follows, therefore, that the key to halting the spread of AIDS is to target the youths with all the advocacy mechanism that can be mustered as well as in all the offcial policies of government.

Given the current scale of prevalence and government's limited capacity to respond, it is expected that HIV and AIDS will infect as many as 10-15 million Nigerians by 2010. This number will constitute about 15 to 25 per cent of adults – close to the rates currently being experienced in Southern Africa. Given this scenario, it is also projected that by 2010 there will be as many as 9 million orphans in the country and bed occupancy arising from AIDS-related illnesses could rise to 50-60 per cent in some hard-hit communities in the country.

AIDS did not just grow into epidemic proportions overnight in Nigeria, it was because the country failed to take the early warning signals seriously that its wounds festered. The frst general reaction to the disease was to vehemently deny it, then give half-hearted attention to it when it began to wipe out its frst set of victims. It took the inauguration of President Obasanjo to formulate an articulate response to the epidemic. He constituted a Presidential Committee on AIDS (PAC) with himself in the chair and the Cabinet Ministers as members. He also set up the National Action Committee on AIDS (NACA) to co-ordinate the multi-sectoral and multi-level response to the AIDS challenge.

NACA built an elaborate institutional framework to fght AIDS. It set up SACA at the state level and LACA at the local government level. It also developed a National Policy on AIDS and backed it up with the development of HEAP, a programmatic framework for the national response response whose

twin components are creation of an enabling environment, and specifc HIV and AIDS intervention. The document identifed over 200 activities conceived as short-term (2001-4), high impact interventions.

Indeed, under president Obasanjo, the policy environment became so favourable to the fght against AIDS that donor support for the fght swelled to US$ 300 million. The government demonstrated its commitment by contributing US$ 56 million from its own coffers. It is with this funding support that government was able to implement its HAART programme which placed 10,000 adult and 5,000 children HIV carriers on ARV drugs at over 70 per cent subsidy rate. This amounts to a drop in the ocean if we juxtapose this with the annual death rate of 300, 000 from AIDS-related causes and the projection that by 2010, between 5 and 15 million Nigerians will be HIV positive with almost 9 million orphans, leading the United States' National Intelligence Committee (NIC) to predict that Nigeria will be one of the fve "next-wave" countries that will double or triple the number of global HIV and AIDS by 2010.

Research has shown that 80 per cent of HIV transmissions is spread through sexual intercourse and that unscreened blood transfusion accounts for 5 per cent while mother-to-child transmission accounts for the rest. Although the discussion throws up quite a revealing number of factors that stoke the fre of this epidemic, the core causative factors are poverty, a wide range of deep-rooted harmful traditional practices (such as polygamy, courtesanship, concubinage, "wife hospitality", culturally-approved sexual intercourse with siblings' wives, levirate (i.e., wife inheritance)), and the unintended consequences of rapid modernization and urbanization (including a thriving commercial sex trade, unprotected coercive sex, child labour, overcrowding, and forced or voluntary migration).

The World Bank has described poverty in Africa as "legendary" but in Nigeria it is also paradoxical because the country has all the resources to be one of the richest and most advanced in the world. But, sadly, it is among the poorest 25; it is the 6th largest producer of oil in the world, yet it is the poorest OPEC country, and has been on top of the world suffering index. Poverty manifests itself in the country in at least six ways, namely, (i) human poverty; (ii) physiological deprivation; (iii) income poverty; (iv) poor macroeconomic performance; (v) negative impact of public expenditure on human alleviation; and (vi) social exclusion. The report rightly observes that wherever the foregoing traits co-exist with severe economic crisis, fscal indiscipline and pandemic corruption, then "the resulting environment becomes ideally suited to a rapid growth in the pauperization of the population"

Poverty plays a central role in the spread of HIV in Nigeria; it is the fuel that stokes the fre of the epidemic. Education and health, which hold the key to the alleviation and eventual eradication of human poverty, have been neglected through inadequate investment, poor strategy and even poorer implementation since the mid eighties, resulting in worsening human deprivation and widespread pauperization. Nigeria itself has abdicated all the development-inducing international obligations it freely entered into, including the global conferences on Education for All and Reduction in Adult Illiteracy, Universal Access to Safe Water, Universal Access to Primary Health Care, etc. The offcial attitude to these international commitments appears rather cynical: the country signs up because it agrees in principle with the proposition, not because it is determined to achieve the goal. That is why it makes the right noises and moves in the required direction but never really achieves

the goal of any such obligation.

Drawing profoundly on the nation's experience, the Nigerian *National Human Development Report 1998* makes it clear that additional budgetary allocation is not necessary the answer to individual and national poverty, but that a most serious damage has been inficted on the quality, content, and the moral bases of social services. This makes it imperative to redirect public expenditure priorities in order to achieve anti-poverty objectives. The argument fnds support in the Nigerian Civil Society Network, which states that between 1996 and 1998 when HIV was beginning to exert a heavy toll on the nation, federal budget for the health sector averaged 0.2 per cent – the very lowest in the world and that total expenditure on AIDS in 1998 amounted to US$ 0.03 per capita – the least in Africa. The network states further that debt servicing obligations in year 2000 cost US$ 1.5 billion, which was nine times the total health spending for 2001. The resulting fscal imbalance, coupled with policy and institutional failure, unbridled corruption, capital fight, high levels of poverty, and collapsed public infrastructure has deepened poverty to a level of mass impoverishment.

Besides poverty, it is obvious that the harmful cultural practices like polygamy, courtesanship, concubinage, "wife hospitality", culturally-approved sexual intercourse with siblings' wives, cult prostitution and levirate (i.e., wife inheritance) imply multiple sexual partnership and translates to high risk of contracting HIV. Studies in Benue, Kogi and Nsukka area where these practices are rampart indicate high HIV prevalence rate. All types of sex work (commercial, professional or part-time) belong to this category of high risk. Research has shown that HIV prevalence among CSW in some cities ranges between 50 and 70 per cent. One of the key attractions for CSW is that it provides far greater income for the practitioners than they would get from other jobs. That again is another paradox: commercial sex workers make more money from their illegal trade and people in legal employment earn the peanuts.

Another cultural imposition that makes HIV to thrive in the country is the patriarchal ordering of social life which dictates a subordinate position for women. In many Nigerian communities, women have low earning power, 25 per cent of the marriages they contract are polygamous (meaning that as many as 2 or 10 wives can "share" the same husband), and the women generally have little or no control over their sex lives, or those of their husbands.

The use of unscreened blood products, needle sharing, use of unsterilized sharp objects and practices such as FGM, uvulectomy, scarifcation and so on, are still rampart and they all expose people unnecessarily to HIV infection. It is shocking that many Nigerians have poor knowledge of the disease – most Nigerians recognize AIDS as fatal, but just 50 per cent know about the means of transmission or prevention. It is quite surprising that after two decades of AIDS onslaught in the country the level of ignorance is still considerable. Closely related to this is the refusal of most Nigerians to undertake voluntary test to determine their sero-status. The main reason for this, of course, is the social stigma associated with HIV. Experts estimate that over 70 per cent of infected Nigerians are unaware of their status, and may still be engaging in high-risk behaviour.

HIV and AIDS is a waster of everything good and precious. It has very serious impact on the epidemiological and demographic profles of the country as well as on health care delivery system and manpower development. Finally, it depletes the resources of sufferers, their families, and the society at large.

The epidemic will continue to have negative impact on key government and business elite as well as discourage foreign investment. The professional class will remain vulnerable because adult prevalence rates are already high. It will affect recruitment and staffng in all sectors, including the military. In addition, rising social tensions arising from AIDS-related deaths and allied socio-economic problems can exacerbate regional and ethnic tensions in the country, which may prove diffcult to handle. Similarly, public confdence in the political leadership could be eroded and weakened further if the government fails to respond effectively owing to poor governance. Further deterioration of the already weakened government institutions by the escalating HIV and AIDS crisis could leave Nigeria in a seriously weakened position, resulting in its inability to continue to play a leadership role in West Africa and Africa. Nigeria is a regional power, and the rise in HIV and AIDS in the country will be felt in the entire West African region.

The effect of the epidemic can be very severe on communities, as can be seen in the case of Vandekiya Local Government Area in Benue State which grapple with increased poverty, loss of skilled labour, increased mortality and morbidity, a weakened social and leadership structure, and the risk of extinction. Generations of families have been wiped out by the epidemic and their farmsteads are now desolate. A recent UNICEF review of the impact of orphans on education and child labour in 20 Sub-Saharan African countries found that children aged 5-14 years that had lost one or both parents were less likely to be in school and more likely to be working more than 40 hours a week.

Economists agree that HIV and AIDS will bring about a precipitous decline in productivity and savings. The epidemic will affect businesses, food supply, livelihoods, and the availability of various cadres of professionals. AIDS, therefore, has direct effect on the economic growth of most high-prevalence developing countries

The West African sub-region has much higher HIV and AIDS prevalence and, hence, travelling salesmen and women could facilitate its transmission in the sub-region. The sex industry is also thriving by traffcking of young Nigerian girls to Europe through staging posts in neighbouring countries like Benin, Togo, Ghana, Gabon, Cameroon, Ivory Coast, and Senegal. The Nigerian military has been engaging in peace-keeping operations in Liberia and Sierra Leone for more than a decade. The outcomes of various surveys indicate that there is a high prevalence of HIV and AIDS in the war-torn areas. Nigerian soldiers that had served in these confict areas are reported to have high prevalence of HIV and are likely to spread it among their families and in the general population. On the other hand, many refugees who are believed to be infected with HIV are feeing from war-torn countries like Liberia and Sierra Leone to neighbouring countries like Nigeria.

HIV and AIDS could also exacerbate social unrest, as suggested in a report by the US State Department. The death of adults/community leaders would create a vacuum that the immature and less experienced individuals will only be too glad to fll. The community safety nets and power structures may be disrupted or stretched beyond their limits and this may lead to poor governance, lawlessness and civil disobedience, especially in the rural communities where such power structures are mainly responsible for civil harmony and stability

The epidemic is already over-burdening health personnel and the health services. If the incidence should rise beyond the capability of health personnel the entire system will collapse and the virus

will become more widespread. Patients with HIV and AIDS and other related diseases may take up between 10 and 25 per cent of bed occupancy in most secondary and tertiary hospitals. The fgure may be as high as 30 per cent in parts of the country with high HIV and AIDS prevalence.

Offcially, Nigeria has an estimated 3.5 million people living with HIV and AIDS but most experts believe that a fgure of 5-6 million is more realistic. It is projected that about 20 per cent of identifed cases require comprehensive care, including palliative care, prevention, treatment of opportunistic infections and related malignancies, as well as anti-retroviral therapy. The cost of treatment is so burdensome that the PLWHA themselves, their families and even the government cannot shoulder it.

Another aspect of the national response, which was not given due attention in the past, is care and support (C&S) for people infected or affected by HIV and AIDS. But because this has a telling effect on the economy – decreasing productivity, threatened food security, depleting skills, increased absenteeism, etc. – the stakeholders in Nigeria are becoming increasingly aware that the relegation of C&S of PLWHA and PABA will put all other interventions at a risk of failure. Hence stakeholders have recognized the need to use C&S to deal with DSD at home, in the public and in the workplace. Community and family support for C&S is still very low in Nigeria, hence the PLWHA have organized themselves into effective networks for mutual support with the backing of CSOs and the government which also fashioned a workplace policy in line with ILO recommendations.

Despite these efforts, however, the national response to HIV and AIDS still has many challenges to contend with. For instance, good as the HEAP document appears to be, it is yet to be technically estimated and is thus left to the various actors to take on whatever they can. The document lacks a legal and institutional framework to operate; sectoral roles are poorly defned and co-ordinated, and there are policy gaps and contradictions needing to be addressed. For instance, in view of PMTCT, what should be done with exclusive breastfeeding and family planning campaigns? What is the fate of antenatal and delivery services in the face of poor regulation of blood transfusion and non-availability of screening facilities, which makes possible the transfusion of contaminated blood products?

Also, there are major and immediate challenges to expand VCT, provide drugs and treatment, build infrastructure in response to the outcomes of VCT and other awareness programmes, provide safety nets for the poor, especially through access to drugs, nutrition, counselling follow-up and assistance to help orphans stay in school. About 300, 000 people die every year from AIDS related diseases. If the programmes do not expand rapidly enough health personnel and facilities will be inadequate to cope.

It has been well documented that the resources available for the national response are inadequate. In 2002, the HEAP was grossly underfunded and against the US$ 190 million which the programme was estimated to cost in year 2000, it is suggested that Nigeria will require not less than US$ 500 million (Appendix 4.3). This is partly the result of over-dependence on foreign donors. State and local government hardly make allocations to fght the disease. Apart from the Federal Ministry of Health other ministries lack the capacity to prepare intervention programmes, hence their programmes have been in gestation for a long period; the police which has a very large population at risk has no specifc

response programme and private sector commitment to the AIDS war is but recent. All these suggest that the war is still not being fought multi-sectorally.

Undoubtedly, HIV and AIDS presents a major challenge to human development in Nigeriaand the exact cost of the epidemic is diffcult to calculate. As the death toll increases, skills shortage in all sectors becomes apparent, wearing down the gains of economic growth and human development. AIDS is indeed devastating Nigerian communities, and poses a real threat to poverty reduction efforts and the achievement of the UN Millennium Development Goals (MDGs).

• It is important that HIV and AIDS is now widely accepted as a development issue and not just a health issue. A sustained proactive multi-sectoral approach towards prevention and mitigation of its effects is necessary to stop and begin to reverse its impacts on human development in Nigeria. To achieve this, a number of measures have to be taken, among them the following:

• Much more fnancial, technical and political resources should be invested to ensure the effective and rapid implementation of HEAP and sustain the effort to develop a National Strategic Plan.

• Access to HIV prevention interventions should be provided for all along with appropriate care and support for persons infected and affected by AIDS.

• Affordable treatment options, including access to generic ARV drugs, should be made available to all PLWHA. That is why it is strongly recommended that government should go into the manufacture ARV drugs.

• The commitments of stakeholders at all levels of government and all segments of the society should be sustained in order to achieve effective community mobilization and involvement in the prevention and management of HIV and AIDS control.

• The legal and policy frameworks relating to HIV and AIDS control should be harmonized.

• The social conditions of the people should be greatly improved to minimize vulnerability to high-risk behaviour.

The Road Ahead

The road ahead will brighten signifcantly in the AIDS war if the destitution in the land is made the twin target of the attack. No war can succeed where people are hungry, malnourished, sickly, and patently insecure. The good thing, however, is that government has some control over the situation. It can switch public expenditure pattern and priorities in favour of *genuine* poverty alleviation/eradication strategies. It can formulate specifc women-empowerment schemes; it can target the youths, give them hope, good education and jobs. If it plays the right music, the people will dance. A lot of money will be needed to do all these; but more than just money, there is need for creative invention of resources in government and the creative use of them. The pillars of public education, health care and other social services, which were pulled down a long while ago, have to be rebuilt for those sectors to play their natural role in arresting the march of HIV and AIDS.

The large presence of PLWHA in the country is enough for government to mobilize its strategic partners to begin immediate manufacture of AIDS treatment drugs in Nigeria. If the African Union is slow in deciding on this, Nigeria cannot afford to delay. Local manufacture of the drugs will bring the cost down considerably, facilitate unlimited access to them and create employment locally.

Also, care and support interventions should be expanded drastically in all the four areas of need – medical, psychological,

socio-economic, and human rights and legal. The need to provide the present multi-sectoral approach to HIV and AIDS with an enduring legal and institutional framework through which to operate cannot be over-emphasized.

The very dangerous traditional practices like polygamy, wife exchange among siblings, wife hospitality, cult prostitution, scarifcation, use of unsterilized sharp objects and needles, etc., can be fought successfully with excellently packaged preventive awareness campaigns. To stop the spread of HIV resulting from unintended consequences of rapid urbanization and modernization requires new social planning of public institutions, policies, and urban development. The urban chaos that Nigerians are forced to live in is a product of their legendary planlessness. AIDS has created new challenges that cannot be managed with the same traditional approach that has been in use for so long.

If, as research has borne out, 80 per cent of HIV infections is attributable to sexual intercourse, then this is the strongest point to deal with. Although, sex talk is culturally prohibited, its practice has continued nevertheless to dominate social relations. With the existing knowledge of sexual networking, all the contributory factors should be carefully analysed with a view to adjusting social policy to make people less vulnerable. A great deal of resources will be required to promote safe sex and other wholesome sexual practices among the general public and the high-risk population.

As HIV and AIDS has challenged the foundations of existing social order, it would take a complete social re-engineering to re-assess offcial policies, social norms and values. For instance, with 1.3 million Nigerian children living with HIV and AIDS, which they contracted from their mothers through breastfeeding or during childbirth, is it still necessary to insist on exclusive breastfeeding? Similarly, if education and health sectors which traditionally play a most useful role in the total development of each individual have been allowed to deteriorate so badly, they cannot be looked up to for solutions in their present state. What this means is that we must re-plan and re-build the foundations of education, health care and other social services to make them bear the weight of new realities.

In the social re-engineering plan such as is advocated here, special care must be taken to protect and empower women, the girl-child, and youths in general. The protection and empowerment should encompass statutory and legal avenues to promote women education and advancement; it should include promotion of fnancial independence through entrepreneurship and leadership training and complete eradication of those cultural practices that reduce women to commodities to be purchased, abused and dispossessed of their fundamental rights. It is only when a when a woman has lost every sense of self-respect, direction and stability that she takes to commercial sex work. When the same happens to a man, he takes to crime and becomes a security risk. To avoid the greater risk of HIV spread to the yet uninfected, the re-engineering plan must eliminate the factors that make people vulnerable to infection.

Everything should be done in the process of intervention to tackle the stigma that makes life an ordeal for PLWHA. The social stigmatization associated with HIV and AIDS remains a formidable barrier in Nigeria.. Fear and discrimination prevent many people from disclosure or seeking to fnd out about their status, and hence continue to infect other people, unaware of their status. The challenge is to change attitudes in community and break the silence in order to encourage PLWHA to seek help. There is no gainsaying that success in tackling DSD will

automatically promote VCT, which prevents 70 per cent of Nigerians from knowing (or wanting to know) their sero-status. If DSD were effectively tackled, a major breakthrough would have been recorded in the AIDS fght. It is now widely acknowledged that available regime of medicines and treatment therapies would permit most HIV and AIDS positive individuals to live normal and productive lives.

There are existing windows of opportunity to explore as a way forward in the AIDS war. No matter how hellish things might be, Nigerians don't want to lose their lives for any reason. Another thing Nigerians fear more than death itself is to die with ignominy. *To die of AIDS, in the Nigerian mentality, is to die with ignominy.* That is why DSD is very common. The fear of dying with ignominy makes the average Nigerian to shrink away from any possible contact with an HIV carrier and treat him like a ghost.

The thing to do in this case is to convert this fear to advantage: The people don't want to die, and AIDS is positive death. The point, therefore, is to rub in the Pro-Life message in the preventive awareness campaign. The kind of campaign required is not the intermittent, selective radio and TV message. If we have the right understanding of the disaster coming, then Nigeria must *dominate the public discourse for the next two years with HIV and AIDS*. The message should be beamed aloud to the remotest part of the country that AIDS is real, that it kills in millions, and that unless every individual takes a decisive step to prevent being infected, he will be one of the projected 9-15 million carriers of this disease which has no known cure. If this message goes on air it will gain instant attention everywhere and if it is repeated intermitentlyon all radio and TV stations across the land for two full years, Nigeria will save itself a lot of agony and unnecessary expenses. And it is quite possible. Virtually 95 per cent of the electronic media in Nigeria belong to government; even the independent press can be relied upon to give this cause the greatest support.

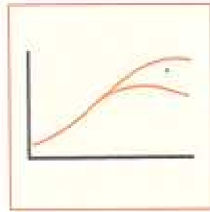
Also, given that the youths are the most vulnerable group, the intervention programmes must target them. The programmes must be properly packaged to infuence students in the secondary schools and tertiary institutions, artisans in the various trades, the stream of sexually active unemployed people who constantly migrate in search of work. Other high-risk populations like women, young girls, CSWs/FSWs, etc., must be specifcally targeted with creative preventive and C&S programmes. Another layer of intervention for them is for the social planning system to expand avenues for work, recreation, further education, etc.

The large network of CBOs, NGOs and CSOs offer another veritable window of opportunity that should be maximized. Reports indicate that the 500 offcially registered groups are not representative of the absolute number and that they are unevenly distributed across the states. All stakeholders (including the government) should ensure that the whole country is effectively covered in number and diversity of intervention. The capacity of the support groups should be built to achieve the goal of the intervention.

Additionally, the public-private partnership should be solidifed. The private sector should be encouraged to play a more active role in the fght against AIDS given its potential to mobilize abundant human, technical and fnancial resources. The sector should establish its own workplace programmes for HIV and AIDS, to include advocacy, counselling, access and support for treatment, and bereavement assistance to staff affected by AIDS-related deaths. Given the fnancial constraints and the non-availability

of certain expertise in government, it is desirable to establish a formal, mutually-benefcial, business arrangement of long-term nature, between government and private partners or consortium involving share rewards and risks and share governance and accountability as an important component in mobilizing resources for the national response.

The partnership must be all-embracing; LACA, SACA, state and local governments and all CSOs must play their part alongside the federal government and the private sector. The existing political commitment should translate to positive results; that is when it will be meaningful. This is one war Nigeria cannot win by throwing money at it. But with deft management of donor assistance, excellent co-ordination of programme execution and special care and empowerment of the vulnerable groups, Nigeria can and will stop the clock of AIDS and turn the tide against it in the country.



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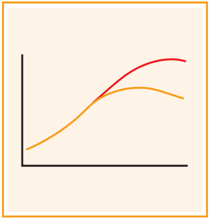


Chapter One

An Overview of HIV and AIDS in Nigeria

"The reality of HIV and its progress to AIDS is no longer in doubt."
-- President Olusegun Obasanjo

AS mankind approached the turn of the new millennium, there was a palpable thrill sweeping across the globe. It was a feeling of being a part of history, of living at a most momentous period in human history. The third millennium represents for man the peak of his civilization, a period of technical perfectness, and an opportunity to recreate the world anew.

Hope in the future (represented by the new millennium) was understandably high, especially as man appeared to have tamed the terrors of his dark past: memory of the two World Wars had receded and the prospect of a third one seemed unlikely, the Cold War too had given way to a new rapprochement in the spirit of mutual integration and globalization. Every resource, every intelligence was now being deployed in the pursuit of universal peace and the achievement of human progress through development initiatives.

The development objective, codified as sustainable development (i.e. development of current potentials without compromising the development of future generations), has human prosperity as its goal. But the emerging picture in the larger part of the world negates the achievement of human progress and sustainable development. The rich picture shows, among other things, growing impoverishment of vast populations, increasing joblessness and homelessness, malnutrition, hunger, diseases of epidemic proportions, collapsed educational and health care services, and general insecurity of life and property. To crown it, the HIV infection has thrown the world into a monumental crisis by arresting every index of development and depleting rapidly the resources badly needed to contain it.

The HIV infection has thrown the world into a monumental crisis by arresting development and depleting rapidly the resources badly needed to contain it.

The first cases of HIV and AIDS were reported around 1981. Two decades later, it has already infected 40 million people worldwide out of

By 2005, HIV infection will rise above 100 million and by 2010, life expectancy in Africa will decrease to the level found at the beginning of the last century.

which 28.5 million (approximately 70 per cent) reside in Africa, meaning that a significant proportion of Africans infected are in Nigeria. It does seem that AIDS is the most prolonged war that mankind has ever had to fight and expert predic-tions show that the epidemic is yet to fully explode.

In its 2001 edition of the Interna-tional Crisis Report, entitled "AIDS as a Security Issue," the Interna-tional Crisis Group (ICG) estimates that HIV infection by 2005 will rise above 100 million and that by 2010, life expectancy, especially in Africa which is bearing the greatest bur-den, will begin to decrease to the level found at the beginning of the last century.

To the rest of the world, HIV and AIDS is a war like none other; but to Africans, particularly Nigerians, it is a most debilitating war that threatens the very foundation of their existence and future develop-ment. The first cases of HIV and AIDS were reported outside Africa, yet the continent has become the worst affected region. This points up, on the one hand, that the prevalence of HIV is closely related to the level of development; and, on the other, that HIV can effectively arrest development. With Africa bearing 70 per cent of HIV infections, there is no gainsaying that the epidemic is one of the new key factors responsible for the continued underdevelopment of the continent.

The differences in the development of the epidemic in different regions of the world clearly suggest that individuals and societies do not run equal risks of becoming infected. Nevertheless, increased risks for individuals, communities and nations cannot be simply explained by differences in sexual behaviour alone, thus drawing attention to the interplay between sexual behaviour and human development issues as a whole.

In year 2000, countries committed themselves to the UN Millennium Declaration of eradicating poverty, promoting human dignity and equality, and achieving peace, democracy and environmental sustainability. Targeting 2015, the leaders pledged to work in partnership towards reducing poverty and advancing development. Among the elements that the world leaders freely endorsed in the Millennium Development Goals (MDGs) are the need to pay a living wage to workers, and greatly reduce widespread hunger, gender inequality, environmental deterioration and lack of education, health care and clean water.

The issues embodied in these goals are vital aspects of human development which continue to serve as useful indices of human progress in these areas. Nigeria's experience in eradicating extreme poverty and hunger, achieving universal primary education, gender equality and empowerment of women, reducing childhood mortality, improving maternal health, and combating HIV and AIDS, malaria and other diseases, shows that going at its present pace, the country is not likely to meet the MDGs, particularly in the face of AIDS onslaught.

The strong concerns over the HIV and AIDS epidemic in Africa led to the gathering at a special summit

in Abuja of the Heads of States and government of the Organization of African Unity (OAU) in April 2001, to address the "exceptional challenges of the disease." The product of this summit was the Abuja Declaration in which the leaders committed themselves to all relevant decisions, declarations and resolutions on health, development and the HIV and AIDS, particularly the "Lome Declaration on HIV and AIDS in Africa" (July 2000) and the "Decision on the Adoption of the International Partnership against HIV and AIDS" (Algiers 1999).

The New Partnership for Africa's Development (NEPAD) is a "vision and strategic framework for Africa's renewal". It was initiated following a mandate given to leaders of five African nations – Algeria, Egypt, Nigeria, Senegal, and South Africa – by the OAU (now AU) to develop an integrated strategic framework for the socio-economic develop-ment of Africa. This was formally adopted by the 37th OAU Summit of Heads of States and government in July 2001 and endorsed by leaders of the G8 countries.

NEPAD provides a vision for Africa, a statement of the problems facing the continent and a programme of action to resolve these problems. The primary objectives are to eradicate poverty, accelerate the empowerment of women, place African countries, individually and collectively, on a path of sustainable growth and development, halt the marginalization of Africa in the globalization process and enhance its full and beneficial integration into the global economy.

NEPAD, which is African leaders' attempt to provide a vehicle for development on the continent, has adopted the MDGs as the focus of its agenda for development, with a stated objective of achieving the overall 7 per cent annual growth required to halve poverty by 2015. HIV and AIDS is unquestionably a formidable challenge to sustainable human development in Africa and has been recognized as a cross-cutting issue which can jeopardize NEPAD's overall goals.

For NEPAD to provide an effective framework for Africa's development, it must integrate HIV and AIDS into all its policies and programmes. The resolve of the Partnership to pay urgent attention to HIV and AIDS will hopefully spur member states, including Nigeria, to increased and sustained action.

Implication of HIV and AIDS for Human Development in Nigeria

The UNDP defines human development as:

A process of enlarging people's choices. Enlarging people's choices is achieved by expanding human capabilities and functionings. At all levels of development the three essential capabilities for human development are for people to lead long and healthy lives, to be knowledgeable and to have a decent standard of living. If these basic capabilities are not achieved, many choices are simply not available and many opportunities remain inaccessible. But the

BOX 1.1
Measures of Human Development

The Human Development Index (HDI)
The HDI is a summary measure of human development. It measures the average achievements in a country in three basic dimensions of human development: a long and healthy life, as measured by life expectancy at birth; knowledge, as measured by the adult literacy rate and the combined primary, secondary and tertiary gross enrolment ratio; and a decent standard of living, as measured by GDP per capita (PPP US$).

Life Expectancy at Birth (years)
The number of years a newborn infant would live if prevailing patterns of age specific mortality rates at the time of birth were to stay the same throughout the child's life.

Adult Literacy Rate (% aged 15 and above)
The percentage of people aged 15 and above who can, with understanding, both read and write a short, simple statement on their everyday lives.

Combined Primary, Secondary and Tertiary Gross Enrolment Ratio (%)
The number of students enrolled in a level of education, regardless of age, as a percentage of the population of official school age for that level.

Gross Domestic Product (GDP) Per Capita (PPP US$)
For the HDI to correctly make assessments over several countries with diverse price levels, the GDP per capita (PPP US$) is used over GDP per capita (US$).To compare economic statistics across countries, the data is first converted into a common currency. Purchasing Power Parity (PPP) rates of exchange allow this conversion to take into account price differences between countries therefore better reflecting people's living standards. Theoretically, at the PPP rate, 1PPP$ has the same purchasing power in the domestic economy as US$1 has in the US economy.

Life Expectancy Index
One of the three indices on which the human development index is built, it measures the relative achievement of a country in life expectancy at birth.

Education index
This measures a country's relative achievement in both adult literacy and combined primary, secondary and tertiary gross enrolment. An index for adult literacy and one for combined gross enrolment are calculated. Then these two indices are combined to create the education index, with two thirds weight given to adult literacy and one third weight to combined gross enrolment.

GDP index
The GDP index is calculated using adjusted GDP per capita (PPP US$). In the HDI, income serves as a surrogate for all the dimensions of human development not reflected in a long and healthy life and in knowledge. Income is adjusted because achieving a respectable level of human development does not require unlimited income.

Human Poverty Index (HPI-1)
Human poverty is a concept that captures the many dimensions of poverty that exist in both rich and poor countries. The HPI-1 (Human Poverty Index for developing countries) measures deprivations in the same three aspects of human development as HDI (longevity, knowledge, and decent standard of living). In the HPI-1, deprivations in longevity are measured by the percentage of newborns not expected to survive to 40 years. Deprivations in knowledge are measured by the percentage of adults who are illiterate. Deprivations in a decent standard of living are measured by two variables: the percentage of people not using improved water sources and the percentage of children below the age of five who are underweight.

The Human Poverty Index is useful in:
- Focusing attention on the most deprived people in a country, not on average national achievement. It focuses on the number of people living in deprivation – presenting a different picture from average national achievement. It also takes poverty away from income poverty alone.
- Guiding national planning for poverty alleviation. Can be calculated for various districts within a country and used to identify most deprived areas in terms of human poverty.

The Human Development Index does not include dimensions of participation, gender and equality. These are measured in other indices and are useful in drawing attention to gender disparities within countries and comparing discrepancies between countries.

The Gender-Related Development Index (GDI)
This measures the same variables as the HDI except that the GDI adjusts for gender inequalities in the three aspects of human development. The GDI uses the same variables as the HDI. The difference is that the GDI adjusts the average achievement of each country in life expectancy, literacy and gross enrolment, and income, in accordance with the disparity in achievement between men and women.

The Gender Empowerment Measure (GEM)
Also measures gender inequality, but in economic and political spheres of activity. It is made up of two dimensions:
- Economic participation and decision making are measured by the percentage of female administrators and managers, and professional and technical workers.
- Political participation and decision making are measured by the percentage of seats in parliament held by women. Power over economic resources is measured by women's earned income (PPP US$)

realm of human development goes further: essential areas of choice, highly valued by people, range from political, economic and social opportunities for being creative and productive, to enjoying self-respect, empowerment and a sense of belonging to a community.

For every individual, the most important indices of human development remain the ability to lead long and healthy lives, possession of the kind of knowledge that is required to lead a happy and productive life, and having access to resources that will enable a decent standard of living. It is in furtherance of the foregoing objectives that the UNDP evolved the Human Development Index (HDI) as an acceptable measure for human development. The HDI was created to re-emphasize that people and their lives should be the ultimate criteria for assessing the development of a country, not economic growth.

HIV and AIDS affects virtually all aspects of human development and is unprecedented in its devastating impact on demographic, social and economic aspects of development. It has moved from being a health crisis to a recognized development crisis. In some parts of the developing world, it has even become a security crisis. The challenge of HIV and AIDS in Africa is enormous, being the worst affected region in the world. The Joint United Nations AIDS programme (UNAIDS) has noted that hunger and AIDS are threatening Sub-Saharan Africa on two fronts, working together to endanger millions of lives and drive back development. According to UNAIDS, HIV and AIDS has killed 7 million farmers in Africa over the last 20 years, causing an adverse impact on both labour productivity and food production.

The UNAIDS Fact Sheet notes that even if exceptionally effective programmes and treatment occur immediately, "the scale of the epidemic, means that the human and socio-economic toll will remain for many generations." This raises strong concerns for Nigeria, being Africa's most populous nation. It might be argued that the prevalence rates seen in some Southern and East African nations far exceed that of Nigeria; however, because of its large population, more people are infected in Nigeria than in other countries (thus, ranking second in Africa in absolute figures).

While remarkable efforts are being made to control the growing epidemic, the effects of increasing prevalence rates are beginning to take its toll on human development at national, community, family and individual levels. The major impact on Nigeria is yet to become visible and would bring with it overwhelming demands for care of those infected or affected by the virus.

There is increasing evidence that the epidemic will bring with it macro and micro level effects which will reduce the human development potential. At the macro level, it will impact significantly on economic growth which affects infant, child and maternal mortaility; at the micro level, there will be a heavy burden and suffering at individual, household and community levels.

BOX 1.2

The MDG target of reducing under-five mortality by two-thirds, maternal mortality ratio by three-quarters, between 1990 and 2015, remains difficult in the face of challenges in the health systems in Nigeria, given the per capita expenditure on health ($30) and percentage of government budget spent on health care (5.1)

Current estimates put life expectancy at birth at 51years, under-five mortality rates at 178 per 1,000 live births, infant mortality rate at 105 per 1,000 live births, and Maternal Mortality Rate at 704 per 100, 000 live births. These figures are unacceptably high.

These effects will be particularly visible in terms of demography, education and food security.

Demographics

The HIV and AIDS epidemic in Nigeria as, in most African countries, is taking its greatest toll on the young and productive age groups with the majority of new infections occurring within the 15-29-year-age group. The peak of new infections occurs about five to ten years earlier in females than in males. The high morbidity and mortality among these age groups is doubtless going to cause profound changes in the population structure in Nigeria. The rise in the number of AIDS deaths is exponential, growing from 50,000 in 1995 to 209,000 in 2000 with the tendency to rise to as high as 700,000 in 2010. Although demographic surveys have not been carried out since the recording of new highs in HIV and AIDS prevalence rates were observed, projections based on the experiences of other African countries indicate that child mortality rates may increase by up to threefold by 2010. The expected changes in structure can be attributed to mortality, particularly among young adults and under-five children. Owing to the high Total Fertility Rate of approximately 5.9 per cent in Nigeria, population will continue to grow possibly with an indentation in the population pyramid in young adults who are the main contributors to social and economic development. As the disease decimates the young productive age groups, provision of care will increasingly fall on the very young and the elderly.

Increasing mortality rates as a result of HIV and AIDS epidemic in Nigeria will no doubt bring a drastic cut in life expectancy at birth. By 2000, AIDS had already cut back life expectancy at birth by an estimated four years. By 2010 the projected loss will have reached 26 years, bringing it to the levels of the 1950s.

Reductions in life expectancy and increased mortality rates for adults have wide implications for children. As the deaths of adults increase, children become more vulnerable as AIDS turn many of them into or-phans (losing one or

TABLE 1. 1.
Life Expectancy with and without AIDS in Selected African Countries

	2000			2010		
	With AIDS	Without AIDS	Years Lost	With AIDS	Without AIDS	Years Lost
Botswana	39.3	70.5	31.2	29	73.2	44.2
Ethiopia	45.2	56.1	10.9	42.1	60.1	18
Kenya	48	64.9	16.9	44.3	68.4	24.1
Nigeria	53.6	57.8	4.2	38.9	64.9	26
South Africa	51.1	65.7	14.6	35.5	68.3	32.8
Swaziland	40.4	57.7	17.3	29.7	61.5	31.8
Zimbabwe	37.8	69.9	32.1	32.5	72.8	40.3
Zambia	37.2	58.7	21.5	38.9	72.8	33.9

both parents). In 2001 UNAIDS estimated that approximately 1million children had already been orphaned. The number is expected to rise to as high as 1.97 million by 2005. A large number of these vulnerable children may not be infected with the virus since very few infected children outlive their parents. As a result, children orphaned by AIDS outnumber HIV positive children 24: 1.

The long-term outcomes of increasing adult deaths is the increasing numbers of child-headed households. Although the extended family system in the country is still effective, the pressure of increasing numbers of orphans and care of infected family members are bound to affect these social safety nets, forcing such vulnerable children into adult roles. The outcomes for the children and the larger society range from increased impoverishment of such households and the national economy, and increase in unemployable youths, not to mention the increased risks for national security.

Educational Level

According to an analytical framework developed in Zambia, formal school education of children and youths is reduced by HIV and AIDS, affecting (i) the demand for education; (ii) the availability of resources for education; and (iii) the potential clientele for education.

As the number of AIDS-affected households increases, such families are forced to divert available financial resources from other needs to the care of infected family members. Fewer children are likely to be enrolled in schools or allowed to complete their education because of scarce family resources. The same holds true for children who have been orphaned by AIDS. A large number of such children may be forced early into the labour market either to support sick parents or their siblings. As children drop out or are withdrawn from school, enrolment at primary, secondary and tertiary levels will automatically decrease.

FIGURE 1.1
Projected Cumulative Deaths Due to Aids (1990-2015)

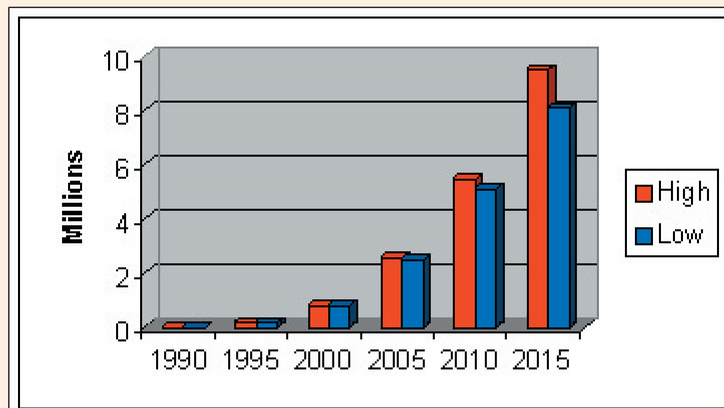
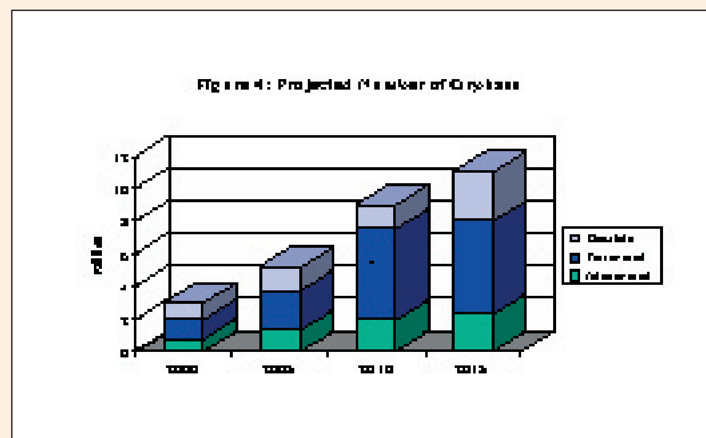


FIGURE 1.2
Projected Number of Orphans



BOX 1.3
School Enrolment: Primary and Secondary

Primary school enrolment showed absolute figures of total enrolment for the decade, ranging from 12,690,798 in 1988 to 16,348,324 in 1998. Although the absolute figures for 1998 appear higher than those for 1988, this might not indicate better enrolment rates given the projected population increase expected over the 10-year period. Throughout the period under review, males accounted for higher enrolment than females. Primary school enrolment was consistently higher throughout the period for boys than for girls. Within the same period, total enrolment for junior secondary school showed increases from 1,717,136 in 2,728,728. Also, while male enrolment remained higher than female enrolment throughout the period, the percentage of female participation grew larger from 712,403 in 1988 to 1,300,976 in 1998. Senior Secondary School enrolment was 1,396,557 in 1988 and 1,777,779 in 1998. The two extremes would have led to the conclusion that the population of students grew, however, the decade's annual change (-0.65per cent) indicates otherwise. The level of enrolment for females remained lower.

Primary School Enrolment Ratio: Male 109.4, female 86.6; Secondary School Enrolment Ratio: male 36.2, female 30.3.

Women are discriminated against in access to education for social and economic reasons. The Total Adult Literacy Rate is 60; 69 for males and 51 for females). Rural women are more at a disadvantage than their counterparts in the urban areas. Only 42 per cent of rural girls are enrolled in school compared with 72 per cent of urban girls. In the northern parts of the country, Muslim communities choose boys over girls in deciding which children to enrol in primary and secondary schools. In the southern parts, economic hardship also restricts families' ability to send girls to school; instead, they are directed into commercial activities such as hawking all kinds of commodities.

Significant reductions in school enrolment and adult literacy levels, which are bound to occur if the trend in HIV and AIDS-related illness and deaths continue, will ultimately lead to gaps in human resource requirements particularly for the formal sector. The quality of education is likely to be affected by AIDS-related deaths of schoolteachers and other key support staff. The cost of training teachers for replacement will increase tremendously, adding to the strains on the economy.

Macroeconomic Development

GDP declines

There is growing evi-dence that HIV affects total national income and incomes per capita significantly. Studies show that African countries with HIV prevalence rates below 5 per cent may experience only modest changes in the GDP growth rate, while those with increasing prevalence rates record declining GDP growth rates. Nigeria has already gone beyond the 5 per cent prevalence mark. It is estimated that HIV costs the country 0.5 per cent of her per capita growth a year. In 1999, the levels of infection recorded were three times those of 1991.

This suggests a potential for exponential rises in prevalence levels which, if not aborted, will cost losses of up to 2 per cent of GDP in the next couple of years. In the long term, there will be increased national impoverishment affecting all sectors. Although there has been increased international commitment for assistance towards HIV programmes, additional assistance in the form of loans and credit would increase national poverty. Nigeria has a crippling foreign debt overhang of approximately US$28.6 billion.

Overall, poor families are getting poorer while those living on the margins of poverty are becoming poor because of the strains of HIV and AIDS.

Food security

Like many African countries most affected by AIDS, Nigeria is hughly dependent upon agriculture. Over 70 per cent of its active workforce is employed in this sector, and it accounts for about 90 per cent of non-oil exports.

The HIV and AIDS epidemic portends huge implications for national and household security. A household is considered food secure if food availability, equal access to food, stability of food supplies, and the quality of food are in balance. Declining food supplies and increasing food prices are likely results of continued reduction in food production as a result of a reduced agricultural workforce and productivity. Although the agricultural workforce remains mainly rural, the results of HIV surveillance carried out so far indicate that the virus is spreading as widely in Nigeria's ru-

ral populations as among the urban populations.

The changes expected in the demographic structure, as discussed in the previous section, will take its toll on food production as the dependency ratio alters. As the productive age groups are lost to AIDS, the ratio of dependants increases in relation to producers. Food availability is predicted to be seriously affected by a change in the dependency ratio as a result of the altered age/gender distribution. An important outcome of the reductions in the number of people engaged in agriculture due to HIV and AIDS would be the loss of farming skills usually passed on from generation to generation, as younger members of the family usually acquire such skills from adults who would have been incapacitated or killed from AIDS-related illness.

At household level, HIV and AIDS reduces household earning power and the ability to purchase food and related goods and services. As the family's earning power (and ability to purchase food) reduces, widespread malnutrition and starva-tion is expected.

The sheer numbers of mal-nourished individuals is a challenge which has not been met so far. FOS estimates for 1995 show that 40 per cent of households had experienced food insecurity, and 43 per cent were affected by malnutrition. Prevailing conditions suggest an increasing trend in these rates. Widespread malnutrition will increase individuals' susceptibility to acquiring infections and will in turn worsen the HIV and AIDS situation.

Deepening poverty

The links between poverty and HIV and AIDS have been well estab-lished through studies. Poverty has been established, albeit in a complex manner, as not only a cause but also a consequence of HIV and AIDS.

The effects of HIV and AIDS are likely to be more severe for the poor and the very poor. Individuals with relatively secure livelihoods who become infected are more likely to continue to live a positive life since they would have access to drugs and be better able to support their fami-lies. For individuals already living in or close to poverty, the consequences of infection are likely to be seen earlier. The income situation in such households become very quickly insecure. The increasing costs of medical expenses strain already poor earnings, savings are lost because of the need to sell whatever property the family owns to meet health care needs and support the family.

Overall, poor families are getting poorer while those living on the margins of poverty are becoming poor because of the strains of HIV and AIDS. Drawing down savings at individual, family, community and national levels is likely to occur as the needs and costs of welfare and health expenditures increase.

The National Policy Environment

The policy environment is the substructure on which the super-

BOX 1.4

An estimated 70.0 per cent of Nigerians live below the poverty level, which is a deterioration from 27.2 per cent in 1980, 43.6 per cent in 1985 and 42.8per cent in 1992. Nigeria is already hanging precariously with a greater percentage of its population living on less than 1 US dollar per day without any sign of change. The proportion of total income of the core poor and the moderately poor spent on food is estimated at 75 per cent and 73 per cent respectively.

Approximately 47-48 per cent of the labour force remains unemployed and does not produce. With a labour force estimated at 33 million, this suggests that over 15 million are in need of suitable employment.

structure of plans and programmes are built. A programme cannot succeed, no matter how well conceived or progressive it may be, without a favourable policy environment. In recognition of this and in order to arrest policy failure, which is one of the fundamental problems in Nigeria, the Policy Project, Nigeria, conducted the first policy environment scores (PES) in year 2000. This was followed up in 2002 by the Federal Ministry of Health (FMH)/ Policy Project's collaborative assessment of the Nigerian policy environment in respect of family planning, adolescent reproductive health and HIV and AIDS/STIs.

The report defines the policy environment as including all factors that affect the performance of programmes but which are beyond the complete control of programmes and programme managers. Among the factors listed as constituting a supportive policy environment are:

- Political support and commitment at all levels, including supportive national policies, laws, and plans;
- Policies that meet client's expressed needs;
- Operational policies that promote access, demand and quality, etc.;
- Adequate financial and human resources;
- Active private sector participation; and
- Programmes that are implemented according to policies.

The study shows considerable differences in the policy environment for the three components of reproductive health studied. The PES for family planning programmes was strong in policy formulation and legal regulations, but weak in evaluation, research, and availability of resources to implement the programmes. The only strong point in the adolescent reproductive health component was policy formulation. In the HIV and AIDS/STI component, however, the PES had a strong showing in policy formulation, political support, and organizational structure. Its weak points were in resource mobilization, and legal/regulatory environment.

As can be seen in Table1.2, there was a general improvement in the Nigerian policy environment from 2000-2002, especially as it affected the three components of the study. Furthermore, the report shows that Nigeria is good at policy for-mulation but weak in finding the resources for its implementation; thus creating a loophole for policy failure. Finally, the report indicates that HIV and AIDS/STI had a relatively better policy environment in at least five of the seven indices

TABLE 1.2
Comparison of Policy Environment Scores, by Component of Policy Environment

(%)	Family Planning		Adolescent Reproductive Health (%)		STI and HIV and AIDS (%)	
Political support	2002	2000	2002	2000	2002	2000
Policy formulation	59.8	51.7	53.4	46.0	73.0	68.3
Organizational Structure	66.4	62.8	65.1	57.0	75.3	72.2
Legal/Regulations	51.7	40.4	46.9	37.7	76.1	71.0
Resources	60.6	59.7	30.9	19.3	48.8	36.0
Programmes components	46.4	33.6	35.2	27.6	43.9	38.6
Evaluation and Research	52.8	49.3	52.4	40.7	54.2	40.8
	46.5	42.7	41.2	28.3	57.3	53.2

Note: The 2000 figures did not include the care components which were evaluated separately with a score of 33%

compared in the PES than other reproductive health programmes. This is expected given the devastating effect of HIV and AIDS on human health and the overall health of the nation and its economy.

Overview of Chapters

Objectives of the National Human Development Report on HIV and AIDS

HIV and AIDS reverses the gains accruable from building basic human capabilities and denies people the basic opportunities of living long, healthy, creative and productive lives. HIV and AIDS impoverishes people, places burdens on households and communities to care for the sick and the dying, results in social exclusion and violations of human dignity and rights, affects people's psychological well-being, and its longer-term human development impact is felt in all sectors of public and private life. It strains national and local budgets, depletes sectors (education, health, economy) of skilled workers, and inhibits the capacity of various sectors to sustain previous levels of productivity or services.

Therefore, applying the human development approach to HIV and AIDS helps to focus the analysis and policy recommendations on people rather than the virus, a prerequisite for mobilizing effective action to reverse the epidemic and care for those living with AIDS. The value added of applying a human development framework to HIV and AIDS is that it lends itself to a more inclusive, people-centred and rights-based approach to analysing the problem and promoting effective action.

For this reason, the NHDR on HIV and AIDS can provide:

- A more comprehensive analysis of the status, trends and projections of the epidemic, including its socio-economic implication for individuals, households, communities, and public sectors, and the economy;
- Policy-relevant analysis of the deeper social, cultural, economic and political factors that are driving the spread of the epidemic, looking beyond the primary causes of infection;
- A useful vehicle for critical assessment of the country's response to HIV and AIDS thus far, looking squarely at both achievements and constraints; and
- Powerful recommendations of what needs to be done to reverse the epidemic, offering concrete policy messages, promoting a comprehensive approach, multi-sector action, and full mobilization of actors and institutions well beyond the health sector.

For the analysis in the report to be qualitative and the policy options unassailable, all stakeholders must be consulted. Hence, the involvement of leaders from various secors (governmental and non-governmental), in the preparation of this report means that they can be relied upon to serve as powerful advocates for the report's recommendations. This will promote active policy dialogue and ensure a sustained follow-up and spin-off activities.

Conclusions and Recommendations

The first chapter of this report is largely exploratory as it presents an overview of HIV and AIDS in Nigeria, locating it in the correct historical context as one the fiercest and definitely the longest "battle" in human experience. The chapter dwells on the implications of the disease for human development, emphasizing the drastic depopulation of young adults, school enrolment dips, declining productivity, food insecurity and deepening poverty. Finally, the chapter notes that the policy environment in the country has improved (though weak in some vital areas) and ends by summarizing the conclusions and recommendations of the remaining chapters.

The second chapter examines the prevalence of HIV and AIDS in the world, in Africa and in Nigeria and concludes that with its 5.8 per cent prevalence rate, HIV and AIDS has become a "generalized epidemic" in Nigeria and that current evidence suggests that the epidemic is emerging; it is still far from maturity. Already, all the geo-political zones are affected, and the prevalence gap between the urban and rural areas of the country has narrowed down significantly. The burden of infection continues to be borne by young people with more females than males infected.

Given the current scale of prevalence and government's limited capacity to respond, it is expected that HIV infection will jump from its official figure of 3.5 million to 10-15 million by 2010. This number will constitute about 15 to 25 per cent of adults – close to the rates currently being experienced in Southern Africa. Given this scenario, it is also projected that by 2010 there will be as many as 9 million orphans in the country and bed occupancy arising from AIDS-related illnesses could rise to 50-60 per cent in some hard hit communities in the country.

The chapter observes that despite this grim statistics, HIV prevalence in the country can be curtailed drastically as it was in South Africa, Ethiopia and Uganda, if only the country has the political will. Also, it says that since the majority of Nigerians are youths (over 60 per cent, 44 per cent of which are 15-year-olds or under) and, as the most sexually active (25 per cent of which initiate sex at age 15 and 50 per cent at age 18), they constitute the most vulnerable group. It follows, therefore, that the key to halting the spread of AIDS is to target the youths with all the advocacy mechanism that can be mustered as well as in all the official policies of government

The chapter insists on government formulating an innovative youth policy on employment, education, trade and other aspects of social development. It notes that Nigerian youths have neither hope nor belief in the future of the nation and that government must demonstrate genuine care and commitment for its AIDS control programmes to be well received. Programmes must target young people in and out of school, engage them, eliminate fear and feature in-

built strategy for poverty alleviation that would give them hope.

The chapter points out that the AIDS awareness campaign in the country is still too weak to make a meaningful impact on the population. It concludes that if Nigeria is not to experience the explosive and exponential growth in infection, as predicted in the "next wave" of the epidemic, then there should be a vigorous national campaign that reaches all corners of the country. The campaign should support projects that constantly remind people of the threat of HIV infection.

Finally, the chapter enjoins all the stakeholders to analyse the underlying factors in the prevalence of AIDS and work out strategies to contain them. As there is no known cure, special care should be taken of the three classes of the population – the non-infected, the infected and the affected – to ensure that they continue to live a quality life devoid of discrimination, denial and abuse of their human rights and dignity.

The main focus of the third chapter is the spread of HIV in Nigeria and its impact on the people. The chapter indicates that 80 per cent of infections are sexually transmitted, another 5 per cent can be traced to the use of unscreened blood and blood products while mother-to-child transmission accounts for the balance.

The three main causes of the infection are poverty, harmful traditional practices and the unintended implications of urbanization and modernization. The harmful traditions are identified as polygamy, courtesanship, concubinage, "wife hospitality", culturally-approved sexual intercourse with siblings' wives, and levirate (i.e., wife inheritance). Because these practices encourage multiple sexual partners, they constitute high-risk factors. The consequences of uncontrolled and unplanned modernization and urbanization in the country include a thriving commercial sex trade, unprotected coercive sex, child labour, overcrowding, and forced or voluntary migration. The chapter indicates that poverty is the fuel driving most of the causes of HIV and AIDS because it renders people vulnerable and deprives them of the resources to fight the disease. That is why poverty is regarded as the cause and consequence of AIDS.

The chapter also notes that "bridge factors" like CSW/FSW, long-distance trucking, wars and conflicts and the military service tend to reinforce very high prevalence rates of HIV that is subsequently spread to the rest of the population. The chapter equally identifies the contributory roles of ignorance, high prevalence of STIs in the country, denial of rights, stigma and discrimination (DSD) to the incidence and re-inforcement of the epidemic.

The impact of HIV and AIDS on every aspect of life in the country has been, and could be, more devastating if not checked. More deaths and loss of work force/ job skills, imply a rise in the number of orphans, propitious decline in productivity and savings, over-burdened health personnel

and system, food insecurity, state insecurity, and aggravated social unrest.

The chapter recommends the weeding out of all cultural practices that encourage multiple sexual partners and the design of social policies that will root out abject poverty which fuels high-risk behaviour in the nation. It recommends that stakeholders should work within and outside the frameworks of national and international economic development strategies such as NEEDS, NEPAD and ACOSHED to bring about the economic and social empowerment that Nigerians need to feel secure and live fulfilling lives.

To achieve the set objectives, the chapter recommends the re-planning of education, health care and other vital sectors that help poverty reduction which holds the key to attitudinal change. Observing that the commitment to the AIDS fight is still grossly inadequate, it insists that every level of authority in every sector of the economy – Governor, Local Government Chairman, Vice-Chancellor, Managing Director/ Chief Executive, etc. – should lead the advocacy in his area of jurisdiction. Each leader must have total control of the situation under him and prevent spill over effects to the immediate community so that new infections can be prevented and the existing PLWHA can be supported.

In the fourth chapter, which details Nigeria's response to the HIV and AIDS onslaught, the emphasis dwells on Nigeria's "evolutionary" response – from initial denial through half-hearted initiatives to a pro-active response anchored on the HIV and AIDS Emergency Action Plan (HEAP) document, the mobilization of resources to fight the challenge and the promotion of care and support (C&S) as a veritable means of intervention to mitigate the effects of AIDS on the victims, their families and every segment of the society, including the workplace.

The chapter reveals that Nigeria has obtained over US$ 300 million for the war against HIV. It notes that these resource have made it possible for the government to implement its HAART programme which supplied 15,000 PLWHA with ARV drugs at over 70 per cent subsidy. Stakeholders in Nigeria are increasingly aware that ignoring the Care and Support of PLWHA and PABA could lead to the failure of all other interventions. This points to the need to use C&S to deal with DSD at home, in the public and in the workplace.

The chapter underscores that community and family support for C&S is still very low in Nigeria. PLWHA have organized themselves into effective networks for mutual support with the backing of CSOs and the government. In addition the government also fashioned a workplace policy in line with ILO recommendations.

The chapter observes that despite the above efforts, the national response to HIV and AIDS still faces several challenges. For instance, although the HEAP is a sound document, there are

implementation weaknesses.

Moreover, it shows that the HEAP lacks a legal and institutional framework to operate, that sectoral roles are poorly defined and co-ordinated, and that there are some policy gaps and contradictions. These include the issue of breastfeeding and family planning campaigns in the face of mother-to-child transmission of HIV, and antenatal and delivery services in the face of rampart transfusion of unscreened blood and blood products.

Other conclusions reached in the chapter are the major and immediate challenges to the expansion of VCT, provision of drugs and treatment, development of infrastructure in response to the outcomes of VCT and other awareness programmes, and provision of safety nets for the poor. These include access to drugs, nutrition, counselling and assistance to help orphans stay in school. It emphasizes that 300, 000 people die every year from AIDS-related diseases and that if the programmes do not expand rapidly enough health personnel and facilities will be inadequate.

Finally, the chapter says that (i) the resources available for the national response is inadequate; (ii) HEAP was grossly underfunded in 2002; and (iii) although it was estimated that the programme would cost US$190,000 it has been suggested that the actual amount needed is US$500,000. It observes that there is an over-dependence on foreign donors funding and that state and local governments do not make sufficient allocations to fight the disease.

Among other conclusions reached, the chapter says that apart from the Federal Ministry of Health other ministries lack the capacity to prepare intervention programmes. For example, the police which has a very large population at risk has no specific response programme while the private sector commitment to the AIDS war is recent. It concludes, therefore, that the response to HIV and AIDS is still not multi-sectoral and that unless the trend is reversed, Nigeria would not achieve the UN Millennium Development Goals (MDGs).

Consequently, the chapter recommends that much more financial, technical and political resources should be invested to ensure the effective and rapid implementation of HEAP and sustain the effort to develop a National Strategic Plan. Access to HIV prevention interventions should be provided for all, along with appropriate care and support for persons infected and affected by AIDS.

It also recommends that affordable treatment options, including access to generic ARV drugs, should be made available to all PLWHA. That is why it is strongly recommended that government should go into the manufacture of ARV drugs. In addition, the chapter insists that the commitment of stakeholders at all levels of government and all segments of the society should be sustained in order to achieve effective community mobilization and involvement in

the prevention and management of HIV and AIDS control.

The chapter also recommends that the legal and policy frameworks relating to HIV and AIDS control should be properly instituted, harmonized, and implemented to support preventive and C&S interventions and, finally, that the social conditions of the people should be greatly improved to minimize vulnerability to high-risk behaviour.

The fifth chapter, which focuses on the way forward, concludes that although the policy environment for control of HIV and AIDS in the country has improved since the civilian administration of President Olusegun Obasanjo, there are serious weaknesses in the areas of legal framework, resource mobilization and the contents of the programmes being implemented. As in chapter 3, this chapter identifies poverty as a major hindrance to be tackled in the AIDS war.

Another conclusion in the chapter is that the socio-economic and cultural "traps" that many people fall into such as polygamy, wife exchange among siblings, wife hospitality, cult prostitution, scarification as well as the use of unsterilized sharp objects and needles, can be successfully fought with excellently packaged prevention and awareness campaigns. To halt the spread of HIV resulting from unintended consequences of rapid urbanization and modernization, the chapter recommends appropriate plans and policies for current problems faced in urban centres due to inadequate planning. AIDS has created new challenges that cannot be managed with the same traditional approach.

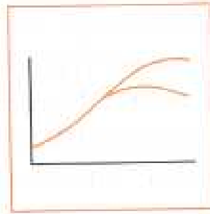
The chapter concludes that if 80 per cent of HIV infections are sexually transmitted, the sociology of sexual networking should be critically examined so as to inform a social re-engineering process that would create the foundations of a new social order. It says this re-engineering must make education practical and not just theoretical to promote self-employment; and that special care should be taken to empower women in every way and liberate them from traditional barriers to their development.

The chapter identifies several windows of opportunity such as (i) Nigerians' fear of death which can be used positively in the AIDS war; (ii) the known identities of the most vulnerable groups – young adults in and out of school, CSWs/FSWs and other bridge populations like military personnel, long distance drivers – which calls for carefully targeted interventions; and (iii) the growing activities of CSOs, NGOs, CBOs and the recent private sector involvement in the AIDS challenge.

The chapter recommends that preventive awareness campaign should be mounted that goes beyond intermittent, selective radio and TV messages. The message that should reach the remotest part of the country is that AIDS is real, that it kills in millions, and that unless every individual takes a decisive step to prevent being infected, he/she will be one of the projected 9-15 million carriers of this disease which has no known cure.

The chapter suggests that if radio and TV media were to be used to constantly repeat this message to dominate the public discourse with HIV and AIDS messages it would be well received and would result in saving of human and material resources. It notes the opportunity presented by the fact that 95 per cent of the electronic media in Nigeria belong to government and that even the independent press can be relied upon to give this cause the greatest support.

The chapter ends finally by saying that public-private partnership should be solidified to play a more active role in the fight against AIDS, given its potential to mobilize abundant human, technical and financial resources for the AIDS challenge.



Chapter Two

The Prevalence of HIV and AIDS in the World, Africa and Nigeria

THE main goal of this chapter is to show what HIV and AIDS has done to our world, how it has ravaged the world and turned Africa and Nigeria into a spectre of human misery. The chapter details how Nigeria initially wished away the dreaded disease through denial only to find it decimating its people. It shows that Nigeria is firmly established as the fourth most affected country in the world as its 3.5 million cases account for 10 per cent of the global incidence of HIV and AIDS and 20 per cent of the African figure.

To explain how Nigeria arrived these chilling statistics, the chapter delves into the reinforcing factors that made the disease so prevalent in the country. It predicts, based on available data, that in the "next wave" of the HIV and AIDS epidemic around 2010, the current alarming figures would be totally eclipsed if more urgent steps are not taken to contain new infections and treat those already infected.

Box 2.1
Global: People newly infected with HIV, December 2002

Total	5.0 million
Adults	4.2 million
Men	2.2 million
Women	2.2 million
Children < 15 yrs.	800,000

People living with HIV/AIDS: December 2002

Total	42.0 million
Adults	38.6 million
Men	19.4 million
Women	19.2 million
Children <15 yrs.	3.2 million

AIDS deaths: 2002

Total	3.1 million
Adults	2.5 million
Men	1.3 million
Women	1.2 million
Children <15 yrs.	610,000

HIV Infection and Transmission

Estimates by the Joint United Nations Programme on HIV and AIDS (UNAIDS) and the World Health Organization (WHO), a co-sponsor of UNAIDS, indicate that by the end of 2002, over 42 million

people were infected with HIV, the virus that causes AIDS, and that 28.5 million people around the world had already lost their lives to the disease. Unless a cure is found or life-prolonging therapy can be made more widely available, the majority of those now living with HIV will die within a decade.

Nearly 800,000 children were infected with HIV in 2002, mostly through their mothers either during childbirth or through breastfeeding. Currently, 1.3 million children are living with the disease. Since the onset of the epidemic, the death toll among children under age 15 has risen to 5.3 million.

Some 3.5 million adults and 500,000 children died of AIDS during the course of 2002. Roughly the same number of HIV infections developed into symptomatic AIDS. HIV has more than doubled the adult death rate in some places, and is the single biggest cause of adult death in Sub-Saharan Africa (SSA). Indeed HIV and AIDS is among the top ten killers worldwide, and given the current levels of HIV infection in SSA, it has moved into the top five, overtaking such well-established causes of death as malaria, tuberculosis and diarrhoea in many highly infected countries.

HIV in Nigeria

Nigeria has a projected population of 130 million people – representing about 20 per cent of the total African population. With projected 4-6 million people infected with HIV, the country accounts for about 20 per cent of the total African burden of people living with the disease.

HIV infection increased from 3.8 per cent in 1993 through 4.5 percent in 1995 and 5.4 per cent in 1999 to 5.8 per cent in 2001 (Figure 2.1). In the 2001 survey, HIV 1 was the most prevalent infection (accounting for 98 per cent) while HIV 2 accounted for only 2 per cent. Infection was highest in the younger age groups of 15-24. Although the national average during the 2001 Sentinel Survey was 5.8 per cent, the rates in 8 out of the 85 Sentinel sites were greater than 10 per cent. The HIV epidemic in Nigeria has, therefore, entered the stage where the epidemic is likely to increase in an exponential manner.

Incidence and Prevalence of HIV and AIDS in Nigeria

Before Nigeria recorded its first case of AIDS in 1986, it was loud in its denial of the infection in the coun-try. By the time reality dawned on it, however, the dreaded disease was already decimating its population. One of the significant events that brought the message home to many Nigerian sceptics was the announcement on 2 August 1997 that Fela Anikulapo-Kuti, one of the country's most prominent musicians, had died of AIDS. That announcement dispelled whatever illusion many people had held on to and the nation began to grapple with the reality of the devastating disease.

Official estimates of the rate of in-fection are the 2001 figure of about 5.8 per cent (or 3.5 million). This rate was based on antenatal clinic attendance that was used as a proxy for the general population. Field experts strongly suggest that

BOX 2.2
The Epidemic in Africa

- 10,000 infections every day with 3.5 million infections yearly
- 7 people infected every minute on the continent
- African girls (15-19) are 5 to 6 times more likely to be infected than boys
- HIV is the biggest threat in the world's poorest continent
- HIV rates have reached 38 per cent and 33 per cent in Botswana and Zimbabwe

Groups most affected

- 70 per cent of all HIV infections in Sub-Saharan Africa which has only 10 per cent of the world's population
- Women have surpassed men now! (55per cent)
- Over 50 per cent of infections in 15-25 year age group more children infected from their mothers and through breast milk

BOX 2.3
People newly infected with HIV: December 2001

• Total	430,000
• Adults	4.2 million
• Men	2.2 million
• Women	2.2 million
• Children < 15 yrs.	800,000

People living with HIV/AIDS: December 2002

• Total	3.5 million
• Adults	3.2 million
• Men	1.2 million
• Women	1.8 million
• Children <15 yrs.	270,000

AIDS deaths: December 2002

• Total	170,000 (adults & children)
• Men	48per cent
• Women	52 per cent

unoffcial estimates range as high as 10 per cent among the general population, which translates to the infection of about 4-6 million people.

Reliable statistics on HIV and AIDS are diffcult to get as estimates of infection and their trajectories go far beyond offcial statistics by including the assessments of the academia and NGOs with feld experience. CSW, IDU and MSM are usually not key political constituencies considered in providing HIV statistics. Many people do not get tested because of discrimination, stigma and denial (DSD). Some avoid testing because of non-availability of treatment for the disease. Estimates of HIV prevalence might vary but the message conveyed is unmistakable: the epidemic has reached emergency proportions. Although countries like Botswana, Zambia and Cote d'Ivoire have high prevalence rates, Nigeria ranks second in Africa in terms of absolute fgures. It is also the fourth worst affected country in the world.

Based on the 2001 offcial estimates of the number of HIV infections (3.5 million), Nigeria with a population of 130 million people,

TABLE 2.1
HIV Prevalence at Community Level: Selected Communities

Location	Prevalence (%)	Group	Time Period	Source
Ibadan	21.3	Pregnant women attending ante-natal clinics in the inner city	May-Nov 2001	a
Ibadan	34.3	Commercial sex work-ers	2002	a
Ondo State	12.8	Pregnant women attending ante-natal clinics in 9 towns	2001-2003	a
Jos	8.9	Pregnant women	Oct. 2001-Jan. 2003	a
Jos	39.2	Commercial sex work-ers	1993-2002	a
Jos	11.7	Blood donors (male)	Jan. -Mar. 2004	b
Jos	14.1	Pregnant women attending ante-natal clinic	Jan. -Mar. 2004	b
Zamfara	35.4	All tests	May 2003-Jan2004	c
Zamfara	24.4	All tests	Jan-0Dec 2003	d
Zamfara	35.4	All tests	May 2003-Jan 2004	c

Note: a. Various contributors to Regional and Global Conferences on HIV and AIDS: Compiled by the Nigerian Institute of Medical Research and NACA, Sept 2003
b. Jos: Our Lady Apostolic (OLA) Catholic Hospital
c. Zamfara: Duala Hospital, Gusau
d. Zamfara: Royal Medical Laboratories.

has over half of the population of West Africa and nearly 20 per cent of the continent's. Therefore, the burden of the epidemic that Nigeria bears out of the total figure for West Africa and Africa is tremendous. It is projected that by 2004 more than 4.0 million Nigerians would have become infected with HIV and 10-15 million by 2010.

Between 1991 and 2003, the HIV prevalence in Nigeria increased by more than 300 per cent, from 1.8 percent to 5.0 per cent(Figure 2.1). The rates in some parts of the country have increased by over 700 per cent. The highest HIV rate of 12 per cent was recorded in Cross River State while Osun State had the lowest rate of 1.2 per cent (Figure 2.3)

These figures were largely conservative; many field experts believe that PLWHA in Nigeria number about 4-6 million with possible 1.5 million children orphaned by AIDS, one of the highest in the world. Nigeria accounts for nearly 10 per cent global burden of HIV and AIDS.

There is some data now, though limited, which suggests that HIV sero-prevalence may be particularly high among sex workers (up to 50 - 70 per cent in Lagos) There is, however, little or no data for their primary clients (long distance truckers, commercial motorcyclists and men of the uniformed services who act as the "bridge" spreading HIV to the general population.

Figure 2.1 : Median National HIV Prevalence Rates in Nigeria (1992-2003)

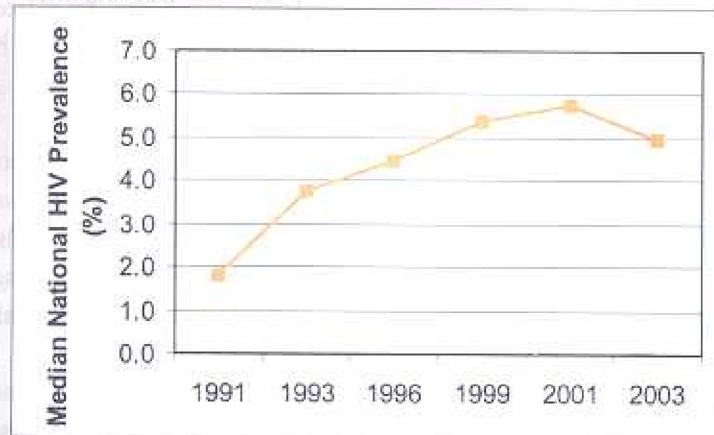


Figure 2.2 : HIV Positive Population

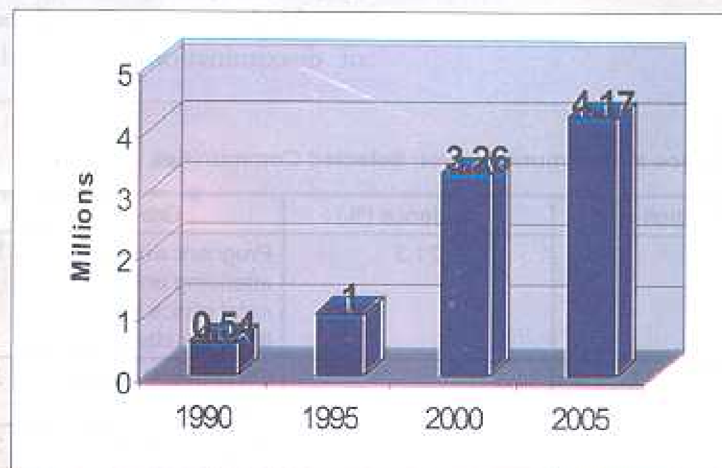


Figure 2.3 : HIV Prevalence Mapping of States in Nigeria

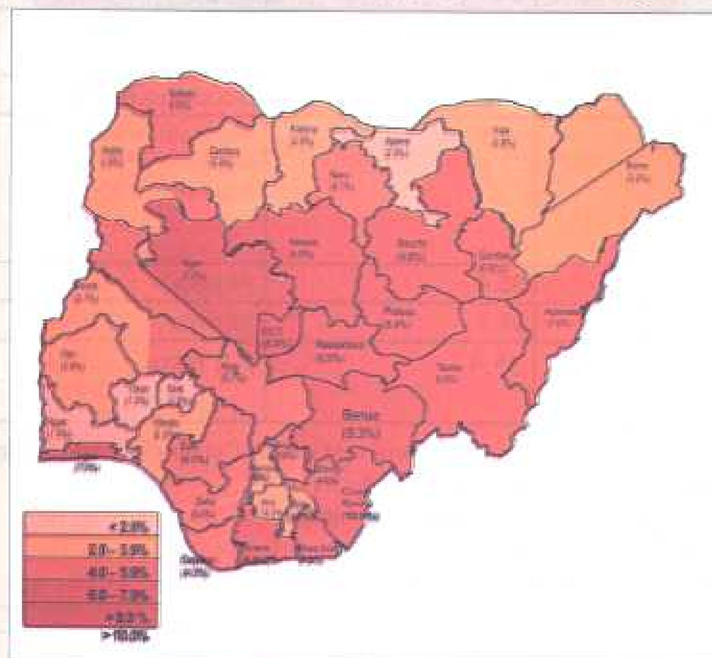


Figure 2.4 : HIV and AIDS Prevalence among Age Groups (2003)

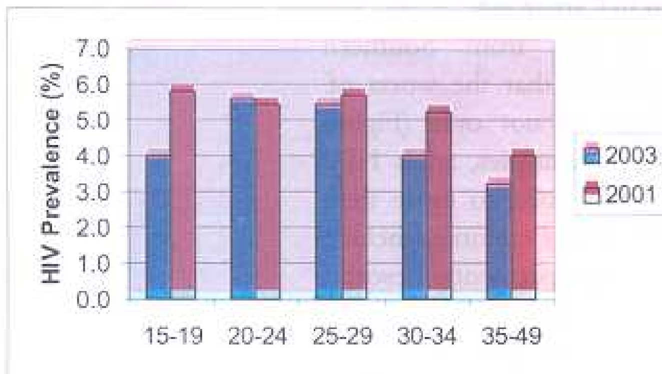


Figure 2.5 : HIV and AIDS by Geo-political Zones (2003)

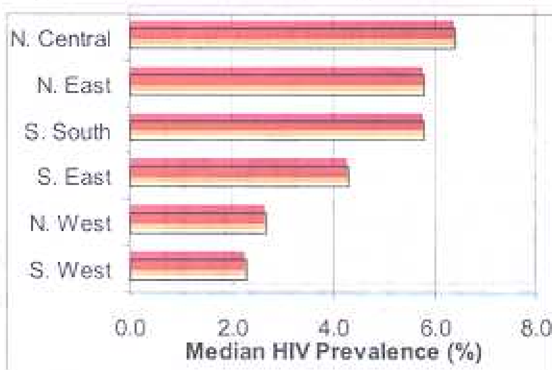
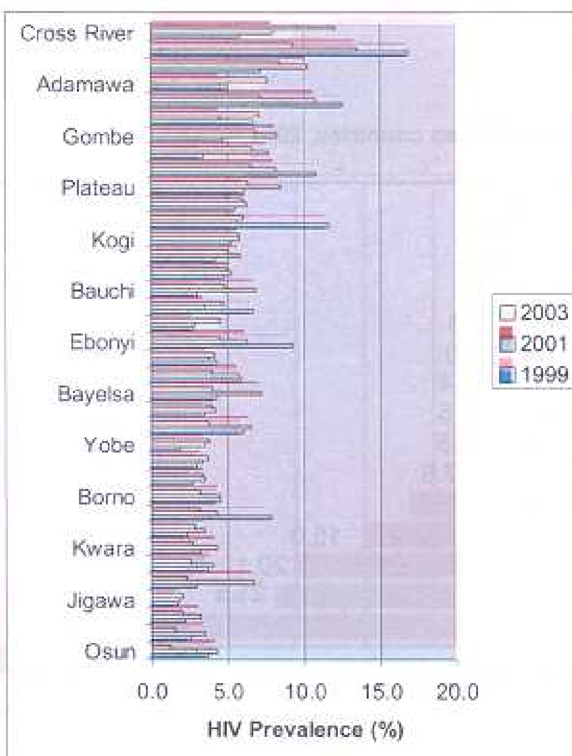


Figure 2.6 : HIV Prevalence Rates by States (1999-2003)



The highest prevalence rates correspond to the most active sex groups; 20-24 year-olds at 5.6 per cent, 25-29 year-olds at 5.4 per cent, and 15-19 year-olds at 4.0 per cent. The prevalence rate decreases with age: 30-49 year - olds have a 3.2 per cent rate (Figure 2.4). Of the total population infected in Nigeria, 60 per cent are young people below 25 years, and 54 per cent of all adult infections are women. Moreover, women are infected at a younger age than men and in some parts of the country the percentage of women infected.

While the present HIV and AIDS situation has already reached epidemic proportions the potential for an explosive growth in the near future is of concern. Given the large proportion of young Nigerians (44 per cent, under 15 years) and the evidence that by age 15, 25 per cent have initiated sex and 50 per cent by age 18, the youths of today form the largest and most vulnerable than men. Women aged 15-24 constitute the vulnerable group.

As shown in figure 2.5, HIV prevalence is high across Nigeria. The North-Central, South Eastern zones had the highest average sero-prevalence rates. The 2003 survey, like that of 2001, also observed both cold and hot spots of HIV transmission in each geo-poloitical zones. Cold spots would be areas of a zone withlow prevalence and hence, low transmission, compared to the hot spots with high HIV sero-prevalence and therefore, considerable transmission. When compared with previous figures

1999 to 2003 (Figure 2.6), the current HIV prevalence rates support the UNAIDS position that the epidemic is still growing in the country and is far from maturing. In Nigeria, like most countries in Sub-Saharan Africa, transmission of HIV is by heterosexual intercourse with more cases reported in urban than rural areas. However, in the 2003 FMOH Sentinel Survey, there is evidence that the gap between the urban and rural areas may be narrowing (Figure 2.7), an indication of how generalized and far spread the epidemic is in the country. Whether this is an indication of the maturity of the epidemic needs to be seen over the next few years with subsequent surveillance.

HIV Prevalence in Africa

In West and Central Africa, the relatively low adult HIV prevalence rates in countries such as Senegal (under 2 per cent) and Mali (1.7 per cent) are over-shadowed by more ominous patterns of the epidemic in other countries in the region. HIV prevalence has exceeded 5 per cent in eight countries of West and Central Africa, including Cameroon (11.8 per cent), Central Africa Republic (12.9 per cent), Cote d'Ivoire (9.7 per cent) and Nigeria (5.8 per cent). This shows that no country in the region is shielded from the epidemic. The sharp rise in the HIV prevalence among pregnant women in Cameroon (more than doubling to over 11 per cent) has demonstrated how suddenly the epidemic can surge. This is a serious warning sign for Nigeria, the most populous country in Africa. Even though Nigeria's national fgure is 5.8 per cent (low), some states in the country are already experiencing the rates seen in Cameroon.

The picture from Southern Africa indicates that the worst of the epidemic is not over (Figure 2.8). In four countries, adult HIV prevalence has risen to more than 30 per cent. These countries include Botswana (38.8 per cent), Lesotho (31 per cent), Swaziland (33.4 per cent) and Zimbabwe (33.7 per cent). Despite these figures, there are

FIGURE 2.7
HIV Prevalence in Urban and Rural Areas, by Zones (2003)

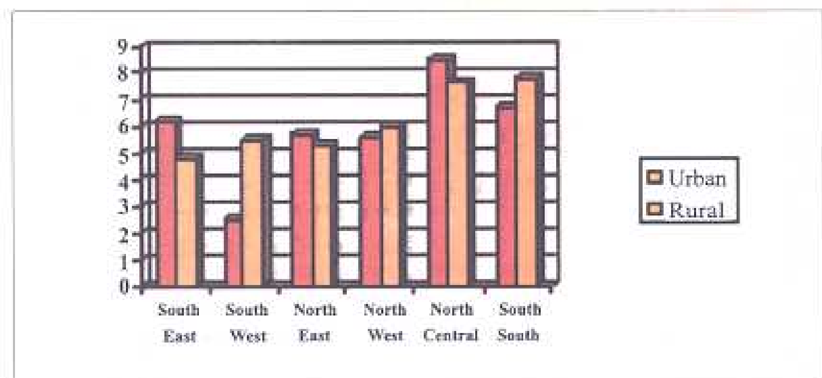
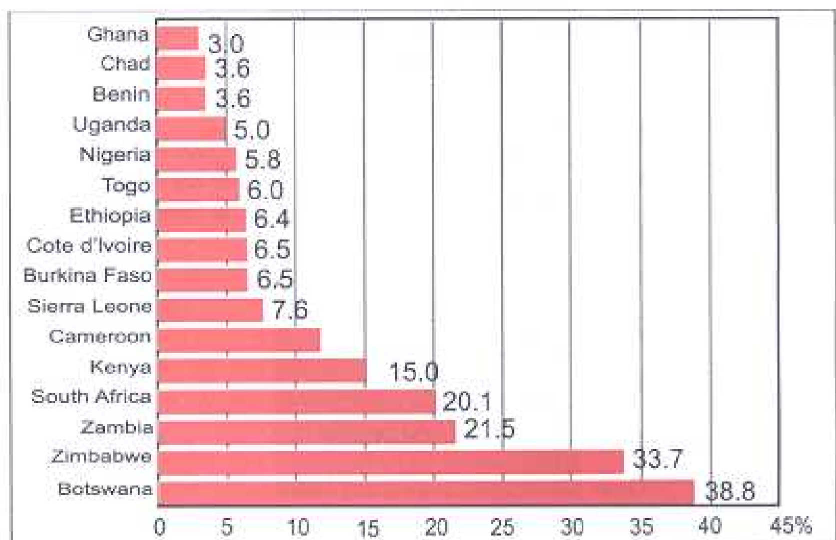


FIGURE 2.8
HIV Prevalence in African countries, 2001



signs that the epidemic is being brought under control. For example, in South Africa, HIV prevalence among pregnant women under 20 fell to 15.4 per cent in 2001 from 21 per cent in 1998. Similarly, in Addis Ababa, Ethiopia, HIV infection among pregnant women aged 15-24 years fell from 24.2 per cent in 1995 to 15.1 per cent in 2001. However, it is Uganda that has continued to witness the dividends of human intervention through prevention efforts. HIV prevalence has been on a decline from 30 per cent in 1991 to 11 per cent in 2001.

BOX 2.4

Nigeria has ratifed the following documents:

- African (Banjul) Charter on Human and People's Rights
- Convention Against Torture and Other Cruel, inhumane, or Degrading Treatment or Punishment
- Convention on Elimination of All Forms of Discrimination Against Women
- Convention on the Rights of the Child
- International Convention on Elimination of All Forms of Racial Discrimination
- International Covenant on Economic, Social and Cultural Rights
- International Covenant on Civil and Political Rights

Nigeria's obligations are further defned by the following documents:

- Universal Declaration of Human Rights
- UN Special Session on HIV/AIDS (UNGASS) Declaration of Commitment
- Cairo Programme of Action
- Beijing Platform for Action
- Beijing +5: Further Actions and Initiatives to Implement the Beijing Platform for Action

The Documents listed above require Nigeria to protect and promote the following rights:

Right to development
Right to education
Right to freedom from inhuman or degrading treatment
Right to highest attainable standard of physical and mental health
Right to liberty and security of the person
Right to life and survival
Right to marry and found a family
Right to non-discrimination on grounds of age
Right to non-discrimination on grounds of disability (e.g. HIV positive status)
Right to non- discrimination on grounds of marital status
Right to non-discrimination on grounds of race and ethnicity
Right to non-discrimination on grounds of sex and gender
Right to non-discrimination on grounds of sexual orientation

Why HIV and AIDS is Prevalent in Nigeria

Socio-cultural context

The socio-cultural features prevailing in most societies in Nigeria play a signifcant role in the continued spread of the HIV infection. Culture and religion have signifcant infuences on people's lives and the decisions and actions that they take. These include the subordinate position of women in society, impoverishment and decline of social services, and rapid urbanization and modernization. Cultural expectations and changes determine the vulnerability of individuals and communities. The deep moral and social beliefs that shape sexual behaviour and sexuality are not usually accessible to open discussions and, therefore, are diffcult to infuence.

Higher educational attainment has often been associated with a greater risk of HIV infection in Africa. Nevertheless, the pattern of new HIV infections may be changing to greater burden on the less educated groups. HIV continues to be seen largely from the perspective of sexual behaviour, or rather, misbehaviour. This draws with it the deep-seated stigma and discrimination with which PLWHA are treated. It shapes the scale of denial surrounding the infection. Such widespread denial ensures that the epidemic remains underground, providing fertile grounds for its rapid spread among the people.

Gender status and HIV and AIDS

The AIDS epidemic poses severe challenges to the human rights of women and young girls. As in most

African societies, Nigerian women have a gender-ascribed role that traditionally places men above them. The 1999 Constitution provides citizens with the right to freedom from discrimination based on "community, place of origin, ethnic group, sex, religion, or political opinion." Nevertheless, customary and religious discrimination against women persists as well as occasional religious violence and social discrimination on the basis of both religion and ethnicity.

Gender inequalities, which exist within the Nigerian society, give room for the epidemic to grow The lower status of women decreases their right to make choices, including those related to their reproductive health – hence their susceptibility to sexually transmitted infections, including HIV, is higher. This inferior status of women also makes it more diffcult for HIV infected women to seek care and to fght the discrimination and stigma associated with the infection.

The lower income-earning power of most women acts as a driving force for them to sell sex. As part of their survival strategy, a number of women are compelled into some form of commercial sex work to sustain themselves and sometimes their children. They are a heterogeneous group propelled largely by economic factors. The now significant problem of traffcking of young women to Europe and some African countries is an example.

At the First Pan-African Conference on Traffcking in Human Persons, held in Abuja, Nigeria, on February 2001, the wife of the Vice-President of Nigeria, Mrs. Titilayo Abubakar, declared:

BOX 2.5

Rachel and Abigail Obeten's story . . .

Rachel Obeten was born normal and healthy, weighing 4.2kg at birth. Unaware of her sero-status, her positive mother breastfed her. After four months, she came down with tuberculosis and pneumonia, and later diarrhoea, skin rashes and thrush. These infections prompted the mother to go for HIV test without counselling. She came out positive. At two, Miss Rachel Obeten tested positive for HIV.

In an effort to give a human face to HIV and AIDS and help fght the stigma and discrimination, Mrs Abigail Obeten featured on a Nigerian Television Authority programme, Newsline, on Sunday, 21 July 2002 and declared her HIV status. In an effort to help break the silence surrounding HIV in Nigeria, she pleaded with Nigerians to treat people living with HIV or AIDS with love and care. When she took her daughter to school thereafter she was received very coldly by the school authorities, which had hitherto treated her with warmth and respect. On inquiry, she was told that her daughter could no longer continue in that school because of her HIV status. On 23 July 2002, little Rachel was expelled from Fabio Nursery and Primary School, Agboju, in Amuwo Odofn Local Government Area of Lagos because of her HIV status.

Rachel is one among many affected children who suffer isolation, stigmatization, and discrimination as a result of either of their parents being infected.

Martha's story (in her words)...

"I registered for antenatal in a private hospital near my house. I was told to do an HIV test as part of the routine test. When I refused they told me bluntly that they could not take the delivery if I did not take the test. I went to a government hospital, they flled out a form for a blood test, I read it but there was nothing indicating HIV test so I went for the test. During my next visit, I was worried when the midwife told me that I had to go to the teaching hospital for special management. She would not explain why, instead she gave me a letter. Out of curiosity I read it on my way home and learnt that I had tested HIV positive. My world crashed. I locked myself up and cried for weeks.

At the teaching hospital, the nurses kept passing the letter from one to another and eventually asked me to return in four weeks' time because the doctor who would attend to me was on leave. By this time I was already seven and half months pregnant. I fell into labour before the appointment date and had to go to a traditional birth attendant, who took my delivery. I did not tell her my HIV status because I was scared she would refuse to attend to me too."

Mr Z's story. .

"I had a second- class upper degree in economics. I was told I had the highest score in the aptitude test conducted by a bank. All the interviewers ranked me the best during the interview. Some management staff even began to treat me as if I had already been employed. The next phase they said was just a routine medical exam. I had no anxiety at all about that. I went to the bank's clinic, gave my blood, urine, and had an x-ray done.

After a month, I still had not heard from the bank despite their initial anxiety to have the vacancy flled. I went to fnd out the reason for the delay. On arrival, I found that someone else had flled the position. The personnel manager gave me no reason for this change. Out of desperation, I went to see the doctor who asked me to come back with a close relation. I went back with my aunt and received the news that changed my whole life. The doctor said I tested HIV positive.

My aunt was quiet throughout all this. When we got home, she told me to pack my things and leave her house. According to her, her children were still too young to be exposed to any complications in life. This was only the beginning of my ordeal. It is a miracle I am still alive."

A Nurse's account. . .

"I am the only one in this hospital that willingly attends to known HIV patients, from dressings to injections to bed baths. Once an AIDS patient arrives in the ward, they will send for me saying my people have come. They call me AIDS nurse. This whole problem started with the introduction of mandatory HIV testing in the hospital. When patients test positive they are treated like dogs. It is so bad now that laboratory scientists are making money out of the situation.

For a fee you can have your HIV status changed from positive to negative. A lot of doctors and nurses are now swimming in the perceived 'HIV negative' blood. I do not blame the patients one bit. This is the price we have to pay for being so discriminatory and inhuman."

BOX 2.6
The Next Wave of HIV/AIDS: Nigeria, Ethiopia, Russia, India, and China

The number of people with HIV/AIDS will grow signifcantly by the end of the decade. The increase will be driven by the spread of the disease in fve populous countries – Nigeria, Ethiopia, Russia, India, and China – where the number of infected people will grow from around 14 to 23 million currently to an estimated 50 to 75 million by 2010. This estimate eclipses the projected 30 to 35 million cases by the end of the decade in Central and Southern Africa, the current focal point of the pandemic.

"It is a twist of history that at a period when socio-political and technology winds are blowing across the globe, when we should start brainstorming on the faster way to chart a progressive path for our generation and humanity, at the jet of computer and accelerated socio-economic advancement, some barons still engage in the disdainful act of seeing fellow human beings as an object rather than subject, which must be exchanged like a commodity for monetary desires".

More than anything else, this statement shows the degree of dehumanization that is going on in the

FIGURE 2.9
HIV Projections in Nigeria (1990-2015)

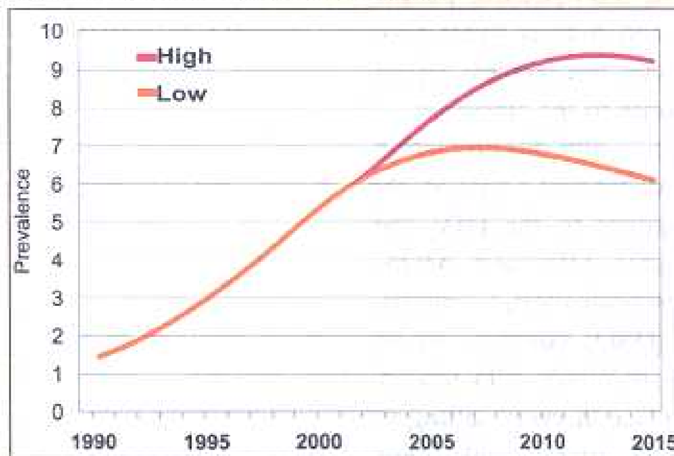
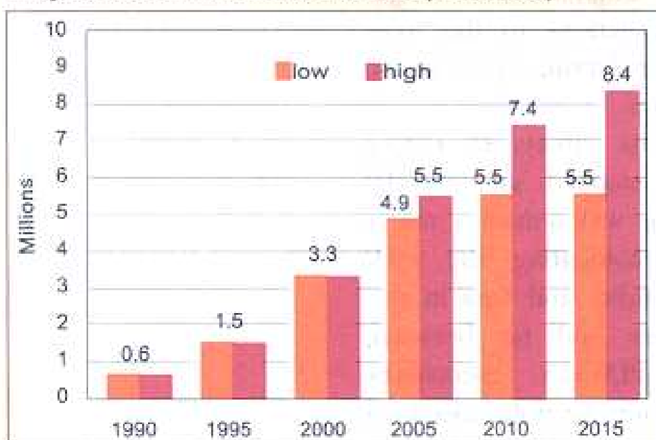


FIGURE 2.10
Projections of HIV Positive Persons (1990-2015)



less developed countries (LDCs).

Mobile populations, conf icts and HIV and AIDS in Nigeria

People migrate for a large number of reasons. Increasing urbanization with rural to urban migration in search of better livelihoods is an important factor in migration within our Nigeria's borders. Movement of professional groups characterized by mobility, for instance, of military personnel, truck drivers, traders, etc., contribute to mobility.

Of increasing signif cance also is the number of internal conficts between communities and natural disasters, resulting in whole communities becoming internally displaced. Eighteen out of Nigeria's 36 states have had recent incidents leading to displacement of parts of the population. Notable examples include communal clashes between the Tiv in Benue and Jukun in Taraba; communal clashes in Akwa Ibom, Delta, Cross River, Adamawa, Gombe, and Nassarawa states; rainstorms in Kogi, and Ekiti; foods in Bayelsa, Niger, and Bauchi, and explosions in Lagos.

So far no study has given specif c prevalence rates for HIV infection among displaced populations in Nigeria. The rising population of internally displaced persons in the country calls for urgent HIV prevention programmes for them. The effects of the vulnerability may not be seen immediately since there is usually a time lag between infection and conversion to a sero-positive status.

Human rights status and HIV and AIDS-related stigma and discrimination

Vulnerability to HIV and AIDS is often exacerbated by lack of

respect for the rights of individuals. The AIDS epidemic poses severe challenges to the human rights of individuals, particularly in the developing nations. Rights very often compromised include the right to information and education, freedom of expression and association, the rights to liberty and security, freedom from inhuman or degrading treatment, the right to privacy and confdentiality and the right to health. In its Declaration of Commitment on HIV and AIDS, adopted in June 2001, the UN Gen-eral Assembly acknowledged the important connection between HIV and AIDS and human rights. It says:

The full realization of human rights and fundamental freedoms for all is an essential element in a global response to the HIV and AIDS pandemic including in the areas of prevention, care, support and treatment, and that it reduces vulnerability to HIV and AIDS and prevents stigma and related discrimination against people living with or at risk of HIV and AIDS.

International human rights instruments play an important role in HIV and AIDS since they provide a guide to laws, procedures and obligations at regional and national levels to state and non-state actors. The 1998 International *Guidelines* on HIV and AIDS and Human Rights (issued by the United Nations High Commissioner for Human Rights and UNAIDS) further emphasizes the relationship between human rights and public health. The *Guidelines* state that:

In the context of HIV and AIDS, an environment in which human rights are respected ensures that vulnerability to HIV and AIDS is reduced, those infected with and affected by HIV and AIDS live a life of dignity without discrimination and the personal and societal impact of HIV infection is alleviated.

The proclamation and ratification of relevant human rights documents by Nigeria makes them every individual's birthright, but ignorance and violations of these rights abound in all spheres of our society. It has been widely acknowledged that respect for human rights is central to an effective response to HIV and AIDS, yet discrimination and stigmatization of HIV-positive people remain rife and human rights protections remain the feeblest aspect of the response to the epidemic.

Although anti-discrimination measures have formed a part of the national response to the HIV and AIDS epidemic, HIV and AIDS-related discrimination, stigma, and denial (DSD) continue to be reported by PLWHA. HIV-related DSD takes place in every setting in which PLWHA interact with other people: at home, in the community, in health care settings, and in the work place. Stigmatization ranges from subtle actions to the most extreme degradation, rejection and abandonment.

Unless the efforts to reduce stigma are stepped up in HIV campaigns, it will remain a major barrier to combating the HIV epidemic. Studies and data in this area are few and far between, but the PLWHA themselves provide incontrovertible anecdotal evidence.

Future Projections

While the current HIV and AIDS situation in Nigeria is of serious concern, more alarming is the potential for an explosive and exponential growth of the infection in the coming years. The factors in consideration are (i) the high proportion of young Nigerians (44 per cent are under 15 years of age) and (ii) the age of frst sexual intercourse (more than 25 per cent of women have sex by age 15, with 50 per cent by age 18). This means that the youths of today are both the largest and most vulnerable group.

As in other parts of Sub-Saharan Africa, women are more vulnerable than men and young women aged 15-24 constitute the most vulnerable group. As shown in Figure 2.8, the HIV prevalence will continue to rise (high) in the next 5-10 years to about 9.5 per cent despite current efforts to stem the tide while the second (low) predicts a levelling off to about 7 per cent in the next 5 years. As earlier indicated, however, experts believe this to be a very conservative projection. It is projected that by 2010, between 5 and 15 million Nigerians will be HIV positive with almost 9 million AIDS orphans. It is the sheer size and vulnerability of Nigerian youths that prompted the National Intelligence Committee (NIC) to predict that Nigeria will be one of fve "next-wave" countries that will double or triple the number of global HIV and AIDS cases by 2010.

Conclusion

HIV and AIDS has become a "generalized epidemic" in Nigeria and current evidence suggests that the epidemic is yet emerging; it is still far from maturing. Already, all the geo-political zones are affected, and the prevalence gap between the urban and rural areas of the country have narrowed down signifcantly. The burden of infection continues to be borne by young people with more females than males infected.

Given the current scale of prevalence and government's limited capacity to respond, it is expected that HIV and AIDS will infect as many as 10-15 million Nigerians by 2010. This number will constitute about 15 to 25 per cent of adults – close to the rates currently being experienced in Southern Africa. Given this scenario, it is also projected that by 2010 there will be as many as 9 million orphans in the country and bed occupancy arising from AIDS-related illnesses could rise to 50-60 per cent in some hard hit communities in the country.

Recommendations

The profle of AIDS in Nigeria and the pattern of its prevalence strongly suggest what needs to be done to contain the big bang coming. In the frst place, it should be made very clear that the incidence and prevalence of HIV can be curtailed drastically. South Africa, Ethiopia and Uganda are African examples which boldly indicate this possibility if we chose to exert the right political will.

Also, since the majority of Nigerians are youths (over 60 per cent, 44 per cent of which are 15-year-olds or under) and, as the most sexually active (25 per cent of which initiate sex at age 15 and 50 per cent at age 18), they constitute the

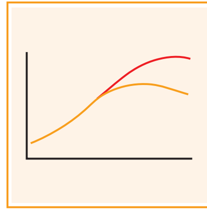
most vulnerable group. It follows, therefore, that the key to halting the spread of AIDS is to target the youths with all the advocacy mechanism that can be mustered as well as in all the offcial policies of government.

Asastartingpoint,government must formulate an innovative youth policy on employment, education, trade and other aspects of social development. The youths of this nation have neither hope nor belief in the future of the nation. Government must demonstrate genuine care and commitment for its AIDS control programmes to be well received.

In planning advocacy and intervention programmes for youths, it should be borne in mind that there are two wide streams to plan for – the ones in secondary and tertiary institutions, and the street boys and girls ("area boys" and sex workers). The programmes must be practical enough to identify and remove fear in their psychology. To redirect their energies for constructive national engagement, youth programmes must be appealing by the sheer force of their quality, variety and in-built poverty alleviation mechanisms.

The AIDS awareness campaign in the country is still too weak to make a meaningful impact on the population. If Nigeria is not to experience the explosive and exponential growth in infection, as predicted in the "next wave" of the epidemic, then there should be a vigorous national campaign backed by statistics all over the country on a sustained basis and support projects to keep the message in people's mind at all times.

Finally, all the stakeholders should analyse the underlying factors in the prevalence of AIDS and work out strategies to contain them. As there is no known cure, special care should be taken of the three classes of the population – those who are infected, those who are affected, and those who are not infected – to ensure that they continue to live a quality life devoid of discrimination, denial and abuse of their human rights and dignity.



Chapter Three

Determinants of the Spread of HIV and AIDS and Impacts of the Epidemic

Eighty per cent of HIV infections in Nigeria occur through heterosexual transmission

IN the previous chapters of this report, a clear attempt was made to create what might be called a rich picture of the onset, march, and goal of the human plague called HIV and AIDS. The first chapter prefaced the entire discussion with an overview of what the Nigerian experience has been since the onset of the disease, followed by an examination of the policy environment and the implications HIV and AIDS on human development in the country. In discussing how HIV and AIDS is ravaging the world, Africa and Nigeria, chapter 2 focuses on the reinforcing factors that made the disease so prevalent in Nigeria that it is responsible for 10 per cent of global infections.

In this chapter, our aim is to identify the underlying factors that drive the infection, and the impact and consequences of the epidemic on every aspect of Nigerian society.

HIV sub-types and mode of transmission

Approximately 96 per cent of HIV infections in Nigeria are caused by HIV-1, and 2 per cent by mixed infection, i.e., the combination of HIV-1 and HIV-2. The remaining 2 per cent is caused by HIV-2. HIV-1 has shown a remarkable ability to exploit and adapt to changes in the social environment. At the molecular level, it has also been observed that the virus is constantly changing. In order to map the genetic variation of HIV-1, scientists have classified different strains of the virus into three groups, including M (main), O (outlier) and N (non-M, non-O).

The main group (M) is further classified into a number of sub-types and variants as a result of the combination of two or more sub-types, known as "Circulating Recombinant Forms" (CRF). A recent study which mapped out the different sub-types from different parts of Nigeria showed two major sub-types, A and G, with a growing population of recombinant form of A/G (CRF02) in all parts of the country.

Another report observed that more of sub-type A predominates in the south while G predominates in the northern parts with significant A/G recombination in the East and

West. However, such demarcation is being blurred by the increasing spread of CRF02 AG in all parts of the country, especially in the middle belt. Sub-type C, an aggressive form of HIV-1 circulating in Southern Africa has also recently been identified in Nigeria. Apart from changing constantly at the molecular level, the HIV mapping is bound to be problematic because people have become extremely mobile. As they move across national and international boundaries, people transmit whichever strain or sub-type of HIV they have.

There is a dearth of information about all the various modes of HIV transmission but research has confirmed that heterosexual encounters are mostly responsible for the transmission of the epidemic. Studies in Jos and Lagos report that 80 per cent of the HIV infections in Nigeria occur through heterosexual transmission, 5 per cent through unscreened blood transmissions, and mother-to-child transmission accounts for the remainder. However, there is evidence of homosexuality and lesbianism, which has not been well documented in some settings such as prisons, in male or female dominated groups and professions and in some urban settings. Most homosexuals and lesbians in Nigeria are also bisexuals.

Factors Driving HIV Infections and Transmissions

Poverty

The Nigerian economy has witnessed negative growth in the last two decades. Oil revenues represent 95 per cent of the country's exports but account for only 40 per cent of the GDP and 70 per cent of budget revenue. Between 1991 and 2001, the average growth of the gross national product (GNP) of the economy declined by 2.2 per cent. Similarly the GDP growth rate declined from 4.8 per cent in 1991 to 2.4 per cent in 1999. Given the annual population growth of 2.8 per cent, the annual growth rate per capita has remained negative in recent years. To worsen the situation, Nigeria has a huge external debt of US$28.5 billion or 70 per cent of GDP. Actual debt servicing in the year 2000 cost US$1.9 billion, representing four times the federal allocation to education and about 12 times the allocation to health.

The deterioration and subsequent decline of health services, education and other social services means a loss of opportunities for the prevention of HIV. People with little or no education have poor access to safe sex information. For example, condom use was higher among individuals with higher levels of education among young people and their adult counterparts in the Tudun Wada area of Jos in North Central Nigeria. Similarly, reduced provision of quality health services also represents a loss of opportunities to control other STIs, offer reproductive health services and even provide quality care and support for individuals infected with HIV.

Poverty increases vulnerability to HIV and other STIs. Under conditions of grinding poverty, the risk of HIV assumes a lower priority among people's daily concerns. People in such circumstances are more concerned about the immediate consequences of survival than

Faced with grinding poverty, the risk of HIV assumes a lower priority. People are more concerned about the immediate consequences of survival than the chances of contracting a virus whose effects do not manifest immediately.

While official statistics point to minute gains in the economy, grinding poverty, as etched on human faces, and the growing misery and mass pauperization indicate that very little human progress is being made in the Nigerian landscape.

the chances of contracting a virus whose effects do not manifest immediately. Young people who grow up in poor conditions have little access to education and few prospects for the future. They lack recreational facilities and often sex becomes the means for passing time. Poverty may also drive women into trading sex for money, food and other goods. Poor people migrate from rural areas to urban settings in search of jobs, leaving their closely-knit family settings for an environment where sexual risk taking is higher than their rural areas.

Indeed, it has been argued that poverty is the greatest single facilitator of HIV transmission in Nigeria and carries the epidemic to the remotest corner of the country. Not only is poverty observable at the individual, family, local, and national levels, it has become a national culture and the chief index for measuring the degree of the nation's under-development. While official statistics point to minute gains in the economy, grinding poverty, as etched on human faces, and the growing misery and mass pauperization indicate that very little human progress is being made in the Nigerian landscape.

If the economy of Nigeria and, consequently, the fortunes of her citizens are not growing, there is an awareness of the country's poverty profile, the reasons for it and the measures to arrest it.

According to *Poverty and Welfare in Nigeria*, a joint publication of FOS and the World Bank, out of Nigeria's estimated population of 124 million in 1997, the population of the poor increased by 61 per cent to 55.8 million, compared to 33.5 million poor in 1992 out of a total population of 102 million. In the human poverty index (HPI) rankings of 78 developing countries and nine Organization of Oil Exporting Countries (OPEC), the global Human Development Report 1997 ranks Nigeria 54th and ninth, meaning that the country is one of the 25th poorest countries in the world and the poorest OPEC country.

Relying on statistics from this same report, the Nigerian National Human Development Report 1998 says one in every two Nigerians is poor and that as many as 33.8 per cent of the country's population is not expected to survive to age 40.

This has offered significant insights into the nature and depth of poverty, only that its warnings have not been heeded. According to the report, Nigeria's poverty manifests in (i) human poverty; (ii) physiological deprivation; (iii) income poverty; (iv) poor macroeconomic performance; (v) negative impact of public expenditure on human alleviation; and (vi) social exclusion. The report rightly observes that wherever the foregoing traits co-exist with severe economic crisis, fiscal indiscipline and pandemic corruption, then "the resulting environment becomes ideally suited to a rapid growth in the pauperization of the population".

The report highlights that Nigeria has abdicated all the international obligations it freely entered into, including the global conferences on Education for All and Reduction in Adult Illiteracy, Universal Access to Safe Water, Universal Access to Primary Health Care, etc. It adds that education and health, which hold the key to the alleviation and eventual eradication of human poverty, have

been neglected through inadequate investment, poor strategy and even poorer implementation since the mid eighties. The result is increased human deprivation and poverty.

Among the indices of acute social deprivation contained in the report are (i) widening income inequality; (ii) household food insecurity and malnutrition in micro-nutrients, leading to learning disabilities, mental retardation, poor health, low productivity, blindness and premature death; (iii) denial of safe water to 50 per cent of the population; and (iv) epileptic power supply which badly affects productivity in the country and non-availability of electricity to about 60 per cent of the population. The report makes it clear that additional budgetary allocation is not necessarily the answer, but that a most serious damage has been inflicted on the quality, content, and the moral bases of these services, stating that this is what ought to be urgently addressed.

The maiden edition of the *Nigerian Human Development Report (1996)* strongly advocates a redirection of public expenditure priorities in order to achieve anti-poverty objectives. It urged the federal government to commit 20 per cent of the budget to two goals in education and four in health, namely, basic education for all, and reduction of adult literacy by half, including bringing the female illiteracy rate down to that of the male. Others include universal access to primary health care and sanitation, total immunization of all children, reduction of maternal mortality by one half, and eliminating severe malnutrition. The plea went unheeded.

In the two years following the publication of this report (1997 and 1998) the government spent more on defence than on education and health combined even though there was no apparent threat of external aggression.

HIV and AIDS and poverty are twin terrors operating in mutual concert. Poverty enfeebles the fight against the epidemic, leaving it free to spread misery and death, especially to the productive force. With Nigeria's high unemployment and under-employment rate, it is said that every jobholder in the country caters for at least six dependants. Thus, as the epidemic continues to target the labour force, it is by implication targeting the hope of containing it (i.e., the disease).

Nigeria has a fairly long history of development planning, which, unfortunately, is not matched by appreciable level of human and physical development. Given the sheer volume and variety of its natural wealth and the benefit of all the National Development Plans of the 1970s, the Rolling and Perspective Plans of the 1980s and 1990s, Nigeria ought to be in the league of one of the most advanced countries. But it is among the poorest 25 countries with inherent disability to meet any national or international target.

As is typical of the country, overall development planning for the country is in shambles – whether it is for AIDS or the economy. According to the Nigerian Civil Society Network between 1996 and 1998 when HIV was beginning to exert a heavy toll on the nation, the federal budget for the health sector averaged 0.2 per cent – the very lowest in the world. Total expenditure on AIDS in 1998 amounted to US$

Education and health, which hold the key to the alleviation and eventual eradication of human poverty, have been neglected through inadequate investment, poor strategy and even poorer implementation since the mid eighties. The result is increased human deprivation and poverty.

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0.03 per capita – the least in Africa. Debt servicing obligations in 2000 cost US$ 1.5 billion, which was nine times the total health spending for 2001. The resulting fiscal imbalance, coupled with policy and institutional failure, unbridled corruption, capital flight, high levels of poverty, collapsed public infrastructure, etc., has deepened poverty to a level of mass impoverishment.

It is true that the government has shown more seriousness in overall planning of the economy and other aspects of social life since the civilian administration of President Obasanjo. The whole burden of social planning to take care of youth unemployment, debt relief, empowerment of the vulnerable groups in the society, etc., is hinged on the twin strategies of New Economic Partnership for African Development (NEPAD) and the National Economic Empowerment Development Strategies (NEEDS), both still needing to take root.

NEPAD is an initiative of the African Union (AU) for addressing the common development challenges of the continent on a collective basis. It is the collective voice of Africa on development issues and the chief platform for achieving the MDGs. Many international agencies have built strategic alliances with NEPAD, among which is the African Council for Sustainable Health Development (ACOSHED), an African-initiative for radical health and development reforms. Nigeria is the host of the International Secretariat of ACOSHED, which leads the advocacy campaigns for urgent health reforms in order to contain AIDS and other STIs.

NEEDS, on its part, is a National domestic blueprint of development that seeks to unify national planning with that of states (through SEEDS) and local governments (LEEDS).

The standpoint of government on the two initiatives looks good, only that several of the challenges have become national emergencies. An instance was the initial disbelief and inactivity of government on the HIV scourge. This has turned it into a national disaster, with a propensity for a more monumental disaster if very drastic actions are not taken. The Nigerian Civil Society Network states that the HEAP, which was estimated to cost US$ 190 million in 2000, was grossly underfunded in 2002. In addition, Nigeria needs at least US$ 500 million to expand its AIDS programme over the next 5-10 years if it is to avert a disaster (see Appendix 4.3).

It can be seen from the foregoing that although abject poverty is the chief problem confronting the nation, neglecting all the strategic social services like education and health care, which are key in eradicating poverty, is a sure way to aggravate the problem. Consequently, by uprooting these twin pillars on which the social fabrics of our civilization rest, the nation has been exposed to any looming epidemic. This is the reason why tuberculosis, guinea worm, polio, and other deadly diseases that have been successfully eradicated in different parts of the world still exist in epidemic proportions in Nigeria. The colossal failure of official policy and public institutions in Nigeria make HIV and AIDS a disaster waiting to happen.

Socio-economic and cultural factors

The socio-economic and cultural factors in the spread of HIV and AIDS in Nigeria incorporate (i) those that are embedded in Nigeria's social structure; and (ii) those that can be regarded as the unintended consequences of rapid modernization and urbanization. Of significance in the former are the traditional subordinate role for women, which makes it very difficult for them to negotiate safe sex with their partners.

Others include harmful traditional practices like female genital mutilation (FGM), polygamy, courtesanship or concubinage, levirate (wife inheritance), body scarification and tribal marks, and wife exchange/hospitality. Twice as many young women than men are infected in Nigeria. In 2001, an estimated 6-11per cent of young women aged 15-24 were living with HIV and AIDS, compared to 3-6 per cent of young men. This appears to be the result of a combination of cultural and socio-economic factors.

The patriarchal ordering of social life in the country dictates a subordinate position for women. The social and cultural norms in many Nigerian communities dictate that women have little or no control over their sex lives, or the sex lives of their husbands outside marriage. Most cultures in Nigeria require that women have little experience before marriage and are expected to remain monogamous thereafter while men are allowed (tolerated) and even expected to have premarital and extramarital sex. Young men and boys are often pressurized by their peers to demonstrate their masculinity by engaging in sexual initiation and premarital sex.

In some communities, the payment of high bride price (financial compensation by the husband to the bride's family) perpetuates the idea that the woman is the husband's property, thus denying her ab initio the power to negotiate safe sex. This culturally prescribed lack of control over their sexual relationships has exposed women, particularly married women, to HIV-1. Wives are not allowed to refuse marital sex to their husbands or request for the use of condoms even when their husbands have STIs (including HIV). This has been confirmed in several recent studies where women admitted that they would not refuse sex with their partners even when they (women) had no desire for it.

Other implications of the subordinate position of women include the accepted norm that men know all about sex and cannot be ignorant; conversely, the woman is supposed to demonstrate ignorance about sexual issues. The consequence of this is that women are unable to protect themselves from HIV even when they are equipped with adequate preventive knowledge.

The high rates of HIV infection among women and girls often have less to do with biology and more to do with fundamental issues of power and control over women. Women's vulnerability to HIV is increased by economic or social dependence on men. As has been noted by several activists, it is men "who determine whether sex takes place, when and whether a condom is used". In situations of economic dependence, women's ability to insist on condom use becomes even more difficult. If women refuse sex or request condom use, they

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The colossal failure of offcial policy and public institutions in Nigeria make HIV and AIDS a disaster waiting to happen.

BOX 3: 1
Major Socio-Cultural Factors in the Spread of HIV/AIDS in Nigeria

The major socio-cultural determinants of HIV/AIDS in Nigeria include:

- Low literacy level, especially among females.
- Poor economic leading to with widespread unemployment and under-employment, and generalized poverty.
- Commercial sex work as easy means of making money in urban centres.
- Culturally-approved male dominance, which supports male having multiple female sex partners, most of them much younger.
- The erroneous belief that a disabled female and/or virgin could cure sexually transmitted infections (STIs) and HIV. This is responsible for some cases of rape among children by older men.
- Heavy infectious disease burden.
- High STIs rates in Nigeria, majority of which are treated through self-medication and herbalists.
- Weak health care delivery system and lack of Anti-retroviral (AVR) drug.
- Poor community support for HIV and AIDS preventive programme, including the use of condom during casual sexual intercourse.

risk abuse or suspicion of infidelity. They may even be abandoned or forced to leave the home.

Sexual violence (including rape and sexual molestation) is a common occurrence even though it is dangerous to the reproductive health of women and girls, and heightens the risk of HIV infection. Because they are economically dependent on their spouses, few women can negotiate safe sex for fear of risking violence, mistrust, or withdrawal of financial support. Hence, women continue to be passive and non-assertive in sexual relations. Economic dependence also forces them to endure forced sex, early marriage, and incest, all of which could cause vaginal tearing and expose the young ones to HIV.

For the same reason, most women accept their partners' extramarital affairs even though it puts them at risk. Most HIV cases are rooted in heterosexual contact involving monogamous women and their philandering husbands. Seven out of every 10 married women investigated at the ART clinic in Jos University Teaching Hospital (JUTH) remain in monogamous sexual relationship with their husbands.

Various traditional practices expose Nigerian women to HIV infection. In the northern part of the country, girls are often forced into early marriage. In several cultures, female genital mutilation (FGM), vaginal douching, uvulectomy, blood letting, sexual relationships with infertile women and the absence of universal precautions and sterile procedures by traditional birth attendants are all veritable means of transmitting HIV. FGM is widespread in Nigeria, and many Nigerians patronize assorted traditional healers or circumcisors who are by no means equipped with a basic knowledge of human anatomy. The use of unsterilized instruments (e.g., blades, knives) by healers exposes their "patients" to various infections, including HIV and AIDS.

Moreover, other socially approved traditional practices like polygamy, courtesanship, and concubinage increase the risk of being infected with the virus. These practices that are rooted in the patriarchal nature of Nigerian society promote multiple sexual partners. About a quarter of the married people in Nigeria are in polygynous unions. Nigerian men enjoy unparalleled power over all matters, including sexual intercourse. Men usually shun the condom, and women cannot insist on its use even when they know that they could be infected by their spouses/partners.

Various widowhood rites also contribute to the spread of HIV and AIDS in the population. One of such rites is levirate, otherwise known as wife inheritance. This is a practice whereby a man inherits a widow, as prescribed by the culture, in order to keep the woman within the extended family and to procreate on behalf of the deceased. The other is the ritual of "freeing the spirit" of a dead kin through sexual intercourse between a surviving kin and the wife of the deceased. Yet, the deceased in any of these contexts could have died of AIDS!

The sustenance of these rites/practices, especially among the urban poor as well as the rural dwellers, is a major factor in the spread of HIV and AIDS in Nigeria. There is also deep-seated belief especially among the non-literate that sexually trans-

mitted diseases could easily be cured through sexual intercourse with virgins or disabled girl-children/ women, an obvious by-product of the magico-religious worldview of the illiterate.

One of the last vestiges of our changing culture is scarification on the cheek (i.e., tribal marks), abdomen, chest, back, and/or hand. This carry-over from the olden days is still performed in the rural areas and among the urban poor. They were performed in the past for identification or aesthetic reasons and in some contexts to make girl-children/women unattractive to suitors from other ethnic groups. Along with these are complete shaving of the head and the cutting of the nail to the skin, all of which are done with unsterilized blades and/ or scissors. The contribution of the Gwazami (traditional surgeons) in Northern Nigeria who perform "surgery" on patients that cannot afford treatment in regular hospitals cannot be ignored. The procedure is fraught with the risk of infections, including HIV and AIDS.

The widely shared belief-system is also critical in the spread of HIV and AIDS in Nigeria. Most Nigerians belong to two worlds, namely, the Western and the African. They subscribe both to the scientific and the magico-religious worldviews. It is therefore not surprising that a significant number of the population believe that HIV and AIDS can be prevented and/ or cured by traditional healers/ medicines. Consequently, Nigerians take additional risks when they consume concoctions that they believe are sure antidote against HIV and AIDS prior to, and/or after sexual intercourse. Closely related to this is the belief by a still

Box 3: 2
Case Report on a Nigerian Girl

... let me start this contribution on the interplay between poverty and infectious diseases like AIDS by narrating a true live story of a young Nigerian girl that I met while we were on a flight from Lagos to another city in the country. We got into some sort of a conversation soon after our aircraft was airborne. After a few pleasantries and short talks about the problems of our country, she began by asking me about my final destination, mission, and where I was working. I observed that she became enthused when she realized that my work place was in Abuja, the new Federal Capital Territory that is now the hot bed of economic activities and a new frontier for those in search of opportunities. She was quick to underscore this fact by pointing out to me that Abuja seems to be the greenest pasture in the country. In her estimation, Abuja is the place for *contacts* and *contracts* and a place where one could easily "make it".

In turn, I was curious to find out a little bit about her, her mission, and also her final destination. Surprisingly, she opened up and began to narrate the story of her life. She indicated that she was on a short visit to the country to see her parents and friends, and she planned to be back in Europe where she had been living for six years. She indicated that she left Nigeria some ten years ago, travelled in the first instance to South Africa because it was easy to obtain a visa for that country. After a short stay in South Africa, she obtained a South African passport which she in turn used to procure a visa to one of the European countries since she could not gain one to a preferred one— the United States. She subsequently succeeded in relocating to Italy where she spent three years before finally moving to Germany where she was then residing.

The young Nigerian woman further revealed during our conversation that she was married to an obese German that was wheel chair-bound all day except at bed-time in the night. She had been taking care of him and also fulfilling all conjugal obligations. However, her ultimate goal, according to her, was to save enough money and return to Nigeria at a future date to establish a business, possibly build and manage a hotel in one of the major cities with Abuja high on the list of cities for this venture.

To my utter surprise, she bemoaned her present circumstance and looked forward to a day when, to quote her, "she would be properly married", indicating that her current marriage to the obese German was for convenience. I was taken aback by her remarks about her "marriage of convenience" and therefore was keen to find out why she had to go through all of these in order to raise the capital that she needed to fulfill her dream of establishing a lucrative business venture in Nigeria. After pausing and taking a deep breath, she responded as follows:

"I just had to find a way of surviving. I had no choice but to leave Nigeria to seek opportunities elsewhere in other parts of the world in order to survive. My father was a policeman with five wives and twenty children, and he obviously was unable to provide the wherewithal to meet our needs…food, shelter, clothing etc. Some of us (his children) went without our main meals daily. On the other hand, my mother who had four among the children could also not fend for us. It was always the survival of the fittest in my family. I therefore had no choice but to find my way out of the family and the country in search of opportunities to keep life going. I was determined to leave the family for some other place rather than waste away. I realized that it was not going to be easy to travel to Europe and therefore opted for South Africa with the help of a man who assured me that he could assist me. I was involved in a variety of activities which to tell you the truth I would not be happy to describe. I eventually was able to obtain a South African passport with which I traveled to Italy. I know that my present marital relationship was not what anyone should be proud of but it is the only way by which I could get by, raise funds, and ultimately fulfill a life long-dream. Marrying the disabled man gave me access to a German passport and it would also help me to raise funds that I could use to establish a business venture and possibly build an ultra-modern hotel and be in a position to support mother, brothers, sisters. And I look forward to a day when I shall begin a new and fulfilling life in Nigeria."

> *Ethnographic anedotal reports suggest that wivws are offered as sexual partners to honoured guests by their hosts, and sexual intercourse between spouses of siblings is socially approved in some cultures in the Middle Belt while women offered to cults in the Nsukka area are made targets of unprotected sex. The prevalence of HIV and AIDS in the affected regions is usually high.*

significant number in the society that the disease is not real.

Some traditional practices that are still widespread in some parts of the country that have not been given the prominence they deserve in the spread of HIV include wife hospitality, unbridled exchange of spouses among siblings, and what has been referred to as "cult prostitution". Ethnographic and anecdotal reports suggest that (a) wives are offered as sexual partners to honoured guests by their hosts (e.g., in parts of Benue State); (b) unbridled sexual intercourse between spouses of siblings is socially approved among some groups in Kogi and Benue States; and (c) women who are offered to cults (viz., cult prostitution) in the Nsukka area are targets of unprotected heterosexual intercourse.

These practices may be accounting for the unusually high prevalence rate of HIV and AIDS that has been recorded among the various ethnic groups in the middle-belt of Nigeria.

Migration, urbanization and modernization

The growth of certain urban areas like Lagos, Abuja, Kano and Port Harcourt in Nigeria, resulting from increased birth rates and continued migration from rural areas, has fuelled the rapid spread of HIV in Nigeria. For example, the HIV seroprevalence rate in Abuja increased from 7.2 per cent in 1999 to 10.2 per cent in 2002. The results of previous sentinel surveys in 1996, 1999 and 2001 observed a higher HIV prevalence in urban than in rural communities. Urbanization and modernization substitute traditional village norms with an urban modern ethos with fewer restrictions on sexual behaviour and marriage. This has been typified in the new federal capital, Abuja, where civil servants moving into the city from Lagos and separated from their families acquire "new sex partners" through what is called "Abuja marriage". Part of the high urban prevalence of HIV-1 infection in Nigeria has resulted from massive migration of young, unmarried adults from conservative rural environments to more sexually permissive cities. Furthermore, loss of culture and erosion of social networks are associated with drug use and other social vices that encourage high-risk behaviour.

Migration to urban towns in search of jobs separates spouses for long periods. Urban men and women who are separated from their wives and husbands are more likely to engage in high-risk sexual behaviour than their counterparts in the rural areas. Male migrants may engage in high-risk behaviour with sex workers, thereby increasing the vulnerability of their families to HIV and other STIs. In Nigeria, young women recently graduating from secondary and tertiary institutions form a significant number of new migrants to urban cities like Lagos and Abuja. These end up with no jobs or low status, low wage production and service jobs, and may be forced into commercial sex work as a survival strategy.

Modernization has led to better and quicker modes of transportation and communication, and hence, higher mobility. Better communication and means of transportation now link urban and rural areas economically and socially. Inter-country and intra-country population movements have been a critical factor in

the spread of HIV in many parts of Nigeria. This spread is facilitated by the porous nature of the country's borders coupled with the high volume of across-the-border trade between Nigeria and many of its neighbours where the prevalence of HIV is high. Intra-country mobility is typified by the mass movement of many urban dwellers to various rural settlements over the weekends. Key groups with high mobility and, therefore, at high risk of HIV transmission include sex workers, transport workers, travelling sales men and women, truck drivers, the military, mobile employees of large industries and seafarers. *Occupational travel* has been associated with high rates of sexual partner change, transactional sex, and unsafe sex. Travellers, therefore, play a prominent role as "bridge" population between areas of high and low HIV prevalence.

In addition, the unintended consequences of rapid modernization and urbanization are playing critical role in the spread of the epidemic in the country. Though they need not be, the processes underlying modernization and urbanization in the country are accompanied by:

- involuntary and voluntary internal and international migration;
- bourgeoning urban squatters and overcrowding;
- child labour;
- thriving commercial sex;
- the proliferation of substandard health care facilities, including quacks that masquerade as health care agents; and
- abject poverty.

These factors severally and collectively engender risky sexual practices as well as other lifestyles that contribute to the spread of HIV and AIDS in Nigeria.

Overcrowded housing units in urban centres have become the breeding ground for sexual activities among neighbours and between older men and children/wards of their next-door neighbours. Similarly, female hawkers and/or female migrants to urban centres and other parts of the world whose expectations are not easily fulfilled fall prey to male predators or voluntarily resort to commercial sex. There are anecdotal reports of widespread unprotected sexual intercourse between older men and young female hawkers who ply their trade in market places and urban neighbourhoods.

The rapidity of urbanization in Nigeria has bred urban poverty among millions of people. This has become the propelling force for commercial sex, as has been reported in various studies on sexual networking in urban centres in the past decade. The case described in Box 3:2 exemplifies how poverty could drive young women into risky sexual activity.

Another poverty-linked factor in the spread of HIV and AIDS in the country that is also an unintended by-product of modernization is "needle-sharing" in health care and other contexts. Poverty drives the poor to seek health care from assorted health care agents that are usually quacks. These quacks, including patent medicine sellers, are wont to use infected needles for intravenous injections. The implication of this cannot be underestimated in the spread of HIV and AIDS. Similarly, the traditional healers that constitute a formidable sub-group among

Key groups with high mobility and, therefore, at high risk of HIV transmission include sex workers, transport workers, travelling sales men and women, truck drivers, the military, mobile employees of large industries and seafarers. Occupational travel has been associated with high rates of sexual partner change, transactional sex, and unsafe sex. Travellers, therefore, play a prominent role as "bridge" population between areas of high and low HIV prevalence.

The use and abuse of blood is rife in Nigeria and many unscrupulous Nigerians compound the problem by selling infected blood to unsuspecting clients. Screening facilities are poor and the country lacks effective blood transfusion policy. The need for blood transfusions from pregnant-related illness and road traffic accidents is huge.

health care providers in Nigeria oftentimes use unsterilized blades and knives for incisions to protect their clients from diabolical attacks. It is, therefore, not out of place to suggest that the most serious threat to social and physical well-being can be linked to the nefarious activities of these quacks, patent medicine sellers, and traditional healers that use infected needles or blades or knives.

HIV infections may occur through the use of unsterilized equipment used for medical or other purposes such as injections, male and female circumcision, barbing, tattooing and surgery by traditional healers in uvulectomy. There are no studies to determine what impact this has on the HIV transmission in Nigeria though these practices are common in many parts of the country. Research has shown that the use of unsterilized needles and syringes was capable of transmitting hepatitis B virus, a closely related virus in mode of transmission to HIV.

Demographic

The most sexually active age group (15-30) is larger than other age brackets in Nigeria, accounting for up to 35 per cent of the general population. Two out of every 5 Nigerians are below age 15, creating a large population of potential HIV infection targets. On the other hand, this leaves a huge window of opportunity for prevention. There is evidence that young people in Nigeria are becoming sexually active at an earlier age and that premarital sex is increasing. Yet awareness and knowledge of HIV and AIDS remains dismal in many parts of the country. The challenge is to expand coverage, develop and implement more comprehensive approaches for reducing vulnerability among young people, and caring for those infected.

Blood and blood products

The use and abuse of blood products is rife in Nigeria. Blood transfusion poses serious threat to the health of Nigerians because the skills and the facilities needed for screening blood products are either not available or have deteriorated and/or broken down. Many unscrupulous Nigerians have further compounded the situation by selling infected blood products to unsuspecting clients. The urban poor and rural dwellers are at a particular risk of contracting HIV and AIDS from such sources.

The factors underlying the transmission of HIV through blood in Nigeria include the lack of an effective central blood transfusion policy, poor screening infrastructure and commodity management in both public and private health institutions, and poor infection control measures. Other factors that play important roles include indiscriminate blood transfusion practice, the use of commercial donors and the huge need for blood transfusions from pregnancy related-illnesses and road traffic accidents.

Routine visits to antenatal clinics indicate that many pregnant women suffer from nutritional poverty, which sometimes accounts for blood transfusion. Anecdotal evidence suggests that a large proportion of expectant mothers have very low PCV, sometimes as low as 12-18. Most Nigerians are ignorant of the nutritional value of the food they eat; they eat just to fill the stomach. Many families make ends

meet through self-imposed fasting. The apt Yoruba expression for this is "awe bawe nle" (i.e., fasting as a religious obligation is temporary and secondary; there is a more fundamental and primary fast that is poverty-induced).

Additionally, many of the foods that are known to supply the essential vitamins and nutrients are priced beyond the reach of the average income-earner. Meanwhile, the breadwinners of a sizeable chunk of expectant families are unemployed or underemployed. The Nigeria's daily calorie supply of 2125 per capita is just a little above the national nutritional poverty line of 2100 calories. This indicates no considerable differences among different age groups, between the two genders, between urban and rural dwellers, and among people of different states of the country. As the *Nigerian National Human Development Report 1998* shows, it can be safely assumed that *most pregnant women are malnourished*. The report further confirms this when it says, "48 per cent of under-5 children suffer from underweight owing to malnutrition and 16 per cent of infants have low birth weight". The consequences are stunted physical and mental development. Poor nutrition in pregnancy is bound to result in these dangerous consequences and the avoidable risk of blood transfusion to save the life of the mother.

Drug use, which is increasing in some of the big cities in Nigeria, poses grave consequences for the transmission of HIV. Intravenous drug use and the use of the contaminated needles are associated with increasing risks of HIV. Recent reports from scientists in Lagos have also documented an increasing number of intravenous drug use particularly among criminals and "Area boys".

Commercial sex work (CSW)

In Nigeria, CSW is illegal but practised both in formal settings and in a clandestine manner. Like many other Sub-Saharan African countries, female sex workers (FSW) have a higher prevalence of HIV. A survey conducted by the FMOH in 1996 observed that 1 in 3 FSWs was infected with HIV. More recent reports have observed 50-70 per cent HIV sero-prevalence among FSWs in some cities. Other reports have also noted that Nigerian men who patronize FSWs do not use condoms. These clients form the "bridge" between the FSWs and their other partners and, subsequently, the general population. High rates of partner change and sex with FSWs have been identified as key risk factors for HIV transmission in Nigeria.

In recent years, the sex industry in Nigeria has been growing owing largely to the decline in the national economy, causing increased unemployment among out-of-school youths, particularly women. The problem is likely to worsen given the continuous downward trend of the economy.

A report by the Society for Family Health in 2001 emphasizes that significant challenges confront the national effort to mitigate the HIV epidemic in the country. The report observes that CSW is highly remunerative, providing far greater income for the women than they would get from other jobs. Young women are particularly popular with

Many families make ends meet through self-imposed fasting. The apt Yoruba expression for this is "awe bawe nle" (i.e., fasting as a religious obligation is temporary and secondary; there is a more fundamental and primary fast that is poverty-induced).

customers but are more vulnerable as they lack the key knowledge about HIV transmission.

There is a sub-classification of commercial sex work that unites millions of young women in Nigeria into the "hip culture" of permissive, casual, and commercial sex. There are those who may be called professional sex workers, the regular CSWs, there are also student sex workers who, though are in institutions of higher learning, also engage part-time in prostitution. There are the career-minded ambitious female workers in offices who routinely trade sex for official favours and promotion. Therefore, the CSW who trades sex for money, the student who trades sex for high grades and/or money, and the ambitious worker who trades sex for promotions are all in a booming sex trade which creates room for HIV and AIDS to bloom.

As a result of this development, women trafficking has been on the increase in Nigeria. Young girls and women are sold into commercial sex work in Europe and other African countries. This practice has been found to be rampant in Edo, Rivers and some of the eastern states in the country. The most frequently highighted association between trafficking and HIV is the increased likelihood of HIV infection in women. Rates of HIV infection among sex workers returning from trafficking has not been studied, but there has been frequent newspaper reports of such women being deported back to Nigeria after contracting HIV and AIDS.

Wars and conflicts

Wars and civil disturbances provide a conducive environment for the spread of HIV. Nigeria has been indirectly affected by the war situations in West Africa by contributing the bulk of the ECOMOG peacekeeping forces, first in Liberia and later in Sierra Leone for about a decade. In August 2003, another round of peacekeeping commenced in Liberia with troops deployed from Nigeria and other West African countries. In conflict situations, soldiers live in a high risk HIV and AIDS situation that is balanced by the stressful situation and the dangers posed by the war.

The HIV prevalence in the Nigerian armed forces has been much higher than the normal population and is much higher among soldiers returning from the conflict areas of Liberia and Sierra Leone. This assertion is supported by UNAIDS estimates. Studies carried out in Sierra Leone observed a rise of HIV prevalence among FSWs from 26.7 per cent in 1995 to 70 per cent in 1997 at the height of war. Similarly, the HIV prevalence rates among Nigerian soldiers returning from war zones in Liberia and Sierra Leone were much higher than the average Nigerian population in 1999. Hence, the mixing of civilians with armed forces and paramilitary personnel increases the risk of HIV transmission, particularly in times of conflict.

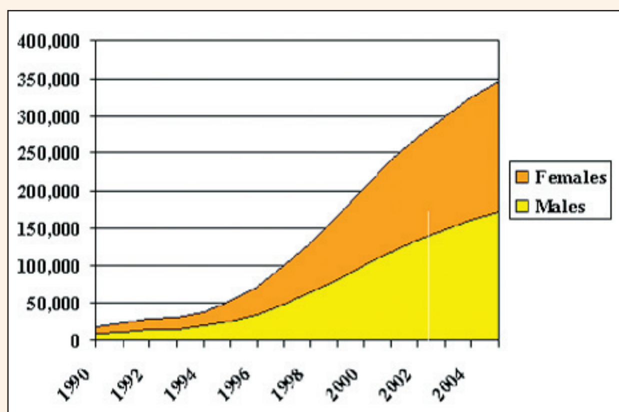
Civil disturbances are common in all the six geo-political zones of the country. They may result from

BOX 3.3
Local factors that enhance the transmission of HIV in Nigeria

Ignorance

The level of awareness about HIV in most communities in Nigeria has been rising in recent years, but there is still high level ignorance particularly in the rural areas. The report of the last NDHS (1999) indicated that 90 per cent of men but only 74per cent of women were aware of HIV. The figures for rural areas were much less than those of urban settings. And the level of awareness varied from zone to zone. There was generally very poor knowledge about ways of transmitting and preventing HIV. For example, only 52 per cent of men and 43 per cent of women knew about mutual fidelity as a key prevention method and 15 per cent and 25 per cent of women and men respectively of abstinence as a way of preventing the spread of HIV. In addition, only 29.9 per cent knew that condoms could prevent HIV, while 26 per cent of women and 14 per cent acknowledged that they were unaware of the methods of preventing HIV.

FIGURE 3. 1: Projected Annual AIDS Deaths in Nigeria



communal/ethnic clashes, religious disturbances or among oil producing communities in the Niger Delta. These disturbances result in massive displacements of people and are associated with interruption of social cohesion and relationships, promiscuity, inadequate shelter, and commercial sex. These civil disturbances sometimes spill across international boundaries, creating streams of beggars who are often exploited sexually for next to nothing. Many Nigerian cities are swarming with these foreign beggars (women and children). They left their home countries many years ago, yet the women are almost always carrying infants perhaps from predators who could not resist even insane women. This confirms that civil disturbances create a cesspool of sex and automatic hot spots of HIV infection.

Stigma and discrimination

Stigma and discrimination discourage individuals who are positive from disclosing their status. This in turn prevents people from taking up voluntary counselling and testing, a major entry point for prevention of HIV and care and support of individuals infected. *Experts estimate that in Nigeria, over 70 per cent of infected individuals are unaware of their status, some of who may still be engaging in high-risk behaviour.* Similarly, fear prevents individuals from accessing VCT to determine their sero-status, thus making infected people unaware of their status, hence they continue to spread the disease to their sexual partners.

HIV and AIDS prevention treads on sensitive topics such as sexual behaviour, marital fidelity, prostitution, sexual orientation, alcohol and drug use – all issues that neither government nor the public is eager to discuss. Every country has denied the existence of HIV and AIDS in their domain at some time or the other during the epidemic. But we know that behaviours that spread HIV exist and are rampant in Nigeria. The pervasiveness of the epidemic has restricted denials largely to the domain of individuals who turn their backs on VCT because of the stigma and discrimination should they be positive. It follows, therefore, that stigma and discrimination constitute a formidable barrier to any initiative to eradicate the epidemic.

Ignorance

One key factor contributing to the current and future HIV and AIDS crisis in Nigeria is poor knowledge about the disease. Most Nigerians recognize AIDS as fatal, but only 50 per cent know about the means of transmission, of prevention and management of the disease. The result: high risk behaviour, low service demand and stigmatization of PLWHA. While individual social behaviour such as sexual exposure and intravenous drug use largely determine the degree of vulnerability and risk infection, other factors such as the low level of education and high level of ignorance about HIV and AIDS exist in communities that increase the risk for HIV infection.

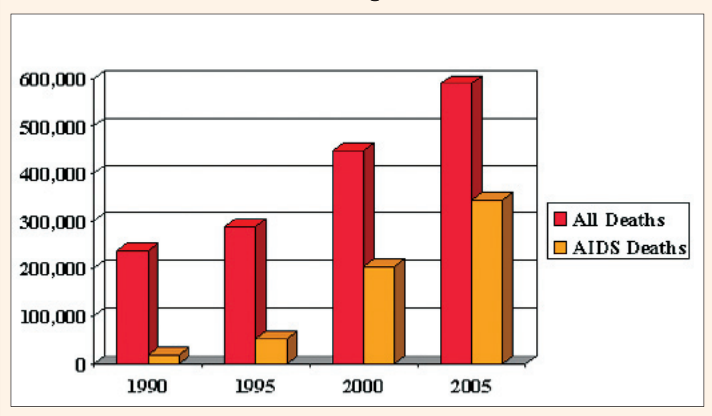
High STI prevalence

STIs enhance HIV-1 transmission

BOX 3. 4
Human Development Profile of Nigeria

- Population: 123.6 million
- Population growth: 2.8per cent
- Infant mortality rate: 105 per 1000 live births
- Life Expectancy: 50.6 years (total population)
- HIV prevalence: 5.8per cent (2001)
- GDP per capita: $260
- GDP growth rate: 3.5per cent
- Gini Index (distribution of family income): 50.6 External Debt: $28.5 billion

FIGURE 3. 2: AIDS Deaths in Nigeria



by increasing the ability of STI infected individuals to transmit HIV, while HIV negative individuals are more susceptible because of the alteration in their muscosal integrity as a result of genital ulcerations and inflammation, which recruits HIV-1 infected or susceptible target cells to the genital tract.

Several studies have confirmed the role of STIs as co-factors for the transmission of HIV. This include observational studies linking STIs and HIV-1 and other studies that show increased shedding of HIV-1 from ulcerative genital lesions and secretions. Results from such studies indicate that ulcerative lesions such as syphilis and herpes simplex virus-2 (HSV-2) have stronger effects than non-ulcerative lesions. Community-based studies from Tanzania (Mwanza) and Uganda (Rakai) suggest that efforts at treating and controlling STIs are more likely to reduce HIV transmission when they form part of the broader comprehensive HIV and AIDS prevention strategy.

Behavioural and biological factors

Higher rate of partner change between young girls and older men (cross-generational sex) and more frequent contacts with highly infected groups is a major driving force for HIV transmission in Nigeria. Nigerian women typically marry or have sex with older men. Several reports have observed a higher risk of HIV infection for women if their husbands or sexual partners were three or more years older.

Also, for biological reasons, the risks of contracting HIV through unprotected sex are higher for women than for men:

- the lining of a woman's vagina and cervix contains mucous membranes that provide a large, hospitable environment for infection. The mucous membranes are thin tissues through which HIV and other viruses can pass to tiny blood vessels and;
- infected semen typically contains a higher concentration of the virus than a woman's sexual secretions.
- Women are also more susceptible than men to other STIs, which, if not treated, multiply the risks of contracting HIV. Tearing and bleeding during intercourse, whether from coerced sex or prior genital cutting, also heighten the risk of infection;
- the risks of contracting HIV are even higher for younger women whose immature cervixes pose less barrier to infection. In girls, the risk of micro-lesions in the genitals is greater because of the added factors of lower

BOX 3:5
Impact of HIV and AIDS on the Family and Communities

Potential impact on Families	Impact on Children	Impact on Communities
• Loss of members, grief • Change in family composition and in adults and child roles. • Loss of labour • Forced migration • Dissolution • Stress • Inability to parent and care for children • Loss of income for medical care and education • Demoralization • Long-term pathologies (increased behaviour in children) • Number of generational households lacking middle generation will increase	• Loss of family and identity • Depression • Reduced well-being • Increased malnutrition, • Starvation • Failure to immunize or provide health care • Loss of health care • Increased demands for labour • Loss of schooling and educational opportunities • Forced migration • Homelessness, vagrancy, crime • Increased street living • Exposure to HIV	• Reduced labour • Increased poverty • Inability to maintain structures • Loss of skilled labour, including health workers and teachers • Loss of agricultural inputs and labour • Reduced access to health care • Rise in morbidity and mortality • Psychological stress and breakdown • Inability to marshal resources for community-wide funding schemes or insurance

defences and immaturity of vaginal tissues and cervical mucous;
- women are more prone to tearing and bleeding during sexual intercourse especially if they practice dry sex or use vaginal douching, a common practice among some women in Nigeria.

Sexual coercion/violence

Globally, about 1 in 5 women suffer from physical abuse by their partners, and about one third to a half of abused women also report sexual violence. Girls are particularly vulnerable to sexual abuse, incest, rape and trafficking, all directly putting them at risk of HIV. In addition, fear of abuse or abandonment can deter many women from seeking HIV counselling and testing, as well as sharing the results of their test with their partners.

Sexual coercion exists in Nigeria along a continuum which includes sexual harassment, forced marriage, assault, attempted rape and rape. Adolescent girls and women are disproportionately affected because of their relative inexperience, limited negotiating skills, dependent economic position and traditional gender norms. Sexual coercion is hardly discussed or studied in Nigeria. Yet a study among young women apprentices in Ikorodu, South Western Nigeria, found that the first sexual encounter for 20 per cent of sexually active young women had involved coercion.

Other studies from Ibadan also in the South West found that 4 per cent of female apprentices and 15 per cent of hawkers in bus and truck stations have been raped. Violence against women is high, with 13 per cent reporting assault by partners. Many women face the risk of abandonment and abuse if they disclose their HIV status, thereby encouraging the spread of HIV.

The Impact of HIV and AIDS

The impact of HIV and AIDS is discernible at every level – individual, family, and societal. It is also observable from the demographic, social, economic, and political perspectives. Ajakaiye (2002) aptly sums up the socio-economic and health costs of the epidemic when he said, "just as the virus (i.e., HIV) depletes the human body of its natural defences, it can also deplete families and communities of the assets and social structures necessary for successful prevention and provision of care and treatment for persons living with HIV and AIDS".

Demographic impact

The AIDS epidemic in Nigeria will have significant impact on the country's population directly through the death of the infected individuals. An unusually high mortality will slow population growth and alter the structure over time. In the absence of the epidemic, Nigeria's population is expected to rise to 147.7 million by 2010, based on the national growth rate of 2.8 per cent. But this is unlikely to happen because

BOX 3: 6
Macroeconomic Effects of HIV and AIDS

The macroeconomic effect of the HIV and AIDS is difficult to assess. However, it is obvious that the epidemic has potential to restrict economic growth in a variety of ways:

- Reduction of the numbers of workers available in the economy (human capital) and increased production costs, which may reduce international competitiveness and foreign investment.

- Decline in public sector, corporate and personal savings owing to increased costs of health care and HIV and AIDS, and consequent reduction in investment and raising of cost of capital.

- Reduction in direct government spending on infrastructure as more expenditure on HIV and AIDS increases.

- Recent studies have observed that HIV and AIDS could reduce GDP growth rates by 0.3 per cent and 0.4 per cent annually in the next 15 years. The effect on the economy is more than predicted by the GDP or per capita GDP. Increased illness and deaths, and reduced life expectancy will definitely negatively impact the development agenda of Nigeria. Infected and affected individuals will also have greatly diminished chances of fulfilling their human potential and desires. Apart from the difficulty in nurturing orphans, many affected children will have fewer opportunities for education and there is likely to be increase in social and economic inequalities.

BOX 3: 7
Impact of HIV and AIDS at the Family and Household Levels

- HIV and AIDS is almost always fatal, and often results in disability and death quite soon after people recognize that they are ill. It strikes adults aged between 25 and 45, so people are ill and die in the years in which they tend to have the greatest role as providers. The financial impact of AIDS on households is as much as 30 per cent more than deaths from other causes.
- Households spend an increasing amount on health care for people with AIDS and the family. In addition, people will often visit private doctors or traditional healers as the disease progresses.

of deaths from the epidemic and the lower fertility in HIV positive women.

Out of the 3.5 million Nigerians living with HIV and AIDS in 2001, 170,000 adults (aged 15-49) and 61,000 children (aged 0-14) have died from the disease. The effect of HIV on population structure will be more dramatic, with the relative decline in the number of persons under five years and over 25 years. Over time, these cohorts will move up the age pyramid. With increased mortality and deferred births, the structure of the age pyramid will change with more persons in the above 60 sub-group and less in the 30-40 and 40-50 age brackets.

Many experts are of the view that this scenario is very conservative given the rapid expansion of the epidemic in all the geo-political areas of the country. Figure 3.1 shows the projected annual deaths of 350,000 infected individuals from HIV and AIDS in Nigeria by 2004/2005.

The impact of HIV and AIDS can be discerned in the country's life expectancy that has fallen from 53 years in 1990 to about 50 in 2003. Life expectancy would have risen to 57 years and gradually to 62 years by 2013 in the absence of the epidemic. On the contrary, it is envisaged that life expectancy will decline further by 2010 with the expanding epidemic, thereby wiping away all the gains and improvements in standard of living and health care of the last two decades.

The demographic impact of AIDS is unique for two reasons. First, unlike most other causes of death, AIDS will continue to rise in the coming years as a result of infections that have already occurred (see Figure 3. 2). Second, HIV infection will be highest among young women and men in their most productive years, among the highly educated and skilled, among women of childbearing age and with attendant transmission to children. Finally, the number of dependants may increase with the burden shifting to the aged who are least capable of assuming such a burden.

Social cost

HIV and AIDS undermines the basic social unit (i.e., the extended family). The loss of the head of a household, spouse, or child to AIDS has psychological impact on the extended family unit. The illness and death impose considerable stress on all members of the family. The foundation of such a family is severely weakened. As the illness progresses, members are confronted by two options: (i) whether to pursue their livelihoods regardless of the health predicament of their infected kin; or (ii) spend their time and resources, taking care of them. Oftentimes, the responsibility for meeting the needs of all those infected, orphaned or widowed by AIDS is borne by the extended family in the absence of state-sponsored social security.

The well-being of children in most seriously affected countries like Nigeria will be compromised because they will be forced to live with sick or dying parents or in households that have accepted/adopted orphans. The epidemic impoverishes households and communities while the children, especially the girls, suffer the most. Children experience psychological distress and hardships and are forced to take on greater responsibilities for income genera-

BOX 3.8
Effect of HIV/AIDS on the Workforce

Reduced supply of labour

- Loss of skilled and experienced workers
- Changes in composition of labour force and early entry of children into employment
- Increased pressure on women to earn income as well as care for the sick
- Mismatch between human resources and labour requirements
- Reduced productivity
- Absenteeism and early retirement
- Increased labour costs for employers
- Loss of wage earners in household
- Reduced remittances from migrant worker

tion, food production, and the care of family members such as parents when they become ill. The children may be withdrawn from school, and girl-children face the risk of being denied formal education.

Orphans and widows are likely to be denied inheritance rights and this will further worsen their poor condition. Orphans are vulnerable to malnutrition, lack access to health care and may become vagrants or be forced into the labour market before their time.

The extended family takes over the responsibility of orphans, particularly those who have lost both parents. In many instances, however, orphaned siblings sent to different homes suffer profound loss through such separation. This leads to isolation and HIV and AIDS-related discrimination. Besides, many foster families are large and have inadequate resources to provide for their children and the orphans.

The children also risk being exploited physically and sexually. They may engage in risky sexual behaviour after they have been disconnected from their families. In addition they may be either forced to live on the streets, turn to commercial sex work or crime as a means of survival. Even though most of these children are born free of HIV, they are highly vulnerable to the infection.

One other major impacts of the epidemic on orphans and vulnerable children is the decline in school attendance and educational attainment. A recent UNICEF review of the impact of education and child labour on orphans in 20 Sub-Saharan Africa countries found that children aged 5-14 years who had lost one or both parents were less likely to be in school and more likely to be working more than 40 hours a week.

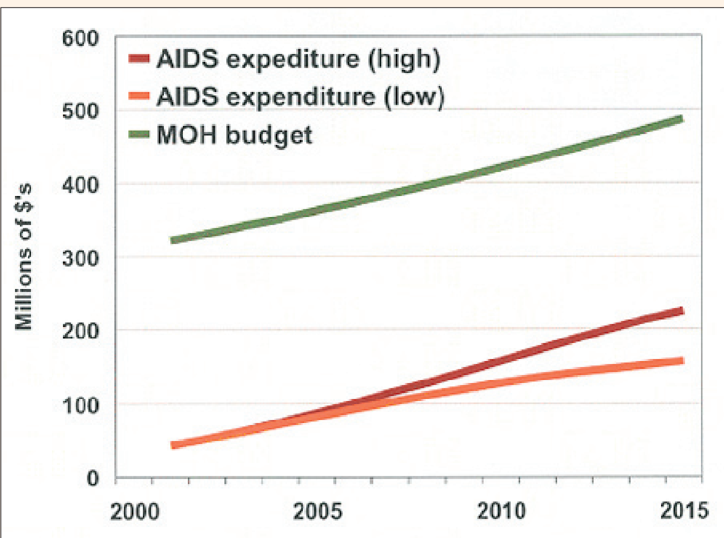
Moreover, HIV and AIDS is socially stigmatizing because infected persons are usually ostracized, labelled, or denied family and communal support and association

Finally, the epidemic severely affects communities, as can be seen in the case of Vandekiya Local Government Area in Benue State which grapples with increased poverty, loss of skilled labour, increased mortality and morbidity, a weakened social and leadership structure, and the risk of extinction. Generations of families have been wiped out by the epidemic and their farmsteads are now desolate.

Economic cost

The HIV and AIDS epidemic is undermining Nigeria's development at a time when its economy is showing little or no growth (0.9 per cent between 1995 and 2001) and inflation is between 15 and 18 per cent annually. In addition, Nigeria has a Gini coefficient (the gap between the rich and the poor) of 0.57 (one of

FIGURE 3. 3
AIDS Expenditure Compared to FMOH Recurrent Expenditure



the highest in the world), indicating gross inequity in the distribution of wealth in the country, a factor that can facilitate the spread of HIV and AIDS.

Economists agree that HIV and AIDS brings about a precipitous decline in productivity and savings. The epidemic impacts on businesses, food supply, livelihoods, and the availability of various cadres of professionals. AIDS, therefore, has a direct effect on the economic growth of most high prevalence developing countries. Per capita income begins to decline by 0.4 per cent annually when the rate of HIV reaches 5 per cent, as has been suggested in the case of Nigeria; if it rises to 15 per cent, close to 1per cent drop may be noticed in the national GDP.

The impact is quickly felt in households when one or more members are infected with HIV. Studies in other African countries suggest that HIV and AIDS not only reverses the capacity to accumulate savings, it also reduces household consumption. It leads to reduction in income, reallocation of labour and land; and increased medical, funeral and legal costs. It is also likely to lead to changes in consumption and investment and dissolution of households. The death of an adult has a significant impact on families and the community, and can force a vulnerable household into poverty.

The high HIV and AIDS burden in the country might alter people's attitude and behaviour to savings and investment. There are a number of reports from other African countries that suggest that high disease burden leads to reduction in household savings. Because household savings make up the national government savings, national saving rates will decline, eventually leading to budget deficits.

The feminization of poverty is also another dimension of the economic impact of HIV and AIDS. The burden of caring for the infected invariably falls on women. HIV infection in households where women are responsible for subsistence farming leads to:

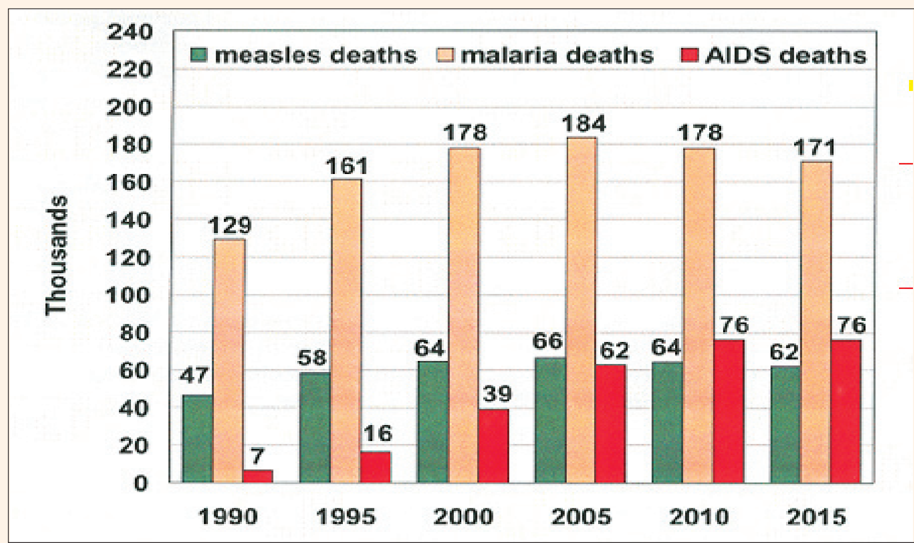
- reduction of productive time on farms;
- threat to the food security of the family;
- withdrawal of the girl child from school to bridge the demand for additional unpaid labour in the household;
- increase in households headed by women – at times by girl children with little access to productive resources, often driving them into sex for survival.

The 15-45-year-olds, which is the most dynamic segment of the labour force (typically 15-59 years), constitute the most vulnerable sub-group in the population Therefore, the

BOX 3:9
ART in Nigeria

While less than 20 per cent of patients make use of government health facilities at the moment, a large percentage will make use of them in the years ahead, especially if subsidized therapy becomes available, since the cost of maintaining health care is usually beyond the ability of most persons living with HIV and AIDS. Estimates of out-of pocket expenses vary depending on the source and type of treatment. It could exceed the N55, 000 mentioned if ARV is included. Anecdotal evidence indicates that the extended family sells off assets in order to pay for treatment; one woman with AIDS recounted how her father had already sold off two cars in order to pay the N24, 000 (approximately US$270) monthly costs of her treatment.

FIGURE 3. 4
High-Prevalence Scenario of Childhood Deaths from Malaria, Measles and HIV and AIDS (1990-2015)



labour force is severely impaired.

As has been reported, absenteeism and drop out are rife among the infected, resulting in colossal loss of man-hours. Long-term care stretches hospital facilities beyond limit, with grave economic implications. The family unit and the society at large are forced to spend enormous resources on PLWA, orphans, and widows/widowers. Although there are no data on Nigeria, available studies in other contexts indicate that the average income falls by 52 per cent to 67 per cent when a family member has AIDS while the expenditure on health care quadruples.

Political impact

Nigeria has a long history of cross-border trade across the West Africa coast, now extending to the East, Central, and Southern Africa. These sub-regions have much higher HIV and AIDS prevalence and, hence, travelling salesmen and women could facilitate the transmission of HIV in the sub-region. The sex industry is also thriving by trafficking of young Nigerian girls to Europe through staging posts in neighbouring countries like Benin, Togo, Ghana, Gabon, Cameroon, Ivory Coast, and Senegal. The Nigerian military has been engaging in peace-keeping operations in Liberia and Sierra Leone for more than a decade.

The outcomes of various surveys indicate that there is a high prevalence of HIV and AIDS in the war-torn areas. Nigerian soldiers that had served in these conflict areas are reported to have high prevalence of HIV and are likely to spread it among their families and in the general population. On the other hand, many refugees who are believed to be infected with HIV are fleeing from war-torn countries like Liberia and Sierra Leone to neighbouring countries like Nigeria.

Although the response of past administrations to the epidemic was lukewarm, the Obasanjo administration has shown serious commitment, and is supporting various initiatives aimed at mitigating the impact of the disease. The national authorities have developed a national plan, secured a World Bank facility, and are also providing matching grants for the implementation of the national AIDS control programmes. All tiers of government have also launched and/or are about to launch various organs, namely, the National Action AIDS Committee (NACA), State Action AIDS Committee (SACA) and Local Government Action AIDS Committee (LACA) to give a high profile to the problem and also to facilitate the implementation of the national workplan.

The discussion hitherto has suggested that the epidemic will impact on the demographic structure of the country and that vast numbers of the young are being affected. Those left behind may lack the strength to provide leadership in society if the epidemic is not checked. In other words, Nigeria may not be able to produce new leaders that can play accustomed role in society, a situation that could undermine its fledgling democracy. Leadership at all levels, national, state, and local is likely to be severely weakened.

HIV and AIDS could also exacerbate social unrest, as suggested in a report by the US State Department. The death of adults/community leaders would create a vacuum that

Economists agree that AIDS brings about a precipitous decline in productivity and savings. Studies from elsewhere indicate that the average income falls by 52-67 per cent when a family member has AIDS and that expenditure on health care quadruples.

The death of adults/community leaders would create a vacuum that the immature and less experienced individuals will only be too glad to fill. The community safety nets and power structures may be disrupted or stretched beyond their limits and this may lead to poor governance, lawlessness and civil disobedience, especially in the rural communities.

the immature and less experienced individuals will only be too glad to fill. The community safety nets and power structures may be disrupted or stretched beyond their limits and this may lead to poor governance, lawlessness and civil disobedience, especially in the rural communities where such power structures are mainly responsible for civil harmony and stability.

The death of adults would lead to more orphans. These orphans are likely to take to the streets, indulging in petty thefts and commercial sex to survive. An army of orphans could easily be recruited into militias for various conflicts. Also likely to contribute to the communal instability are increasing destitution, violence, and delinquency. In the final analysis, national security could be compromised if the general population, including the armed forces, is severely affected by the epidemic.

Furthermore, HIV and AIDS will have implications for the crime rate, loss of social networks and cohesion. Other side effects of this will include violence and social chaos. These forces of social disharmony are also likely to undermine the country's capacity to sustain its fledgling democracy.

Overall, a weakened Nigeria could have a domino effect on the rest of Africa. This is because Nigeria makes up more than 50 per cent of the population of West Africa and accounts for about 20 per cent of the total for Sub-Saharan Africa. It is the second largest economy after South Africa and, as the dominant power in the West Africa, it has been playing a leadership role in the region. Thus, a Nigeria weakened by the AIDS epidemic will be adversely affected in its capacity to provide leadership in the sub-region and can in turn undermine the political stability of the sub-region.

Health cost

HIV and AIDS has become a national epidemic in Nigeria. Its emergence has also resulted in an explosive increase in the number of cases of tuberculosis from two new cases out of every 1,000 persons to three, implying a 50 per cent rise in the incidence. Reports from various studies in the country also indicate that about half of all symptomatic patients with HIV and AIDS has tuberculosis, which is the main cause of death among AIDS patients.

The epidemic is over-burdening health personnel and the health services. Resources that ought to be used for development projects are being diverted to tackle HIV and AIDS. With its HIV prevalence rate, Nigeria is experiencing huge pressures from the increased demand associated with the growing number of PLWHA.

Patients with HIV and AIDS and other related diseases may take up between 10 and 25 per cent of bed occupancy in most secondary and tertiary hospitals. The figure may be as high as 30 per cent in parts of the country with high HIV and AIDS prevalence. Treatment costs are, therefore, likely to eat into the national operational health budgets. One major consequence of higher use of hospital in AIDS-related diseases is diversion of funds from other diseases. This rationing effect will be compounded by deaths among health care professionals from HIV and AIDS.

Officially, Nigeria has an esti-

mated 3.5 million people living with HIV and AIDS but most experts believe that a figure of 5-6 million is more realistic. It is projected that about 20 per cent of identified cases require comprehensive care, including palliative care, prevention, treatment of opportunistic infections and related malignancies, as well as anti-retroviral therapy. The cost of treating an AIDS patient per year is estimated at US$15-25,000, an amount clearly beyond the reach of the average Nigerian, considering that 70 per cent of them lives on one US dollar per day. The World Bank in South America and Rwanda estimates the cost of HIV and AIDS treatment per person at 1 to 2.7 times the per capita gross domestic product (GDP) of a country. Based on such data, Nigeria is expected to spend $250-$675 annually to care for an HIV and AIDS individual.

As the HIV epidemic spreads, more people will require anti-retroviral therapy and other modalities of care through the government-funded ARV treatment programme. This will increase government spending on HIV and AIDS prevention, care, and support for PLWA.

According to the Federal Ministry of Health, the cost of providing health care for AIDS patients will consume a huge part of the nation's health budget as the epidemic rages. It is estimated that this could rise from about 15 per cent in 2003 to as high as 50 per cent by 2015, depending on the prevalence of HIV and AIDS in the country.

Another major area of government spending is the amount of time that will be committed to the care of patients during hospital admissions, which may range from an average of 15 to 40 days for any patient between diagnosis and death. Already HIV and AIDS patients or those of related diseases are occupying about 10-25 per cent of hospital beds in health care institutions. The FMOH projects that bed occupancy by HIV and AIDS patients will rise from the current average rate of 15 per cent to 50 per cent by 2015 in some high HIV prevalence areas of the country. The demand for health care and support from such patients will put a lot of strain on an already fragile health system as well as diminish the ability of the FMOH to offer services effectively.

HIV and AIDS also increases the prevalence of opportunistic infections that are already widespread in affected areas. Almost 50 per cent of HIV and AIDS patients in Nigeria's hospitals have tuberculosis. Data from the FMOH also indicates that 17 per cent of Nigerian tuberculosis patients are also HIV positive. Because individuals with HIV and AIDS are prone to tuberculosis, diarrhoea and pneumonia, the cost of medical care will increase dramatically. For a household, the financial cost of caring for patients, relative to their income, can be overwhelming, especially in poor countries.

Figure 3. 4 shows the number of deaths occurring in children from malaria, measles and AIDS from 1990 to 2000 and projected to 2015, using a high prevalence scenario. While the number of deaths from malaria and measles remain relatively constant over the period, deaths from AIDS continue to rise over the period. It is estimated that about 10 per cent of all childhood deaths in 2005 will be caused by HIV and AIDS and this figure could rise to 14

The cost of treating an AIDS patient per year is estimated at US$15-25,000, an amount clearly beyond the reach of the average Nigerian.

per cent in 2015 if effective strategies are not put in place to prevent mother-to-child transmission.

These projections do not take into consideration the impact of HIV and AIDS on orphans and vulnerable children. The survival of orphans, as has been noted, would well nigh depend on the survival of their mothers. The death of a mother may lead to poor nutritional status and diminished access to education and health care that would negatively affect the ability to survive. These factors will further exacerbate the morbidity and mortality prevalence rate among Nigerian children.

Persons living with HIV and AIDS and their immediate family or household members are the first to feel the negative impact of the HIV epidemic. The most obvious impact is on life expectancy and the health of PLWHA. The daily rate of infection is estimated at 1,500. Consequently, life expectancy at birth has been declining in the country. Children born to women that are infected have reduced chance of survival because of vertical HIV transmission as well as their mother's diminished capacity to care for them. Family income will be threatened as infected members of the household become less productive and their family members give up work to care for the sick. The combination of reduced income and rising medical expenses will in turn affect households' food supplies, the ability to pay for the education and/or health care of surviving members or to even generate future income.

Conclusion

This chapter has described the main factors that promote the spread of HIV and AIDS in Nigeria and the impact of the epidemic on individuals, families, resources, and health services. It has also examined from an interdisciplinary standpoint the grave consequences the epidemic portends for the demographic, socio-economic, political, and health development of the nation.

Although the discussion throws up quite a revealing number of factors that stoke the fire of this epidemic, the core causative factors are (i) poverty, (ii) a wide range of deep-rooted harmful traditional practices (such as polygamy, courtesanship, concubinage, "wife hospitality",culturally-approved sexual intercourse with siblings' wives, levirate (i.e., wife inheritance)), and the unintended consequences of rapid modernization and urbanization (including a thriving commercial sex trade, unprotected coercive sex, child labour, overcrowding, and forced or voluntary migration). These three factors are responsible for the vast majority of infections in Nigeria. In addition, studies in Jos and Lagos report that 80 per cent of HIV spread is the direct result of heterosexual transmission; unscreened blood transfusion accounts for 5 per cent and mother-to-child transmission accounts for the remainder.

Poverty plays a central role in the spread of HIV in Nigeria. Although the country is rich in oil resources and other minerals, Nigerians are among the poorest in the world. Education and health, which hold the key to the alleviation and eventual eradication of human poverty, have been neglected through inadequate investment, poor strategy and even

poorer implementation since the mid eighties, resulting in worsening human deprivation and widespread pauperization. Nigeria itself has abdicated all the development-inducing international obligations it freely entered into, including the global conferences on Education for All and Reduction in Adult Illiteracy, Universal Access to Safe Water and Universal Access to Primary Health Care.

Poverty manifests itself in the country in at least six ways, namely, (i) human poverty; (ii) physiological deprivation; (iii) income poverty; (iv) poor macroeconomic performance; (v) negative impact of public expenditure on human alleviation; and (vi) social exclusion. The report rightly observes that wherever the foregoing traits co-exist with severe economic crisis, fiscal indiscipline and pandemic corruption, then "the resulting environment becomes ideally suited to a rapid growth in the pauperization of the population"

Drawing on the *Nigerian National Human Development Report* of 1998, the chapter makes it clear that additional budgetary allocation is not necessarily the answer, but that serious damage has been inflicted on the quality and content of social services. This makes it imperative to redirect public expenditure priorities in order to achieve anti-poverty objectives.

This view is supported by the Nigerian Civil Society Network, which states that between 1996 and 1998 when HIV was beginning to exert a heavy toll on the nation, the federal budget for the health sector averaged 0.2 per cent – the very lowest in the world and that total expenditure on AIDS in 1998 amounted to US$ 0.03 per capita – the least in Africa. The network states further that debt servicing obligations in the year 2000 cost US$ 1.5 billion, which was nine times the total health spending for 2001.

The chapter also notes that polygamy, courtesanship, concubinage, "wife hospitality", culturally-approved sexual intercourse with siblings' wives, cult prostitution and levirate (i.e., wife inheritance) imply multiple sexual partnership and translates to high risk of contracting HIV. Studies in Benue, Kogi and Nsukka where these practices are rampart indicate a high HIV prevalence rate. Research has shown that HIV prevalence among CSW in some cities ranges between 50 and 70 per cent. One of the key attractions for CSW is that it provides far greater income for the practitioners than they would get from other jobs.

Another cultural imposition that makes HIV thrive in the country is the patriarchal ordering of social life which dictates a subordinate position for women. In many Nigerian communities, women have low earning power, 25 per cent of the marriages they contract are polygamous, and the women generally have little or no control over their sex lives, or those of their husbands.

The use of unscreened blood products, needle sharing, use of unsterilized sharp objects and practices such as FGM, uvulectomy, scarification and so on, are still rampart and they all expose people unnecessarily to HIV infection.

Another key factor contributing to the current and future HIV and AIDS crisis in Nigeria is

poor knowledge about the disease – most Nigerians recognize AIDS as fatal, but just 50 per cent know about the means of transmission or prevention and management. It is quite surprising that after two decades of AIDS onslaught in the country the level of ignorance is still considerable. Closely related to this is the refusal of most Nigerians to undertake voluntary test to determine their sero-status. The main reason for this, of course, is the social stigma associated with HIV. Experts estimate that over 70 per cent of infected Nigerians are unaware of their status, some of whom may still be engaging in high-risk behaviour.

HIV and AIDS has a very serious impact on the epidemiological and demographic profiles of the country as well as on health care delivery system and manpower development. It depletes the resources of sufferers, their families, and the society at large.

The epidemic will negatively impact on key government and business elite as well as discourage foreign investment. The professional class will remain vulnerable because adult prevalence rates are already high. The HIV and AIDS epidemic will affect recruitment and staffing in all sectors, including the military. In addition, rising social tensions due to AIDS and related socio-economic problems can exacerbate regional and ethnic tensions in the country, which may prove difficult to handle. Public confidence in the political leadership could be eroded and weakened further if the government fails to respond effectively due to bad governance. Further deterioration of the already weakened government institutions by the escalating HIV and AIDS crisis could leave Nigeria in a seriously weakened position, resulting in the inability of the country to continue to play a leadership role in West Africa and Africa.

The demographic impact of AIDS includes a rise in AIDS related deaths as a result of infections that have already occurred. Secondly, HIV infection is higher among young women and men in their most productive years, among the highly educated and skilled, as well as among women of childbearing age, together with attendant transmission to children. This means that the number of dependants would increase with the burden shifting to the aged and children who are least capable of assuming such burden.

Economists agree that HIV and AIDS will bring about a precipitous decline in productivity and savings. The epidemic will affect businesses, food supply, livelihoods, and the availability of various cadres of professionals. AIDS, therefore, has direct effect on the economic growth of most high-prevalence developing countries.

The effect of the epidemic can be very severe on communities, as can be seen in the case of Vandekiya Local Government Area in Benue State which grapple with increased poverty, loss of skilled labour, increased mortality and morbidity, a weakened social and leadership structure, and the risk of extinction. Generations of families have been wiped out by the epidemic and their farmsteads are now desolate.

Travelling salesmen and women could facilitate the transmission of HIV. The sex industry is also thriving

by trafficking of young Nigerian girls to Europe. The outcomes of various surveys indicate that there is a high prevalence of HIV and AIDS in the war-torn areas and Nigerian soldiers that had served in these conflict areas are likely to spread it among their families and in the general population.

HIV and AIDS could also exacerbate social unrest. The death of adults/community leaders would create a vacuum that the immature and less experienced individuals will only be too glad to fill. The community safety nets and power structures may be disrupted or stretched beyond their limits and this may lead to poor governance, lawlessness and civil disobedience, especially in the rural communities where such power structures are mainly responsible for civil harmony and stability.

The epidemic is already over-burdening health personnel and the health services. If the incidence should rise beyond the capability of health personnel the entire system will collapse and the virus will become more widespread. The cost of treatment is so burdensome that the PLWHA themselves, their families and even the government cannot shoulder it.

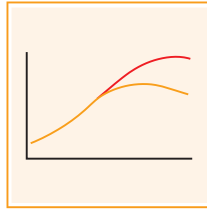
Recommendations

This is the time for Nigeria to weed out all encumbering cultural practices that spell doom to people of this generation. Therefore, all cultural practices that encourage multiple sexual partners should be avoided. Preventive interventions should point out the risks in their re-invigorated campaigns.

All the stakeholders should address the paradox of poverty in the country. Unless the women and youths are specially empowered in order to dissuade them from the vices of prostitution, crime, sexual assault, etc., the AIDS campaign has a bleak future. Stakeholders should work within and outside the frameworks of NEEDS, NEPAD and ACOSHED to bring about the economic and social empowerment that Nigerians need to feel secure and live fulfilling lives.

It is not possible to achieve the above objective without emphasizing the role of education, health care and other vital sectors that help poverty reduction and hold the key to attitudinal change. These are the necessary conditions for preventing the spread of HIV and AIDS in Nigeria. Furthermore, it is desirable to tackle the epidemic from a multi-sectoral standpoint as well as for the authorities to harness all available resources for the task.

Finally, commitment to the AIDS fight is still grossly inadequate. The winning strategy is for every level of authority in every sector of the economy – including Governor, Local Government Chairman, Vice-Chancellor, Managing Director/ Chief Executive to lead the advocacy in their area of jurisdiction. This effort must include total control of the situation under their authority and spill over to the immediate community so that new infections can be stopped completely, leaving the nation to manage the existing PLWHA.



Chapter Four

HIV and AIDS in Nigeria: Response to Date

The Nigerian war against HIV and AIDS is a paradox: the enemy attack is fierce, the war machineery deployed in counter-attack is very elaborate, but the results have been disappointing.

THE preceding chapters covered the history of HIV and AIDS in Nigeria, its prevalence in the country and other parts of the world, as well as the factors that drive its spread. In this chapter, the attention shifts to the national response to the fight against the spread of HIV and AIDS in the country. Specifically, the chapter (i) examines government's multi-sectoral institutional and programmatic framework for the national response; (ii) identifies key roles, the players and resource mobilization efforts in and outside Nigeria in order to contain the spread of the disease; and (iii) examines the philosophy of care and support for people infected and affected by HIV and AIDS.

The chapter depicts the paradox of the Nigerian war against HIV and AIDS: the enemy attack is fierce, the war machinery deployed in counter-attack is very elaborate, but the results have been disappointing. The chapter prepares sufficient ground for what ought to be done for the war to be won.

Evolution of the National Response to HIV and AIDS

The national response to HIV and AIDS moved progressively from initial denial to a more pro-active response that is now anchored on the HIV and AIDS Emergency Action Plan (HEAP) (Table 4.1). From 1986-1990 both government and the public denied that HIV and AIDS was a major threat to Nigeria's development effort. It was because of this scepticism that government's initial response was limited to establishing a National Expert Advisory Committee on AIDS (NEACA) in 1986. When the reality of the epidemic became apparent, this body was replaced by the NACP coordinated by the Federal Ministry of Health (FMOH).

By 1991 the Nigerian public came to a better understanding of the seriousness of HIV and AIDS. This coincided with, or perhaps contributed to, the expansion of the NACP to include STDs. The programme was thereafter renamed the National AIDS and STDs Control

Programme (NASCP).

NASCP has been responsible for the health system response to HIV and AIDS and other STIs. It developed guidelines on key interventions, such as syndromic management of STDs, VCCT, and PMTCT, including treatment of ORIDS, ARVs, and home-based care. NASCP also manages the HIV and AIDS Sentinel Surveillance System, which has become the principal source of official data on the epidemic in Nigeria. Under NASCP, the Federal Ministry of Health developed the First Medium Term Plan (MTP1) as well as the second (MTP2), which ended in 1997.

Although, for a long time, a number of key players had emerged at national and sub-national levels, including NGOs, CBOs, religious organizations, bilateral and multilateral organizations, these were largely confined to the health sector and remained wholly uncoordinated, lacked resources and was heavily dependent on donors.

The period starting from 1999 marked a watershed in the national response to HIV and AIDS in Nigeria. Very early in the Obasanjo administration, the government recognized and accepted the need to establish a vibrant, participatory and multi-disciplinary committee to coordinate a wide spectrum of responses that would truly reflect the multi-dimensional and dynamic nature of the epidemic. This had become a necessity given the understanding that a national response cannot be the responsibility of the health sector alone.

TABLE 4.1
Evolution of the National Response to HIV and AIDS

Year	Evolution of National Response to HIV and AIDS: Key Events
1986	• First official reporting of two AIDS cases to the federal government
1987	• Establishment of Expert Advisory Committee on AIDS (NEACA)
1988	• Signing of Technical Service Agreement (TSA) with WHO through the defunct Global Programme on AIDS GPA-WHO (now UNAIDS)
1988	• Replacement of NEACA (advisory body) with the National Aids Control Programme (NACP) (co-ordination/ implementation body) within the FMOH
1988/89	• Establishment of a National AIDS Committee (NAC) and five Technical Advisory Committees (TACs) as Advisory bodies to the NACP
1990-92	• Creation of States AIDS Control Programmes (SACPs) and the States AIDS Committee in all States of the Federation and Federal Capital Territory, Abuja
	• Implementation of the short-term plan, which focused mainly on blood safety and general awareness
1993-97	• Medium Term Plan II, focused on multi-sector involvement and increased awareness
	• Inadequate funding of response and withdrawal of international donor support owing to sanctions on Nigeria
	• More prominence of NGO's output due to direct support from donors
	• Reality of AIDS became more visible owing to increasing cases and deaths. Fela Anikulapo Kuti's death (1997) further stressed the message— "AIDS is real"
1998/1999	• Development of the "Bridging Plan," which focused on Expanded National Response to AIDS (multi-sector/multi-disciplinary), comprehensive data gathering and analysis, intensive advocacy at high political and general levels, intensive general and targeted education
2001/2003	• High Performance from the Civil Society Organization (NGOs/CBOs)
	• Mr. President pledged to lead the campaign against AIDS personally
	• Presidential Committee on AIDS (PCA) and National Action Committee on AIDS (NACA) established to improve response and ensure multi-sector and multi-level participation
	• Three year Interim Action Plan developed
	• More resources allocated/mobilized
	• HEAP adoption and Implementation
	• Ministry of Health commences treatment of 10,000 PLWHA
	• A new National HIV and AIDS Policy developed.

Institutional framework

In January 2000, President Obasanjo established a Presidential Committee on AIDS (PCA), and the Na-

The HEAP is built on two strategies: creation of an enabling environment, and specific HIV and AIDS intervention.

tional Action Committee on AIDS (NACA) to serve as its Secretariat. The PCA thus became the highest decision-making body on AIDS in Nigeria, which is personally headed by the President. The PCA has the Vice President as the deputy chair, while the Minister of Health and eleven other line Ministers (Health; Defence; Education; Internal Affairs; Finance; Women Affairs & Youths Development; National Planning Commission; Information & National Orientation; Labour & Productivity) serve as members. The Secretary to the Government of the Federation (SGF) acts as the Secretary to the Committee.

The National Action Committee on AIDS (NACA), a multi-sectoral body, coordinates the entire national response to HIV and AIDS through the relevant agencies, partners, programmes and projects. The FMOH, which had hitherto led the response, now focuses essentially on health-related aspects of the epidemic. The FMOH sectoral response is co-ordinated through the National AIDS and STD Control Programme (NASCP) in conjunction with state and local government Action Committees.

To ensure effective co-ordination of the multi-sectoral and multi-level response, efforts are currently being made to establish equivalents of NACA – SACA at the state level and LACA local government level reporting. All the newly mobilized sectors are currently in the process of consolidating their units.

HEAP

The HIV and AIDS Emergency Action Plan (HEAP) is the programmatic framework for the national response to HIV and AIDS in Nigeria. With the establishment of the PCA and the formation of NACA, the government collaborated with the private sector to develop the HEAP. The Plan provides the context for multiple partners to work, including sources of external finance and many types of implementing partnerships.

Strategic components

The HEAP is built around two strategic components – *creation of an enabling environment,* and *specific HIV and AIDS interventions* (see Table 4.2). The over 200 activities identified under the HEAP are conceived as short-term (2001-4), high-impact interventions, which will lay the groundwork for a long-term strategic plan of action against HIV and AIDS in Nigeria. All the proposed activities in the HEAP document are nested within eight areas of work that have been designed to make the two strategic components of HEAP operational. States are expected to develop state-specific action plans. But, in the first instance, the development and implementation strategy calls for state-level activities to be developed, funded and launched first in the so-called hot spot states of Benue, Plateau, Kaduna, Ebonyi, Lagos and Akwa Ibom.

National Policy on HIV and AIDS

The increase in the thrust of the national response in recent years has been reflected in the development of a number of policies pertaining to HIV and AIDS. The Federal Ministry of Health currently has under review a draft Plan of Action

TABLE 4.2: HEAP Key Results

SN	Strategies (Areas of Work)	Objectives	Target Groups
A.		**Creation of an Enabling Environment**	
1	Removal of socio-cultural barriers	To mobilize key influential groups and the general public to respond to HIV and AIDS	Political opinion leaders General public
2	Removal of information barriers	To develop and maintain an information base to permit policy makers, programme managers and the general public to design and implement proactive interventions for the prevention and mitigation of HIV and AIDS.	Programme Managers Policy Makers General Public
3	Removal of systemic barriers	To develop National Programme management capacity to successfully implement the HEAP	Line Ministries NACA, SACA, LACA Private Sector, NGOs
4	Catalysing community-based responses	To mobilize communities to respond to HIV and AIDS	Community-Based Populations
B.		**Specific HIV and AIDS Interventions**	
5	Preventive interventions targeted at high-risk populations: • Youths: high-risk & non-high-risk youth population	To reduce HIV transmission among youths	Young people aged 10-24 years
6	Preventive interventions targeted to high-risk populations: Empowerment of women to negotiate safer sex	To empower women and girls to negotiate sex	Women, Girls
7	Preventive Interventions Targeted to High-Risk Populations: • HIV and AIDS intervention with the armed forces and the police	To reduce HIV transmission amongst personnel of the Armed Forces	Armed Forces, Police Personnel
8	Preventive interventions targeted to high-risk populations: • Prevention of infection through MTCT	To prevent mother to child transmission of HIV	Women of reproductive age and children
9	Preventive interventions targeted to high-risk populations: • Commercial sex workers	To undertake integrated participatory mapping, peer counselling and promotion of condom use by CSWs	CSWs, Partners, Clients
10	Preventive interventions targeted to high-risk populations: • HIV and AIDS intervention in prison and personnel at border immigration border control	To reduce the rate of infection amongst prison population and staff and immigration	Prisoners, Prison Staff Immigration Personnel
11	Preventive intervention targeted at high-risk populations: • Workplace policies and programmes related to HIV and AIDS	To prevent HIV infection and provide care and support for workers infected and affected through the initiation of workplace policies and programmes.	Workers in the public and private sector workplaces, including the informal sector workers.
12	Preventive Interventions Targeted at High-Risk Populations: • HIV and AIDS Intervention for Transportation-Related Workers	To reduce the rate of transmission amongst LDDS, touts, seafarers.	LDDS, Touts, Seafarers
13	Preventive interventions for the general population.	To reduce HIV and AIDS and STD prevalence in the general population through promotion of syndromic management of STIs, safe blood supply, and voluntary and confidential counselling and testing (VCCT)	Health Care Providers General Public, PLWHA
14	Care and support for persons infected with HIV and AIDS	To provide care and support for persons infected with HIV and AIDS	PLWHA
15	Care and support for persons affected by HIV and AIDS.	To provide care and support for persons affected by HIV and AIDS	AIDS orphans, widows guardians, affected families affected communities.

BOX 4.1
Elements of the National Policy on HIV and AIDS

Guiding Principles
Through the new National HIV and AIDS Policy, the government and people of Nigeria have affirmed that:

- the National Policy on HIV and AIDS is complementary to all existing national policies related to the development and corporate existence of the country;
- the Policy shall be based on the principles of human rights, social justice and equity;
- the various governments of the federation acknowledge their responsibility to provide Nigerians with adequate information to take responsibility for, and safeguard their health and well-being;
- the various governments of Nigeria acknowledge their responsibility to provide for the health and well being of the people, which shall be fulfilled by the provision of adequate health and social services; and
- the nation will adopt strategies that are cost effective, practical, socially acceptable, and scientifically sound to ensure that the HIV and AIDS epidemic is brought under control.

Goal
The overall goal of the policy is to control the spread of HIV in Nigeria, to provide equitable care and support for those infected by HIV and to mitigate its impact to the point where it no longer endangers public health and destroy social and economic relations, such that all Nigerians will be able to achieve socially and economically productive lives free of the disease and its effects.

Objectives
The objectives of the HIV and AIDS policy are to:

- promote a national multi-sectoral and multi-disciplinary response to the epidemic in addition to the establishment of an appropriate legal and institutional framework for its co-ordination;
- identify sectoral roles and assign responsibilities for the implementation of programmes based on sectors' comparative advantages and core competencies;
- increase awareness and sensitization among the general population about HIV and AIDS;
- foster behavioural change as the main means of controlling the epidemic;
- improve national understanding and acceptance of the principles that all persons must accept responsibility for prevention of HIV transmission and the provision of care and support for those infected and affected;
- provide access to cost-effective care and support for those infected, including anti-retroviral drugs;
- protect the rights of those infected and affected by HIV and AIDS as guaranteed under the constitution and laws of the Republic;
- remove all possible barriers to HIV and AIDS prevention and control;
- empower people infected and affected by HIV and AIDS through training, counselling, and education to cope with their circumstances
- develop standards and guidelines that lead to the institutionalization of best practices to mitigate the impact of AIDS
- stimulate research, monitoring and evaluation of programmes, relevant documentation of activities related to the epidemic and the dissemination of information generated to stakeholders and the general population;
- ensure that prevention programmes are developed and targeted at vulnerable groups, such as women and children, adolescents and young adults, sex workers, long distance commercial vehicle drivers, prison inmates, migrant labour, etc.

Strategic Components

Prevention of HIV and AIDS
Unprotected, penetrative sexual intercourse is the most common mode of transmission of HIV in the Nigeria. Other modes of infection include mother-to-child transmission, transmission through blood and blood products, the sharing of sharp instruments, including hypodermic needles, and the use of unsterilized tattoo and grooming equipment. Recognizing these modes of transmission and their relative importance in the spread of HIV, policy and strategy will be directed towards reducing the risk of transmission through:

- promotion of safe sexual behaviour
- appropriate use of condoms
- prevention of HIV and AIDS transmission through blood and blood products
- voluntary counselling and testing
- prevention of mother-to-child transmission
- early diagnosis and effective treatment of sexually transmitted infections
- adolescents- and youth-focused interventions

Law and Ethics
The lack of appropriate, HIV-relevant legislation affects the ability of persons living with HIV and AIDS to live positively and persons susceptible to the disease to protect themselves from it. Recognizing that this situation adversely affects the nation's ability to reduce the spread of HIV and AIDS and mitigate its impact, the government of Nigeria commits itself to reviewing existing legislation and enacting appropriate new laws in the following areas.

- HIV and AIDS legislation in the workplace for the protection of worker's rights on the job for those infected, as well as HIV and AIDS legislation in the workplace for the protection of worker's on the job from being infected as a result of their work.
- Legislation on legal rights and property ownership of persons infected and affected by HIV and AIDS.
- Legislation to improve access to legal services, and care and support for persons infected and affected by HIV and AIDS.
- Legislation to protect the rights of victims of sexual violence.
- The establishment and codification of the nation's HIV and AIDS response structure.
- The codification of HIV relevant legislation.

Care and Support
Government recognizes its responsibility to provide access to health care for all its citizens. And given that no effective curative therapy currently exists for AIDS, effective management of the condition includes an emphasis on compassion and support for the persons infected and affected by HIV and AIDS. It is also recognized that the effects of the HIV and AIDS epidemic goes

beyond health, as it affects the ability of persons infected and affected to live productively; therefore, support is needed. The objectives for the strategies for care and support are to provide accessible, affordable and sustainable quality care for those infected by HIV and AIDS and also to provide them and those affected by the disease with the ability to live positively in spite of their condition.

Government further recognizes the stigma and discrimination facing people infected and affected by HIV and AIDS and realizes that the promotion and protection of human rights for all Nigerians can reduce the negative effects associated with the epidemic; therefore the HIV and AIDS policy aims to:

- prevent discrimination against persons living with or affected by HIV on the basis of their health status with respect to education, training, employment, housing, travel, access to health care and other social amenities and citizenship rights;
- prevent human rights abuse and unethical and illegal actions towards persons living with HIV and AIDS;
- respect the right to privacy and confidentiality of people living with HIV and AIDS and prevent the dissemination of information on the HIV status of individuals without their consent, or that of the family when the individual is incapable of giving such consent. And where the dissemination of information is medically indicated, it shall be accorded the strictest measures of confidentiality on a strictly enforced “need-to-know” basis;
- ensure that HIV and STI testing shall not be included as part of a routine medical examination without the knowledge and prior consent of the client. Mandatory HIV testing without consent will be illegal except in the case of a person charged with any sexual offence that could involve risk of HIV;
- provide confidential pre- and post-test counselling services to tested individuals and, if so desired by the individual, to his/her family in all places where individuals are tested and/or notified of HIV test results;
- ensure that insurance of any kind shall not be revoked or affected by an individual’s change in his/her health status following the issuance of an insurance policy; and,
- ensure that government shall monitor human rights abuses and develop enforcement mechanisms for redress.

Communication

It is widely recognized that the support of the public is essential to the success of the HIV and AIDS policy’s goals and objectives, especially as the national HIV and AIDS programme must compete with other national priorities for resources. A comprehensive information, education and communication (IEC) system is central to the nation’s efforts to prevent the spread of HIV and AIDS and mitigate its impact. The communication strategies of the HIV and AIDS response are, among other things, aimed to ensure that:

- all persons have the right to appropriate, accurate and timely information on HIV and AIDS;
- the government shall promote and support open discussion and education on the health consequences of sexual practices, the individual’s role and responsibilities in preventing the spread, and mitigating the epidemic’s impact. This will be undertaken in educational institutions, health institutions, and in other relevant public institutions;
- the government shall promote and support a co-ordinated approach to public enlightenment on HIV and AIDS throughout its ministries and its services and via the media, public and private educational institutions, religious organizations, public forums, labour syndicates and other means and venues of public communication;
- information relating to sexual relationships shall incorporate messages on essential family values such as love, care, respect and faithfulness;
- the government shall actively promote the breaking of silence brought about by cultural and social inhibitions associated with HIV infection;
- it is the responsibility of all citizens to offer strong support for effective prevention of HIV and AIDS, and for the compassionate and comprehensive care of, and support for, persons infected and affected by HIV and AIDS;
- the government will actively discourage all the myths and rumours associated with HIV and AIDS prevention so as not to endanger public welfare;
- the government shall actively discourage, if necessary, through legislation, the promotion, advertisement or sale of uncertified products and services related to the treatment and management of HIV and AIDS;
- the government will promote better communication between the government, implementers of programmes and the general public; and,
- the government shall intensify efforts on programme management and development.

Programme Management & Development

The prevention of HIV and AIDS in Nigeria and mitigation of its impact is as complex as it is urgent. In responding to these challenges, the government affirms its commitment to mobilize, manage and sustain required public, private, and international resources. The following strategies are aimed at promoting and enhancing programme management and development:

- all health workers and care givers shall receive the appropriate level of training in the modes of transmission and management of HIV and AIDS related conditions, and also be trained in the counselling associated with HIV and AIDS;
- no health care institution or health care worker shall refuse to treat AIDS patients or those with HIV infection;
- health care institutions shall provide health workers with necessary equipment to ensure safety from blood-borne pathogens in the health care setting;
- HIV testing of patients before or during their stay in hospital solely for the benefit of health-worker safety shall be prohibited;
- persons being treated for HIV-related illness that are not in themselves public health risks should not be isolated on account of their HIV status;
- appropriate prophylaxis should be made available for health workers by the institutions where they work when they are accidentally exposed to HIV while going about their work. This should include voluntary confidential counselling and testing;
- the government will develop appropriate guidelines for the adequate nutrition of persons living with and affected by HIV and AIDS, and babies borne to persons living with HIV and

AIDS;

- appropriate mechanisms will be put in place to increase the availability of home-based care;
- the three tiers of government in Nigeria shall share and clearly define responsibilities with the communities in caring for the people with AIDS and their families;
- the government of Nigeria shall facilitate and promote the care and support of people living with HIV and AIDS, AIDS orphans and vulnerable children and young persons whose parents are HIV positive;
- guidelines on the medical care for HIV related illness shall be written, reviewed and revised periodically to provide facility-based health care workers and home-based health workers with direction in the prevention and treatment of opportunistic infections for HIV-positive individuals;
- Nigeria shall ensure nationwide access and availability to cost-effective drugs for the treatment of the most common opportunistic infections;
- all health care providers shall be trained in the management of opportunistic infections;
- care provided for patients infected with tuberculosis and all other opportunistic infections shall be governed by established guidelines that have been found to be cost-effective through operational research;
- cost-effective and affordable care shall be made accessible to all people with HIV-related illnesses, including access to anti-retroviral therapy;
- the use of ARV shall be under medical supervision and shall be governed by established effective guidelines. These will be updated regularly with the results of research;
- a cost-effective drug list for the management of HIV and AIDS shall be developed and incorporated into Nigeria's essential drug list;
- sale of ARVs shall be provided solely under strict medical supervision;
- the role of traditional healers, including traditional birth attendants, in the transmission, prevention and care of HIV and AIDS shall be studied and areas of risk eliminated through appropriate training, supervision and legislation;
- government shall encourage traditional healers and other health practitioners to submit their HIV and AIDS remedies for official verification and certification;
- the federal government shall develop a regulatory framework to enhance and monitor the effectiveness of traditional practitioners in the prevention and mitigation of HIV and AIDS in Nigeria;
- government shall guarantee and enforce equal access of every Nigerian citizen to employment, housing, health, education, and social services regardless of HIV status;
- government shall facilitate efforts in support of micro-credit schemes and other economic initiatives designed to eradicate poverty and provide a financial safety net for PLWHA;
- government shall actively facilitate and support community-level efforts designed to provide a social safety net for PLWHA;
- government shall enact, disseminate and enforce legislation focused on protecting the rights of orphans and vulnerable children, as citizens of Nigeria, especially as regards their access to basic housing, education, health care, food and clothing;
- government shall enact, disseminate and enforce legislation focused on protecting inheritance and property rights of orphans and vulnerable children;
- in determining the right of access to government benefits and support, there shall be no discrimination or difference implicitly or explicitly implied between AIDS-related orphans and other classes of orphans;
- the three tiers of government in Nigeria shall facilitate approval sought by private organizations, communities and families for organizational, community and family-based orphan and vulnerable children support initiatives; and,
- the support to orphans and vulnerable groups shall include strategies and policies that ensure a supportive environment for orphans, as well as for other minors infected and affected by HIV and AIDS by providing appropriate counselling and psycho-social support, ensuring their enrolment in school and access to shelter, good nutrition, health and social services on an equal basis with other children; and protect such children from all forms of abuse, including violence, exploitation, discrimination, trafficking and loss of inheritance.

Monitoring & Evaluation Targets

The following targets have been set to monitor the national response to HIV and AIDS and performance:

- achieve at least a 25 per cent reduction in the adult HIV prevalence every five years;
- improve the knowledge, attitude, behaviour, and practice (KABP) of high-risk populations to HIV and AIDS, including youths and adolescents, by 20 per cent by the year 2005 and 40 per cent by 2010;
- improve the knowledge, attitude, behaviour, and practice (KABP) of the general population related to HIV and AIDS by 10 per cent by the year 2005 and 15 per cent by the year 2010;
- improve the behaviour, and practice of the general population and high-risk groups related to safe sex by 20 per cent by the year 2005 and 50 per cent by the year 2010;
- reduce the prevalence and incidence of STIs in Nigeria by 50 per cent by 2010;
- reduce by 25 per cent the percentage of persons openly expressing negative attitudes about persons living with HIV and AIDS by 2005;
- ensure that at least 20per cent of all local government areas will be able to offer home-based care services to the people living with HIV and AIDS in their communities by 2010;
- ensure that by 2010, 50 per cent of health institutions will be able to offer effective quality care and management for HIV and AIDS;
- ensure that by 2005 and 2010 10 per cent 20 per cent respectively of communities affected by HIV and AIDS will have programmes designed to provide social safety nets for persons infected with the disease;
- reduce the transmission of the HIV virus through mother-to-child-transmission by 50 per cent; by the year 2010,
- ensure that by 2010, at least 50 per cent of Nigerians have ready access to quality voluntary confidential counselling and testing services;
- ensure that by 2010, 100 per cent of Nigerian local government areas have at least one safe effective blood banking service; and,
- ensure access to anti-retroviral drugs in all states of the federation by 2010.

for Broad Access to Anti-retroviral Drugs for Nigeria which was produced in February 2002. The draft policy outlines objectives and gaps in the current system.

Similarly, in line with the ILO Code of Practice on HIV and AIDS and the workplace, the Federal Ministry of Labour and Productivity, in collaboration with workers representatives, the private sector, and development partners, has developed a workplace policy which is ready for implementation. In collaboration with other stake-holders, NACA has also developed a policy which takes into consideration most of the recent changes including increased government and donor support, and existing policies on HIV and AIDS. Mr. President launched this in August 2003.

The initial policy response to HIV and AIDS in Nigeria was first developed in 1997 under the leadership of the Federal Ministry of Health, in collaboration with state and local health authorities, NGOs, CBOs, development partners and civil societies. This predates the advent of the National Action Committee on Aids (NACA). With the creation of NACA, a new comprehensive policy framework that reflects an expanded national response in line with contemporary national and international dimensions of HIV and AIDS has been developed and is currently in use.

Interventions

Over 10 sectors including health, education, women's affairs, defence, internal affairs, agriculture, information, culture and tourism, police and labour are currently implementing various interventions in response to the epidemic. The number of participating sectors is expected to grow to 17 by 2004.

Health sector. The demand of the epidemic on the weak national health system constitutes a major challenge.

The initial health sector response focused mainly on creation of awareness and the promotion of safe blood transfusion. However, in 1998, the 43rd National Council on Health (NCH) adopted a paradigm shift from a purely health sector response to an expanded national response, which solicited the participation of other sectors such as civil societies, faith-based organizations, the private sector, and international NGOs. All these joined the traditional sectors such as health, education, agriculture, labour, women's affairs, information, etc., which now constitute NACA. However, the health sector remains the pivot of the national multi-sectoral response. Its strategic focus include:

- prevention of HIV and AIDS through management of sexually transmitted infection (STIs), prevention of mother-to-child transmission (PMTCT), voluntary counselling and testing (VCT) blood safety, condoms use, etc;
- care and treatment for PLWHA through anti-retroviral (ARVs) treatment of opportunistic infections, community home-based care (CHBC), nutrition, etc;
- support of PLWHA and people affected by HIV and AIDS (PABA) through supportive counselling, access to poverty eradication programme(PEP), widows/ orphan and vulnerable children (OVC), care, etc;

Over 10 sectors of the economy are relatively active in response interventions. The number is expected to grow to 17 by 2004.

The three generic ARV drugs used in Nigeria cost N45,000 per annum per patient but are dispensed at N12,000 per annum per patient.

- surveillance studies and research; and
- monitoring and evaluation.

Given the large pool of PLWHA in Nigeria and the primary concern over their welfare, a highly active anti-retroviral therapy (HAART) programme was conceived in 2001 with the target of treating 10,000 PLWHA. Three generic ARVs are currently being used in 25 centres (mainly tertiary hospitals) in the federation. The three drugs, which cost about N45, 000.00 per annum per patient, are dispensed to PLWHA at a subsidized rate of N1, 000.00 per month, amounting to N12,000.00 per annum per patient. Treatment has been provided to over 12,000 PLWHA.

The PMTCT programme is provided in 11 sites located in the tertiary hospitals. No user fees are charged for the ARV drugs used in this programme. HIV positive mothers are expected to enrol in the Adult ARV programme while children would enrol in the Paediatric ARV scheme.

In addition to the above, a Reagent Revolving Scheme facilitates the availability of quality reagent for diagnosis both for blood safety, ARV and the PMCTC programmes.

The health sector response faces several critical challenges, ranging from the need for skilled manpower to undertake complex laboratory and clinical assignments and inadequate financial resources for treatment. The new WHO "3 by 5" programme and President Bush's US$15 billion HIV and AIDS Initiative for Africa imply that significant resources would be available in the next couple of years, which could help push the national response.

Other sectors. The response from other sectors, especially education, defence, police, etc, have focused, in the first instance, on building in-house capacity of relevant personnel to handle planned initiatives in addition to undertaking sector-specific policy level work. In the education sector, efforts have focused on curriculum development and training of trainers for sexuality education, family life skills, and HIV and AIDS. Various educational packages have been prepared for secondary and tertiary institutions. An AIDS Club initiative has commenced in all the schools within the FCT, to be replicated in other parts of the federation.

The *Ministry of Information* is in the process of designing messages to be aired to sensitize the general public, and to complement the awareness campaign of NACA. In the *agricultural sector*, efforts to use rural extension workers to reach farmers are under way. This is in addition to exploratory effort to assist rural dwellers that are affected by the disease.

The *Ministry of Defence* has worked through its Armed Forces AIDS Control programme to undertake extensive sensitization of military formations in the country, especially for troops on peace-keeping assignments under the ECOMOG arrangements. New emphasis will be placed on expansion of VCT beyond military hospitals to the work place and in the field.

The *Ministry of Internal Affairs* promotes knowledge and awareness of HIV and AIDS among prison in-mates and plans to establish VCT centres within prisons. Although

the Police Force has attempted to build the capacity of its workforce, this large group which faces a high risk has not yet developed a specific response to the epidemic.

It is evident that a strong commitment and political leadership in the struggle against the HIV and AIDS epidemic is a key variable in the few successful programmes in Africa. Bold leadership by President Museveni of Uganda is responsible for driving down the country's infection rate from 30 per cent in 1992 to 11 per cent in 2000. Although HIV is still a significant problem in Uganda, President Museveni has been successful in his campaign for behaviour change by urging people not to have sex with multiple partners, and by publicly acknowledging the threat posed by HIV, destigmatizing the disease and decentralizing HIV education programmes down to the village level. Despite the scope and severity of other domestic and foreign policy issues, the challenge to maintain high level political leadership for HIV and AIDS remains.

According to the *Situation Assessment of HIV and AIDS in Nigeria* of August 2000, the constraints to a national response to HIV and AIDS include (i) insufficient funding, given the scale and complexity of Nigeria's epidemic; (ii) over-dependence on donor support; (iii) lack of political will and commitment from policy makers; (iv) insufficient numbers of trained personnel to implement the national AIDS programme; (v) need for increased co-ordination of, and support for, local NGOs; and (vi) low perception of risk among policy makers and the general population.

Other constraints include weak STI interventions and surveillance systems; absence of a reliable national database on HIV and AIDS programmes; lack of supportive legislation for HIV and AIDS programmes; conservative social values and regional, religious and cultural differences; poverty; and low status of women.

Assessment of the National Response

The creation of PCA and NACA strengthened the nation's response to HIV and AIDS to include the highest political level. President Obasanjo's leadership, coupled with the cohesiveness in the directives and oversight responsibilities of cabinet ministers, has created a proactive and responsive environment. However, substantial challenges remain.

Structure. The recent changes and proposals (including the impending bills) by the Presidency, the Minister of Health and others on the location of the body, including what name to call the new entity (NACA, NAPCA, etc.) have led to uncertainty. Furthermore, the lack of a visible and official consensus on NACA's set-up makes the situation all the less tenable.

Relationships. The National Project Team of the World Bank-assisted project serves the members of NACA, SACA & Ministries by helping them to carry out the HEAP. However, SACA and LACA remain very weak, even with the creation of NACA/SACA/LACA Forum. The HIV and AIDS National Health Accounts, a sub-initiative of APIN, has not progressed much to provide the much-needed evidence of the sources and flows of funds for the

SACA and LACA remain very weak, even with the creation of NACA/SACA/LACA Forum.

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national HIV and AIDS response.

HEAP. The HEAP document contains useful interventions and good practices that have been divided into action sections. However, the document lacks explicit implementation arragements and costing which leaves the decision to stakeholders to implement various activities. Some of the major and immediate challenges remain expansion of VCT, provision of drugs and treatment, building basic health system infrastructural response to outcomes of VCT efforts and other related services such as awareness; providing safety-nets within the health care system for the poor in terms of access to drugs, nutrition and strong counselling, including follow-up social support services.

A number of factors contribute to the challenges faced in the national response to HIV. Their legal and institutional framework to support the multi-sectoral approach is missing and the sectoral roles of the various implementers are not well defined. This has led to poor co-ordination, multiplicity of effort and an inability to fully maximize investments in the actualization of the HEAP objectives. A number of policy gaps and contradictions need to be addressed. Simmering disputes over the HIV vaccine and "cure" claims point to the need to develop a clear regulatory framework and mechanism with regard to HIV cures and the practice of traditional medicine as a whole.

The implementation of blood safety measures is also another area of importance. The HIV and AIDS epidemic highlights the need to review other health related policies and standards of practice such as the exclusive breast-feeding campaign, family planning services as well as antenatal and delivery practices. Thus, the HIV and AIDS epidemic has brought about new policy challenges and raises important questions about the appropriateness of the existing legal framework.

The response has focused a lot on prevention at the expense of PLWHAs and PABAs. Inadequate counselling and support services may contribute to the failure of Nigerians to seek voluntary testing. The issue of affordability and access to ARVs is growing in importance especially in relation to the budgets of the Federal Ministry of Health (FMOH).

Resource Mobilization for HIV and AIDS Response

With the constitution of the PCA and the development of the HEAP blueprint, the nation was faced with the challenge of mobilizing resources.

To combat the spread of HIV and AIDS at the international level, the United Nations General Assembly Special Sessions on HIV and AIDS in New York and the African Leaders Summit on HIV and AIDS in Abuja are some important fora where concrete declarations were made in support of mobilizing resources for HIV and AIDS interventions (see Appendix 4.1).

There is a heavy mismatch between resources needed and the funding available which is the biggest obstacle faced by all the stakeholders in the fight against HIV and AIDS. A detailed estimate of the total financial resources needed

for HIV and AIDS prevention and control in low and middle-income countries, prepared by an international team convened by UNAIDS, shows that for 2005 alone, US$9.2 billion will be required.

This amount is several times greater than the spending projections for 2002 in low-and middle-income countries. A sustained increase, therefore, has to be achieved to reach an annual total of US$9.2 billion by 2005. Of that amount, US$5.4 billion is required for countries with GDP of less than US$2000 per person. The projected, staggered rise in spending implies that many countries cannot immediately mount the entire range of activities needed. Most countries, including Nigeria, would take several years to build the human and infrastructural capacity required for their expanded responses.

To secure resources for combating the HIV and AIDS epidemic in Nigeria, the various bodies involved in different interventions have adopted the fund flow system charted in Fig. 4.1.

This indicates that the HEAP is funded from a variety of national and international sources. The government provides support through line ministries (especially those in NACA) at the federal level and the state level. The World Bank support is through a loan while other international donors such as the UN, USAID, DFID provide support directly through their local co-operating/implementing agencies. Additional resources are derived from communities themselves through civil society groups. Family resources are mobilized to assist with care and support for PLWHA and OVC. The private commercial sector are also involved and other humanitarian bodies, through their public social responsibility initiatives, that play vital roles in prevention and impact mitigation of the HIV and AIDS epidemic.

National framework for resource mobilization

In addition to raising funds for intervention, the Nigerian HIV and AIDS response framework for resource mobilization aims to obtain a range of resources – technical assistance, human resources, material goods as well as free services and facilities through well formulated mechanisms targeted at specific resource providers.

Resource providers in Nigeria include international NGOs, bilateral and multilateral organizations, national/state/local governments, private sector/businesses, social/charitable associations and philanthropic individuals.

Financial resources. One of the greatest challenges facing HIV and AIDS programme implementers is how to fund and sustain their programmes. In some states, the government is solely responsible for funding most HIV and AIDS programmes while in others the primary sources of funding may be international or national donor agencies, NGOs and faith-based organizations. Funding partnerships also develop between the government and non-governmental donor agencies. However, in general, the financial resources available within the country are not sufficient to combat the epidemic.

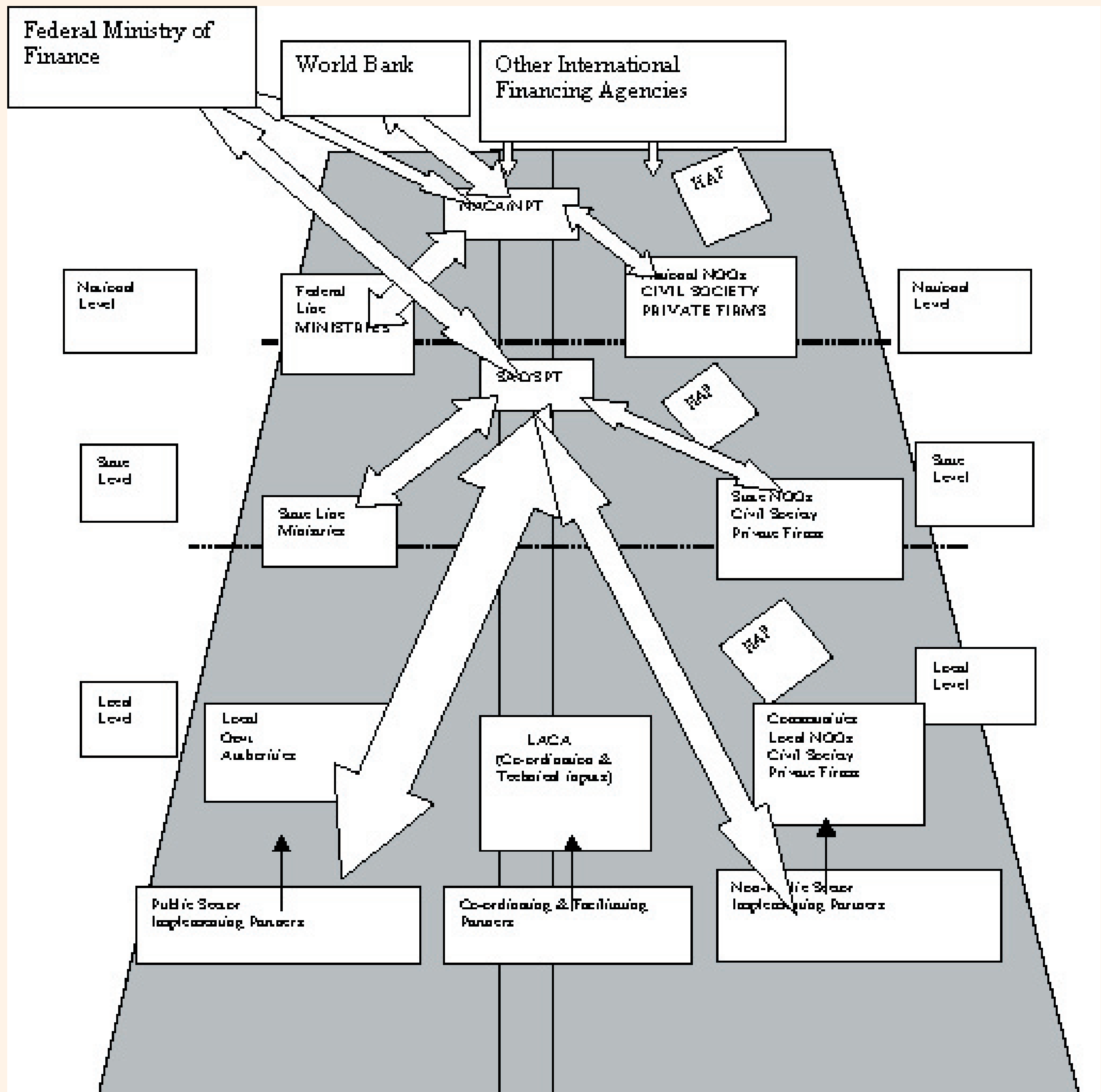
Human resources. To prevent and

HIV and AIDS has brought about new policy challenges and raises important questions about the appropriateness of the existing legal framework.

mitigate the impact of HIV and AIDS through human resources, Nigeria has involved diverse groups of people such as political leaders, religious leaders, community heads, professionals, PLWHA, etc. The level of mobilization is also grossly inadequate and can only grow substantially when awareness and public education on the epidemic have been stepped up significantly.

Technical assistance. Technical assistance targeted at fighting HIV and AIDS includes technical input into programmes organization and execution, scholarships, and sponsorships

FIGURE 4.1
HEAP Implementation and Fund Flow



to relevant training programmes and conferences, research, data analysis, and publications. Donor agencies in Nigeria are responsible for providing the bulk of technical support to local initiatives and organizations.

Another area of resource provision to fight the AIDS epidemic is through *free services and facilities* such as office space, equipment, training facilities, transportation, publishing and printing. National programmes and donor agencies are also providing these to smaller organizations that need them.

Material goods also come in handy in the fight against HIV and AIDS. These come in the form of office or service equipment, condoms, drugs, training materials, vehicles, computers, etc., all of which are important for gaining the support of many programme implementers in the country.

Linking national plan to resource mobilization

The National Policy on HIV and AIDS, as expressed in the HEAP document, has as part of its components a comprehensive resource mobilization plan (see Box 4.3).

The HEAP addresses issues of human, technical, and material resources through the provisions in some of its guiding principles which emphasize the need to (i) empower communities to design and initiate community-specific action plans; (ii) develop and implement a multi-sectoral, multi-disciplinary institutional framework and legal machinery for HIV and AIDS prevention; (iii) implement the activities of the HEAP using a decentralized and participatory approach; (iv) mitigate the impact of AIDS by providing affordable and accessible drugs, encouraging counselling to those infected and affected by AIDS, providing financial assistance to AIDS orphans, and providing micro-credit facilities to PLWHA and PABA.

The involvement of various sectors and groups such as NACA, SACA, Action Committees on AIDS at National, State and Local levels as well as various ministries as principal implementers aims to ensure adequate human and technical resources for the National HIV and AIDS response.

The financial resources to implement HEAP are derived from national and international sources. In view of the scale and enormity of the HIV and AIDS epidemic in Nigeria, resources derived through the HEAP alone would be inadequate for a national response. Available statistics show that the scale of the epidemic requires far more resources.

Resource gaps in the national HIV and AIDS response

Although the country has been able to attract a number of resource providers to participate in its HIV and AIDS national response, the stage which the epidemic has reached before the interventions began and in view of the large size of Nigeria's population and landspace, more resources are still required to reverse the trend of the epidemic in the country (see Appendix 4.3).

In addition, a more effective resource distribution mechanism needs to be developed in order to ensure epidemic-determined resource distribution to all parts of the country as opposed to the present

Despite the recent increase in funds mobilized for HIV and AIDS, a substantial gap remains between required and available funding.

BOX 4.2
Capacity Development in HIV Programming

•The HIV and AIDS pandemic has given urgency to the need for rapid assessment and capacity development, particularly in high prevalence countries. The epidemic is eroding existing human and material resources, while the functions of available resources are also changing, often in response to a far broader and more urgent range of needs. Resources need to be allocated in the planning process to develop the capacity for an expanded and comprehensive response to HIV and AIDS prevention, care and mitigation.

Capacity development can be defined as a process in which human resources as well as organizational and operational capabilities of institutions are improved to better perform priority functions. The overall purpose of capacity building in expanded and comprehensive responses to HIV and AIDS is to ensure effective design, implementation, co-ordination and management of wide-scale prevention, care and support efforts. Capacity development comprises some or all of the following six components:

• ***Human capital.*** This involves the development of human capacity and the effective use of managerial, professional and technical staff, and volunteers. It includes identifying the right people to be trained; developing and delivering training strategies that are responsive to the needs of the target audience; providing an appropriate learning environment for training and education; ensuring in-service/field supervision for continued skills transfer; and, especially in the case of HIV and AIDS, longer-term mentoring for directional, emotional and moral support.

• ***Organizations and their management***. This addresses how organizations, their culture and management styles influence the use, efficiency and retention of skilled human resources.

• ***Public sector institutional context***. This looks at how the policy and institutional environment affect civil service and government operations, and the spillover effect in the private and non-profit sectors. It includes the roles and responsibilities of different sectors in the context of decentralization, for example, as well as laws and regulations that affect hiring, promotion, and remuneration policies.

• ***Networks and linkages***. This includes multi-sectoral alliances and networks of the public and private sectors to optimize resources and broaden the coverage of actions.

• ***Social capital and community participation***. Social capital refers to the processes between people that establish networks, norms and social trust, and facilitate co-ordination and cooperation for mutual benefit. Community organization and participation concern complementarity of action, and strengthening social accountability and advocacy systems.

• ***Contextual environment***. This refers to the socio-economic, cultural and political settings that facilitate or constrain the functional capacity of individuals and organizations. One example is the degree of political acknowledgement and support for HIV and AIDS activities.

Sustainable capacity development requires creating new or employing existing system, through which one or more of the above components can be operationalized on a sustainable basis. Adopting a participatory process to develop a strategy and approach to capacity development is as essential to eventual success as the strategy itself. It is important that members of the target audience for capacity development participate in identifying and prioritizing needs; selecting the most appropriate methodologies, media and materials; and matching needs and available resources to the methods and general approaches adopted.

practice of focusing only on the hot spots and other advantaged areas.

At the federal level, due to the high level of political commitment, there has been a recent increase in funds mobilized for HIV and AIDS. However, a substantial gap remains between required funding and available funding from the government, loans, grants from donors and the Global Fund for AIDS, TB and Malaria. At the state and LGA levels, fewer resources are resources are committed to HIV and AIDS. At all levels donor agencies and NGOs have increased activities and resource provision to the three tiers of government.

Problem identified with regard to resource mobilization include (i) funding for interventions are usually targeted at national bodies; (ii) apart from the health sector, most others suffer from low capacity and inability to prepare requisite programmes and secure funding for them; (iii) states and local governments have not yet developed the needed capacity to autonomously mobilize resources for their programmes; (iv) budgetary allocation and/or disbursement for programmes at all levels are inadequate; (v) there is over-dependence on donors' assistance in all aspects of interventions; (vi) the private sector is not adequately involved; and (vii) religious bodies and communities are not sufficiently consulted and involved in the resource mobilization drive.

Global Partnership

The HEAP provides the context for partnership in resource mobilization and programme implementation.

Some of the target partners are the World Bank, USAID, DFID, the Global Fund, AfDB, and WHO. Others include the UNDP, UNDCP, UNFPA, UNICEF, US-DOD, US-DOL, CIDA, and several international foundations. In the absence of a National Health Account for HIV and AIDS, a provisional estimate puts the total contribution of development partners at well over US$300 million over a number of years.

Notable initiatives from partners include the World Bank's three-year HIV and AIDS Programme Development Project that supports capacity development, expansion of the public sector response, and raising the HIV and AIDS Fund. The project operates in the Federal Capital Territory and 18 states, including Akwa Ibom, Benue, Ebonyi, Kaduna, Lagos, Taraba, Adamawa, Cross-River, Imo, Kano, Plateau, Nasarawa, Anambra, Borno, Edo, Oyo and Niger. The HIV and AIDS Fund within the project is to provide technical assistance and training to NGOs, CBOs, the private sector and communities on programmes preparation and implementation.

The Global Fund to fight AIDS, TB and Malaria (GFATM), was conceived at the G-8 meeting in Okinawa, Japan, and pronounced at the Abuja Summit on HIV and AIDS, TB and Other Related Infectious Diseases (ORIDs) in March 2001 by the Secretary-General of the United Nations, Dr. Kofi Annan. In the first round of proposals, Nigeria is scheduled for assistance in support of Centres of Excellence to expand current Prevention of Mother to Child Transmission of HIV, anti-retroviral (ARVs) programme, and

BOX 4.3
National Resource Mobilization Policy

The Policy

- NACA shall be responsible for co-ordinating the timely and effective development, execution, monitoring, and revision of the HIV and AIDS Emergency Action Plan (HEAP) and of all subsequent plans;
- NACA shall ensure that the government and partners are advised in timely manner of the level of financial, organizational, and human resources support required to undertake and complete programme initiatives;
- NACA shall monitor and report biannually upon progress achieved in responding to identified HEAP objectives and to those objectives incorporated in subsequent plans;
- NACA shall share a fiduciary responsibility with implementing agencies in the interest of ensuring transparent and accurate reporting on the utilization of financial and material resources;
- NACA shall facilitate the institutional capacity development of SACAs and LACAs which, when sufficiently capacitated, shall advocate and support the development of HIV and AIDS activities originating at the state and local levels;
- every federal and state ministry, in co-ordinating with NACA and with SACA, shall define and fund a budgetary line item for HIV and AIDS and STI prevention and control;
- private sector, parastatals, and non-governmental institutions, in co-ordination with NACA and LACA, shall mobilize resources and participate fully in the prevention and control of the epidemic within the framework of the HEAP and subsequent strategic plans;
- all institutions engaged in the implementation of HIV and AIDS and STI activities shall facilitate the monitoring and evaluation of their activities through the development of detailed plans of action;
- all institutions engaged in the implementation of HIV and AIDS and STI activities shall commit a minimum of 5 per cent of their project budgets to facilitate the monitoring and evaluation of their activities.

Applicable HIV and AIDS Emergency Action Plan (HEAP) Strategies

Removal of systemic barriers

Key strategic activities:

- Management training;
- Funding gap and cost effective analysis;
- Financial management system development and effective resources allocation;
- Resource mobilization forum;
- Development of partnerships with CSOs

Goals

- By 2003, the National Action Committee on HIV and AIDS (NACA) shall have completed, submitted and have approved by the federal government guidelines on standardized personnel structures and budget support requirements for adoption by States and Local Government Areas in the formation of State Action Committees on HIV and AIDS (SACA) and Local Action Committees on AIDS (LACA;
- By 2003, NACA shall have defined and have approved by the federal government, the structure, format and content guidelines related to its annual report on HIV and AIDS;
- By 2004, NACA (in all 36 States) shall be fully functional with appropriate terms of reference, scopes of work and at least minimal standardized staffing patterns and budgets;
- By 2005, Local Action Committee on HIV and AIDS (LACA) in all 774 local government areas and in the states shall be functioning fully with appropriate terms of reference, scopes of work and at least minimal standardized staffing patterns and budgets;
- By 2010, NACA, SACA, and LACA shall have mobilized sufficient resources to provide for their long-term sustainability.

To institute any meaningful intervention, people collaborate with people, organizations realte with organizations, nations partner with nations.

the assessment and promotion of effective participation of CSOs in the national Response to HIV and AIDS.

One of the earliest lessons that all HIV and AIDS programme implementers learned was the need for all stakeholders to collaborate. To institute any meaningful intervention, people should collaborate with people irrespective of social, behavioural, economic, racial, or disciplinary differences. Organizations relate with organizations. Nations partner with nations.

The need for this became more apparent with the realization of the developmental dimensions of the HIV and AIDS epidemic, which calls for a multi-disciplinary, multi-level, and multi-sectoral approach.

Partnership with other parts of the world in the fight against the epidemic is of utmost importance to Nigeria and other developing countries. This is necessary to ensure availability of adequate funds for intervention, availability of skilled human resources, and availability of technical and material resources required.

Nigeria's global partnership building has been very successful. The country is working actively and productively with various UN agencies, the World Bank, African Union, NEPAD, bilateral and multilateral donors, the Global Fund as well as many other development partners and foundations.

It is known that countries worst affected by HIV and AIDS are also the poorest in the world, some lacking the capacity to provide less than one-third of the resources required to deal with the epidemic. Therefore, many global partners have been of tremendous assistance to these countries, especially in their project funding, capacity building, provision of materials and equipment, information sharing, networking promotion, etc. (Appendix 4.2 lists some of the global partners and their areas of work in Nigeria.)

Several development partners have played a commendable role in strengthening global partnership in Nigeria. The key ones are briefly discussed below alongside their area of contribution.

- *The UN Group*. The group consists of the full complement of United Nations bodies operating in Nigeria, which make their contributions within the purview of their general mandate areas.
- *The United Nations Children's Fund (UNICEF)* focuses primarily on HIV and AIDS prevention among young people, PMTCT, C&S for young people and parents living with HIV and AIDS.
- *The United Nations Development Programme (UNDP)* promotes an enabling policy, legislative and resource environment for an effective response to HIV and AIDS. It also mobilizes stakeholders to facilitate the social transformation needed to achieve an HIV-free future; promotes strong leadership and capacity for a co-ordinated and enhanced response; helps Nigerian governments raise domestic and international resources; places HIV and AIDS in the centre of national development agenda; and promotes the rights of PLWHA through advocacy and legislation.
- T*he United Nations Population Fund (UNFPA)* targets HIV prevention among young people, com-

prehensive condom programmes for both genders, and prevention of HIV infection among pregnant women.

- *The United Nations International Drug Control Programme (UNDCP)* supports HIV and AIDS intervention programmes in relation to illicit drugs demand or use.
- *The International Labour Organization (ILO)* concentrates on mobilizing governments, employers and workers against HIV and AIDS.
- *The United Nations Educational, Scientific and Cultural Organization (UNESCO)* relies on preventive education to counter ignorance and misconceptions associated with HIV and AIDS and to provide adequate knowledge on all aspects of HIV and AIDS, in order to defeat prejudice and discrimination.
- *The World Health Organization (WHO)* commits itself to strengthening the health systems' responses to HIV and AIDS and STIs.
- *The World Bank* focuses on poverty alleviation and improving the quality of life of people. The World Bank's response is comprehensive, encompassing prevention, care, support, treatment, and impact mitigation. As part of its multi-country programme (MCP) for Africa, the World Bank has committed US$ 90.3 million to HIV and AIDS interventions in Nigeria. The Bank has substantially expanded its efforts against HIV and AIDS in Africa. This work has been carried out through the IPPA framework and in close collaboration with governments. The multi-country AIDS programme (MAP) for Africa, which was approved by the World Bank in September 2000 and represents the Bank's contribution to the IPAA, has driven the expansion in commitments (see Appendix 4.4).

The Global Fund

Following the declaration made in support of a global fund to fight AIDS, Tuberculosis and Malaria at the UNGASS meeting in New York in 2001, the Global Fund to fight AIDS, Tuberculosis and Malaria was launched. It was set up mainly as a financial instrument to complement existing funding for programmes addressing HIV and AIDS, Tuberculosis and Malaria. The Fund concentrates on generating additional resources and making them available at the community and country levels.

It is a global public and private partnership with a sound constitution of official country representatives, business sector representatives, non-governmental organizations and representatives of communities directly affected by the epidemic. As at April 2002, US$ 2 billion has been pledged into the fund, the bulk of which came from Official Development Assistance budgets of donor countries and from the endowment of major philanthropic organizations.

In its initial grants announced in April 2002, the Fund had committed more than US$ 616 million over two years to support programmes to combat AIDS, tuberculosis and malaria in over 30 countries. Around 60 per cent of these funds is tied to HIV and AIDS prevention and

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Support from the global partners has been remarkable and commendable in Nigeria, and this dated back to the period when the government was completely quiescent about the epidemic.

treatment programmes and, in particular, the funding the purchase anti-retroviral treatment. A further 15 per cent of the funds goes into specific programmes to fight AIDS, Malaria and Tuberculosis.

At the launch of the Global Funds, the Nigerian Government contributed US$ 10 million from which it has already obtained $70.9 million to facilitate the participation of CSOs in the national response to HIV and AIDS and expand PMTCT and ARV programmes. With this empowerment, the Government has been funding anti-retroviral therapy for 10,000 adults and 5,000 children, combined with the new increased emphasis on ARVs and PMTCT. Good as this initiative may seem, it is a distraction from more effective and cost-effective strategies. Clear policy leadership, emphasizing what is known to work and cost-effective is lacking.

Bilateral partnership assistance

Efforts to stem the HIV and AIDS epidemic in Nigeria have been contributed to significantly by bilateral donors working with the government, CSOs, NEPWHAN, research institutes and communities. Their work covers prevention, care and support, capacity building, networking, research and development, community mobilization, and funding. Some of the bilateral donors in Nigeria include USAID, DFID, CIDA, Italian Co-operation, JICA and GTZ. Many other countries with bilateral relationship with Nigeria implement their programmes either through their embassies or the European Union.

Resource mobilization from bilateral programmes has been on the increase, especially resources from USAID/Nigeria, DFID and CIDA, which focus on various dimensions of the epidemic: gender issues, preventing mother-to-child transmission of HIV and AIDS, NYSC reproductive health and HIV and AIDS programme, policy activities, condom social marketing, behaviour change, care and support for PLWHA, AIDS orphans, and support for AIDS impact modelling, advocacy and policy.

• *African Union and NEPAD*: Working through the New Economic Partnership for African Development (NEPAD), the African Union has aligned strongly with the Millennium Development Goal on HIV and AIDS, and is mobilizing resources throughout the continent to achieve the goal. The AU is seriously thinking of promoting local manufacturing of drugs that are essential in the management of HIV and AIDS.

• *The International Partnership Against AIDS in Africa (IPAA)* is also of immense importance in the fight against the epidemic in Africa. The IPAA is a coalition of partners – African governments, UN agencies, donors, the private sector and the community sector – that works together to curb the spread of AIDS in Africa. It is based on a common vision of how to respond to the epidemic and calls for (i) the creation of high-level political organs to drive the battle against AIDS; (ii) the formulation and implementation of national strategic plans; (iii) increased political and financial commitment; (iv) decentralized programmes; (v) equitable access and

the constant involvement of people living with HIV and AIDS.

The IPAA has worked tremendously to raise commitment of African leaders to respond to the epidemic. Yearly details of activities are reported in the IPAA Progress Report. This has been a major technical resource to its members who stand to learn from the best practice of interventions of member states. Nigeria is a member of IPAA.

Some other international Partners working in Nigeria are: APIN, Action Aid Nigeria, Pathfinder International, Ford Foundation, Ashoka Innovators for the Public, Africare, Macarthur Foundation, OSIWA, IFESH International, Engender Health, AED, PSI, CEDPA, IOM, BASIC, CAP, PATH, MSF, US Labour Solidarity Centre, SFH, FHI, CDC, Policy Project, and Gede Foundation.

Support from the global partners has been remarkable and commendable in Nigeria, and this dated back to the period when the government was completely quiescent about the epidemic. The new image created for the country by the present administration in the comity of nations is certainly paying off in the fight against HIV and AIDS.

But for Nigerians to fully get the impact of the programmes and resources of the partners, a wider spread of activities and increased co-ordination of programmes may be required. This is to avoid possible duplication and overlap of programmes, as well as avoid neglect of certain parts of the country while others are being inundated with activities.

Also, the National Planning Commission and the National Action Committee on AIDS may need to be involved more significantly by the global partners from the planning stages through to implementation and monitoring of programmes. This is to allow for effective synchronization of activities. The general public should also be made to play more pro-active roles with the global partners across the country. Lastly, given the population of Nigeria and the estimate of PLWHA, more global efforts are still required to secure affordable important drugs required for HIV and AIDS management.

For Nigerians to fully get the impact of the programmes and resources of the partners, a wider spread of activities and increased co-ordination of programmes may be required.

National Partnership Building

The advent of democracy in Nigeria in 1999 has brought a remarkable change in the HIV and AIDS interventions at the federal level. The state government and the local government levels are gradually coming up in their response. This dramatic change is due, among other reasons, to the political will and commitment demonstrated by the president in recognition of the deep socio-economic and negative impact that HIV could have on the country if unchecked. The national response to HIV and AIDS is developed around the objectives of:

- preventing of further transmission and spread of HIV in Nigeria;
- mitigating the impact of HIV and AIDS on PLWHA and PABA;
- co-ordinating and mobilizing national and international resources for an effective HIV and AIDS response in the country.

Given the population of Nigeria and the estimate of PLWHA, more global efforts are still required to secure affordable important drugs required for HIV and AIDS management.

The National Strategic Plan for Nigeria is the HIV and AIDS Emergency Action Plan (HEAP), which was designed to define the roles of every stakeholder in the national response and also to mobilize the partners to contribute to the fight against HIV and AIDS. The HEAP is used as an instrument of national HIV and AIDS implementation, stating strategy, objective, target group, activities, who is responsible for implementing the activities, timing for implementation, indicators and assumptions and risks, the budgets and expected sources of funds.

The national partnerships, collaborations and networks that have emerged with the adoption of the HEAP include the NACA, NPT, UNTG, NEPWHAN and CiSCGHAN. Others include the HIV and AIDS inter-faith body (consisting of Christian and Islamic bodies), JAAIDS (through the electronic interactive process involving many stakeholders), HIV and AIDS Communication Team, Ethics Team and other teams constituted by NACA.

The national response, through its partnership drive, has been able to carry out various advocacy and policy initiatives to advance the fight against HIV and AIDS in the country, raise over US$ 56 million from the government to augment other resources coming from international bodies, increase its programme coverage from preventive interventions targeted at the high-risk groups to preventive interventions targeted at the general public, care and support for PLWHA and PABA, removal of barriers to a large-scale response, and creation and management of an enabling environment. It has also been able to increase its geographic coverage to all parts of the country through NACA, SACA, LACA and CACA, increase the active involvement of other stakeholders such as the military, the business sector and gender-based groups in the national response.

There are countless ways in which the AIDS response can be made truly multi-sectoral by putting it into the agenda of other government sectors.

- *The Ministry of Labour*, for example, can promote workplace prevention and programmes in the public and private sectors as well as assess and prepare for AIDS-related labour market shifts;
- *The Ministry of Defence* can use its budget to implement prevention and care programmes in the military, particularly among young recruits.
- *The Ministry of Education* can introduce HIV and AIDS education, including reproductive health information, into school curricula, and devise ways to broaden access to education (especially for orphans and other vulnerable children).
- *The Ministry of Agriculture* can use their networks of extension workers to bring AIDS-related skills to rural communities, and to ensure that necessary resources and support are made available to help people cope with the impact of the epidemic.
- *The Ministry of Finance* can factor into their economic policy frameworks the long-term costs and benefits of monitoring an effective AIDS response, and prevent vital spending priorities from being sacrificed.
- *All ministries and departments can* assess and plan for the financial, technical/material and human resources impact of the epidemic.

Progress with Implementation

With the political commitment made at the highest level, Nigeria has embarked on a fight against HIV and AIDS by a massive scale-up of the country's response to the epidemic through mobilization of human, financial, material and technical resources.

To date, Nigeria has launched the largest care programme with 15,000 Nigerians accessing ARV and other drugs. Also, having raised about US $300 million for the national response, with over US $56 million contributed by the government, the country launched one of the most ambitious capacity-building programmes in Africa. The National programmes also support initiatives at both state and local government level. An improved institutional capacity, good quality care services, a nationwide campaign on AIDS and access to these services are major targets of the national programme.

However, poor resource mobilization is still a drawback in the fight against HIV and AIDS. Most of the programmes designed to combat the epidemic in the HEAP document have only received pledged commitments rather than actual cash commitments.

Since the development of the HEAP, the country has gone into partnership with local and international stakeholders, and devised many strategies for mobilizing resource, including:

- mobilizing friendly nations, civil society organizations under the framework of IPAA (International Partnership Against AIDS), to redirect and expand national and international, political, programme and financial policies and resources to address the HIV and AIDS epidemic and its impact on development in Africa. Only an urgent mobilization of this kind can curtail the spread of HIV, reduce its impact on human suffering, and reverse the gains of human capital development lost to AIDS;
- encouraging active social mobilization and participatory involvement of relevant stakeholders in planning, programme design and implementation, monitoring and evaluation of all activities related to HIV and AIDS in the development process, thereby strengthening capacity for local development;
- building and enhancing national and local capacity for participatory decision making, to promote self-directed state and community action, enhance gender balance and vulnerable group equity, and promote sustainable livelihood systems;
- embracing and adapting a stakeholder-driven multi-track education and communications system, designed to bring fundamental behaviour change, that will ultimately and uniquely add value to the fight against AIDS;
- activating links between HIV and AIDS, poverty and sustainable livelihoods and social governance, including the rights of people living with and infected with HIV and AIDS, thereby developing institutional partnership and capacity enhancement for the provision of drugs including ARVs and drugs for opportunistic infections at affordable prices as well as developing and transferring appropriate health technology systems that enhance community, household and individual action.

This is being targeted to make services readily available to the

Nigeria has launched the largest care programme and the most ambitious capacity building programme in Africa. The government has raised about US$ 300 million for the national response to AIDS, with over US$ 56 million coming from its own coffers. Also, about 15,000 Nigerians are accessing ARV and other drugs through the government.

The commitment of most governors and local government chairmen to HIV and AIDS is very low. Funds are hardly alllocated in their budgets despite the obvious negative impact of the disease on thier people.

poor and marginalized. Strong linkages between adaptive strategies and contemporary knowledge are being reinforced, as a means of supporting community ownership;

- developing the capacity for targeted interventions among youth groups, vulnerable groups, PLWHA, PABA, and AIDS orphans, as well as prevention of mother-to-child transmission, voluntary testing and confidential counselling and virus screening, and by improving access to HIV care services and protection, reducing the transmission of tuberculosis in the households and communities;
- providing condoms, paying special attention to accessibility and distribution outlets, as well as appropriate IEC materials targeted at improving the usage of condoms by both genders;
- stepping up advocacy to increase public understanding and political awareness of the threat of HIV and AIDS and how it can be prevented. This incorporates development and implementation of massive, broad-based communications programmes to increase public awareness of HIV and AIDS and to foster behaviour change, using mass media, interpersonal communication and traditional communication methods at national, state, local government and community levels. This encompasses educational programmes for in-school and out-of-school adolescents focused on reproductive health, sexuality and HIV and AIDS/STIs.

Apart from the heavy budget that government has been allocating to curb the spread of HIV and AIDS in the country, the US $90.3 million IDA credit given by the World Bank under the multi-country HIV and AIDS for Africa also gave a boost to the realization of the National Action Plan. Eighteen states in the country are also benefiting from the IDA credit; they are eligible to benefit once they provide their counterpart contribution to the fund.

The funds are allocated to fund the three major components of the National AIDS Plan:

- Capacity Development (US $27.57 million)
- Expanding the Public Sector Response (US $ 31.22 million)
- HIV and AIDS fund (HAF) US $ 33.66 million)

These three components of the credit seek to provide support for all the interventions necessary for an effective implementation of the HEAP, human resources, development, capacity building, and technical and financial support. In order to ensure proper management of the IDA credit and other resources available for HIV and AIDS work in Nigeria, a financial supervisory system was set up with ultimate control from the National Project Team, down to State and Local Government Project Teams. The National Action Committee sets the standards acceptable to donor agencies in key areas, such as the creation of financial accounting systems, procurement of goods and services, and monitoring and evaluation.

While the committee does not interfere with the day-to-day running of the state agencies, the states periodically furnish it with the list of approved community projects and progress reports. The committee is also responsible for central procurement of goods and

services required for implementing the national strategic plan (HEAP). It does so in consultation with the state level agencies. The committee also monitors and evaluates outputs jointly with the States based on the data assembled by each state. The system guarantees a more effective and transparent use of resources acceptable to all donors and other stakeholders in Nigeria.

There is commitment at the federal level to fight AIDS, but for the commitment to yield the desired result, it must be fully complemented by the state and local governments. At present, the commitment of most governors and local government chairmen to HIV and AIDS is very low. Funds are hardly allocated in their budgets despite the obvious negative impact of HIV and AIDS to the development of the people in their domains. The State and Local Government Action Committees set up to co-ordinate HIV and AIDS programmes still rely on financial resources from the national purse to the tune of 95 per cent.

Local NGOs remain the key players in providing human, financial, technical and material resources in the fight against HIV and AIDS in Nigeria. They have been very consistent and visible in their advocacy work, hence they have enjoyed the collaborative support of donor agencies.

State and local governments must also coordinate and support the local response for AIDS programmes and services to be appropriate to community needs. Governors, their wives and other state executives should identify with programmes that promote HIV and AIDS prevention and care generally by making allocations directly to HIV and AIDS programmes.

They should also build the capacity of state and local governments to carry out intervention programmes effectively in their various states. Most state campaigns have not been sustainable because they were poorly designed and lacked funding.

Some of the challenges to national partnership include the lack of a specific strategic plan to guide partnership in the country; the delay in understanding of the concept by the actors due to inadequate education; the disproportionate distribution of NGOs, donor agencies, and other stakeholders across the country; poor records and reports on the activities of programme implementers in different localities, the lack of organized stakeholders' forum at the state and local government levels; and poor involvement of CBOs in HIV and AIDS programmes by bigger stakeholders.

A Role for Public-Private Sector Partnership

The private sector has a major role to play in mobilizing resources for combating the HIV and AIDS epidemic. This has become necessary given the need to institute an effective response in the workplace. The trends towards globalization, privatization and the free market system have all called for increased social responsibility of the private sector in combating the HIV and AIDS epidemic as well as addressing other development challenges.

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At the global level, the Global Business Council on HIV and AIDS has recognized the contributions and impact that the private sector can make in prevention, care and support activities. Hence, the Council initiates, supports and implements initiatives of the business community, solely or in collaboration with the public sector, at the global, regional and national levels.

Although the private sector recognized the deadly impact of AIDS and the catastrophic dimension it portrayed in a resource-poor setting such as Nigeria, it only began recently to respond to the challenges. Given the inexorable manner in which HIV and AIDS has spread and the large and multifarious resources required to curtail it, it has become imperative for the private sector to collaborate with other stakeholders to combat it. A major lessons learnt during the first decade of the epidemic in Nigeria when the private sector folded its arms was that no stakeholder working alone can provide all the financial, technical, material and human resources required to fight AIDS; only partnerships can do it.

Also, greater support from business is crucial. Generally, it is often best positioned to institute workplace interventions. Also, it is in a very good position to initiate and/or support community-based initiatives through the various linkages, networks and relationships that may have been built over the years. Private-sector initiatives also provide one of the best avenues of VCCT, care and support of positive workers, OVC care and support of PABA that is almost completely devoid of discrimination and stigmatization, using the existing health and social welfare systems of the sector.

In their HIV and AIDS interventions, the private sector also has a unique opportunity to establish and institutionalize a long-term system of intervention with in-built precursors for effective disease prevention and treatment, such as promoting good education, reducing poverty through job creation and paying decent remuneration, creating opportunities for social recreation, and ensuring health-sector reforms. All these permit more enduring interventions than the present modalities which apparently have temporary advantages. And the private sector, considering its relative permanence of resources and residence in the communities, can do more in this regard. Indigenous foundations, trusts, charitable clubs and religious organizations are also well placed for positive interventions.

Prolonged inadequate information and uncertainty about the effects and impact of HIV and AIDS epidemic on the private sector led to the many years of its indifference to the problem. The recent sensitization efforts have been yielding results, as there is growing involvement of the private sector in HIV and AIDS activities, both at the programming and funding levels in Nigeria. The resources − funding, technical skills, personnel and

materials – required for effective HIV and AIDS prevention and impact mitigation are beyond what the government and donor agencies can provide alone. The communities, of which the industries, companies and other profit-making firms form a part, have to collaborate in mobilizing the resources for the common good of the society.

Consequently, several national and multinational industries have been involved in HIV and AIDS interventions in the country. Some are working directly through their Community Development Initiatives; some through the CSOs and some through the public-sector institutions like hospitals.

More efforts are still needed to fully bring the private sector into the realization and acceptance of this corporate social responsibility to the public. And it appears that the CSOs and CBOs should take up this challenge. Certain challenges are immediately obvious: private sector operators are unevenly distributed across the country; there may be mutual distrust between motives and plans; competing developmental needs may tend to water down the importance of AIDS response; and poor resource mobilization and public relations capabilities of the CSOs representative usually affect the outcome.

However, the growing network of CSOs and support groups; the opportunities for channelling resources through credible intermediaries; opportunities for partnering in all stages of programme implementation; the existence of the HEAP, the National Policy on HIV and AIDS and other vital information documents that could be used to establish the enormity of the HIV and AIDS epidemic; and opportunities for local and international capacity building training on HIV and AIDS, all provide a leeway for a better mutual relationship and collaboration between the programme implementers and the private sector.

Care and Support of People Infected or Affected by HIV and AIDS

The basis for care and support

Nigeria has 10 per cent of HIV and AIDS infected adults globally. The age group of 15-49, which corresponds with the country's most productive workforce, is the most vulnerable. As a result of this, the epidemic weakens economic activities by decreasing productivity, diverting resources and depleting skills. Agriculture and, consequently, food security, are being threatened. Increased absenteeism of staff, increased staff turnover, loss of tacit knowledge of organizational operation, increased demands for training and recruitment, and general decline in morale have all been documented in a few reports. In effect, the overall development of the country is being undermined the same way the epidemic is undermining the individual productive capabilities of the people.

Realizing the enormity of the problems of HIV and AIDS, different stakeholders in Nigeria are becoming increasingly awakened to the reality that the relegation of care and support programmes of PLWHA and PABA put all other interventions at a precarious risk of failure, thereby exposing the

No stakeholder working alone can provide all the financial, technical, material and human resources required to fight AIDS; only partnerships can do it.

Nigeria has 10 per cent of HIV and AIDS infected adults globally, the country's most productive workforce is the most vulnerable.

country to the possibility of a worse pandemic that may be potentially uncontrollable. Policy makers, programme implementers, researchers and even PLWHA groups have all agreed that care and support of PLWHA and PABA are an indispensable component of a complete intervention mechanism to check the spread of the disease.

As in many African countries, care and support of PLWHA and PABA was not included in many interventions at the earliest stage of the epidemic in Nigeira. As the impact of the epidemic became clearer and programme implementers began to realize the need to synchronize care and support with prevention efforts in order to curtail the human wreckage attributable to the epidemic, coupled with various agitations of some PLWHA and care advocates, many stakeholders started including care and support activities in their programmes.

This paradigm shift was justified in that on humanitarian and human rights grounds, it is necessary to treat the over 3.5 million people already infected with HIV in Nigeria, the vast majority of whom will die without it. The treatment is necessary to optimize prevention efforts by increasing incentives for people to take the HIV test, reducing social stigmatization, lowering viral load in infected individuals thereby reducing the likelihood that they will transmit HIV infection to others, and increasing visibility of PLWHA and PABA. Treatment is necessary for continuing economic development, and to save the children and build the fabric of society by reducing OVC, street children, and consequently, poverty, malnutrition and increasing vulnerability of OVC and PABA.

Without treatment, millions of adults in the prime of their working lives will die of AIDS and take with them the skills and knowledge base that are necessary for human and economic development. With these reasons, it became imperative that the goal of simply preventing new HIV infections without simultaneously offering treatment to prolong the lives of those already infected has proved insufficient to appreciably reverse the trend.

Care and support programme usually includes voluntary counselling and testing services, prevention and treatment of opportunistic infections, prevention and treatment of HIV-related illnesses, including palliative care and anti-retroviral therapy. Other important aspects of care and support include prevention and treatment of STIs, prevention of further HIV transmission, promotion of reproductive health and family planning, nutritional support, psycho-social and spiritual support, human rights protection, home-based care, and protection from social prejudices such as discrimination and stigmatization. Other important components of care and support include OVC interventions and PMTCT.

Successful advocacy for the commencement and scaling-up of care and support activities in resource-poor countries in the developing parts of the world is perhaps the most important achievement of the fight against HIV and AIDS in recent times. The integration of care and support programmes at different levels of interventions in Nigeria is a testimonial to the

compliance of the policy makers and programme implementers with these declarations (see Appendix 4.5).

Programmes and Strategies for Care and Support of PLWHA and PABA

In order to achieve a holistic care and support package in the country, different stakeholders have adopted various strategies and programmes that were multi-sectorally formulated.

Through the National Action Committee on AIDS, the federal government has outlined some strategies and activities on care and support of PLWHA in Nigeria. In the same manner, the SACA, LACA and other levels of intervention in the country also use the HIV and AIDS Emergency Action Plan. The strategic plan for care and support for persons infected with HIV and AIDS include activities such as reviewing and upgrading existing guidelines on counselling, community home-based care, AIDS case management, production and dissemination of guidelines to facilitate home-based care providers, training of health care providers on patient management and counselling in 18 states (at zonal level), training of health care providers per community on community home-based care approaches, establishing home-based care programmes in all the local government areas of the selected 18 states to provide support for positive people and NEPWHAN.

The activities also include providing technical support, supervision and basic supplies, e.g., disinfectants, gloves, palliative drugs, mild antibiotics, dressing materials, CHBC first aid kits and tranquilizers for home-based care providers in the communities, building the capacity of NEPWHAN, supporting at least two credible micro-credit NGOs in six hot spot states and six non-hot spot states to develop and implement micro-credit scheme for PLWHA, training PLWHA as counsellors, piloting community-based drug-revolving scheme in six hot spots and six non-hot spots, enhancing sensitization of human rights advocacy groups on stigmatization and access to health care, and reviewing, developing and extending an integrated TB/HIV clinical management curriculum for pre- and in-service training.

Other activities include adapting training manuals for specific cadres, training laboratory workers, strengthening management capacity of NTLCP, formulating state DOTS expansion plans, implementing DOTS programme, establishing formal collaboration between stakeholders on HIV and AIDS and TB, including HIV and AIDS and TB plans in the National Health Sector Strategic plan, developing terms of reference for monitoring of the HIV/TB programme implementation and performance at all levels, piloting acceptability and feasibility of VCT to all patients with TB, and strengthening TB care as part of counsellor training.

Others are conducting operational research on feasibility of Isoniazid and Cotrimoxazole preventive treatment, surveying, designing, implementing and reporting situation analysis on AIDS orphans, widows and guardians, facilitating national strategy development on

Voluntary counselling and testing (VCT) has helped in the prevention and treatment of opportunistic infections.

The relegation of care and support programmes of PLWHA and PABA put all other interventions at a precarious risk of failure, thereby exposing the country to the possibility of a worse pandemic that may be potentially uncontrollable.

care and support for AIDS orphans, developing criteria for identification and selection of affected families, facilitating skills/entrepreneurial building training in hot spot areas for affected families, establishing pilot micro-credit programmes for the families trained under the skills building programme, promoting and supporting NGOs to replicate the skill building, developing and implementing a welfare fund to offset the cost of school attendance for 200 AIDS orphans per state in six states, developing IEC materials on care and support, and facilitating strategy development fund availability for care and support activities for PLWHA and PABA.

Elements of basic care and support activities that programme implementers currently undertake include:

(i) Voluntary counselling and testing (VCT). This process enables an individual to undergo a change in behaviour in order to make an informed choice about being tested for HIV. This decision must entirely be the choice of the individual who must be assured of the confidentiality of the process. It helps people to determine their sero-status and understand their situation with respect to HIV and AIDS more clearly; identify a range of options for improving the situation; make choices which fit their values, feelings and needs; make their own decisions and act on them; cope better with problems associated with HIV and AIDS; develop life skills such as being able to talk and live positively with HIV and AIDS; and provide support for others whilst preserving their own strength.

HIV voluntary counselling and testing has been shown to have a role in both prevention and care for people with HIV infection as an entry point to care and support. It provides people with an opportunity to learn and accept their HIV sero-status in a confidential environment with counselling and referral for ongoing emotional support and medical care. People who are HIV positive can benefit from earlier appropriate medical care and interventions to treat and /or prevent HIV-associated illnesses.

The support provided by the Ford Foundation to AIDS Alliance in Nigeria to provide care and support, including voluntary counselling, has yielded significant results. It has brought about visibility of PLWHA, who no longer deny the existence of the epidemic in the country. Also, through the support of UNDP, it has been possible to train and build the capacity of co-ordinators of support groups on VCCT, community home-based care, etc, and increase public participation in activities.

In addition, VCT has helped in the prevention and treatment of opportunistic infections (OIs). PLWHAs are at the mercy of a number of opportunistic infections and other medical problems because of the immuno-deficiency resulting from HIV impact on the immune cells. However, this does not mean that they will actually experience all of the OIs. Some common OIs in Nigeria include tuberculosis, candidiasis and herpes infections. Interventions that prevent the occurrence of opportunistic infections can result in significant gains in life expectancy and quality of life of PLWHA.

HIV-infected people are more susceptible to acquiring TB, and recent studies have shown that active TB can cause progression of HIV disease. HIV-related immune system depression speeds up the onset of disease in people newly infected with TB, and causes the reactivation of previously infected people. There are high and increasing levels of HIV/TB co-infection in Nigeria. There is also a high mortality rate associated with HIV and AIDS co-infection, with TB being the main cause of death in people who are HIV-positive.

(ii) Prevention and treatment of HIV-related illnesses: The quality of prevention and treatment of HIV-related illnesses remains low in most parts of Nigeria despite increased efforts and expenditures on it. Cost is probably the greatest hurdle: most PLWHA cannot afford to pay for their own health care. Access to treatment has emerged as the most significant issue affecting PLWHA. But this is broader than just provision of anti-retrovirals; the patients need psychological support and practical assistance;

(iii) Regular supply of appropriate, good quality and affordable drugs, including anti-retrovirals. Anti-retrovirals (ARVs) are drugs used to combat the HIV by reducing the viral load (amount of the virus) in a person's body. ARVs do not cure HIV, they only reduce its effects and prolong life. There are three broad types of ARV drugs (see Appendix 4.6). The federal government, through the Federal Ministry of Health, has started an ARV programme at subsidized rates in 25 centres across the country (see Appendix 4.7), and plan to scale-up the programme in future;

(iv) Provision of

- basic commodities, e.g., syringes and condoms;
- effective referral systems, e.g., between the health care facility and AIDS Service Organizations;
- basic medical infrastructure, including laboratories and pharmacies;
- psychosocial services;
- basic needs, including food (see Box 4. 5), water and shelter;
- a social environment that is devoid of discrimination and stigmatization;
- accurate, up-to-date and accessible information about treatment;
- appropriate and positive attitudes among treatment providers and receivers;
- supportive policy environment at local, national and global levels.
- accessible legislative systems to advocate for change;
- appropriate technical, organizational and people skills.

Community and Family Involvement in Care and Support

Community involvement in care and support activities in Nigeria is still largely done through CSOs, including some faith-based organizations and support groups of PLWHA.

Many *caregivers*, including health care workers, counsellors, relations, and support-group members, understand the importance of ongoing counselling and interactions with PLWHA. This is necessary in view of the deprivation and violation that PLWHA may face as a result

ARVs do not cure HIV, they only reduce its effects and proplong life.

BOX 4. 4

Relationship between HIV and TB

Tuberculosis (TB) continues to be one of the most important global public health threats. The World Health Organization (WHO) estimates that the incidence of TB increased by 5 per cent between 1997 and 1999, from 8 million to 8.4 million new cases. African countries severely affected by the HIV epidemic experienced a 20 per cent increase in the incidence of TB; this rise is largely responsible for the TB increase globally.

TB was considered on the brink of elimination in the developed world until the late 1980s, when new HIV-related TB cases and multi-drug-resistant tuberculosis (MDR-TB) surfaced. In developing countries, however, TB has remained an important public health problem, exacerbated in the last decade by poverty, demographic changes and the rapid spread of HIV. Most TB patients in high HIV-prevalent countries are HIV-infected.

The relationship between TB and HIV has been recognized since the early days of the HIV epidemic. Today HIV is known to be an important risk factor, contributing to the development of active TB from latent TB infection. A person co-infected with TB (positive PPD skin test) and HIV faces a 5-16 per cent annual risk of developing active TB disease. HIV also makes individuals with a recent TB infection more likely to progress rapidly to active TB disease. WHO estimates that more than 10 million people worldwide live co-infected with TB and HIV, over two-thirds of whom are in Sub-Saharan Africa.

HIV is not only fuelling the TB epidemic but also making TB control more challenging. The increase in new TB cases is likely to contribute to the overcrowding of health care facilities, and draining human and financial resources from already under-funded health services. This over-crowding could prevent new infectious TB patients from seeking medical care, thereby contributing to lower case detection rates and risking further spread of TB into the community. Over-crowded health facilities will also increase the workload of health care workers, which may result in inferior case detection and treatment monitoring.

of their HIV positive sero-status. This form of psycho-social support, best provided within the family and community structures, is aimed at helping PLWHA fully regain their morale, courage and desire to live. Social support cuts across provision of basic needs of life such as food, housing and clothing, which many PLWHA may lack or have lost as result of their HIV-positive status, and home and community can be effective in providing this.

Many *religious organizations* have been involved in providing counselling as well as material needs and other forms of succour to their members and other people infected or affected by HIV and AIDS. Their involvement is crucial because the religious gatherings usually represent a captive audience where basic information on prevention, care and support as well as group counselling can be passed across to a large number of people. Also, many religious gatherings have the financial capabilities to assist PLWHA in the various forms of care and support they may require. However, a certain level of denial, discrimination, condemnation, faith-based invulnerability and fatalism are still reported in some areas.

Nutritional support, both in the quantity and quality of food, has an important role in care and support of PLWHA. Although it is good to recommend a special diet for PLWHA, more emphasis should, however, be placed on tackling lack of food, a problem that many PLWHA still face as a result of poverty. Good nutrition is the only form of therapy that is available to most people.

Home-based care. This has become necessary because of the large number of PLWHA. It has been said that if all PLWHA are to be admitted to the hospitals, there will be no bed left for other categories of patients. This emphasizes the need to develop the home-based care system to provide some forms of care to PLWHA in their homes. The support groups of PLWHA, civil society organizations, community-based organizations or hospital-instituted schemes with effective collaboration with the family and community structures can do this effectively.

Protection from social prejudices and human rights abuse. As a result of the serious negative consequences that social prejudices such as stigmatization, discrimination and vilification have on HIV and AIDS prevention and care and support, this subject has perhaps attracted more attention than any other subject on HIV and AIDS.

Discrimination occurs when a distinction is made against PLWHA that results in their being treated unfairly and unjustly on the basis of their HIV positive status. HIV and AIDS-related stigma often leads to HIV and AIDS discrimination, which in turn leads to the violation of human right of PLWHA and PABA.

Globally, different stakeholders are countering stigmatization, discrimination and human rights violations of PLWHA and PABA in their HIV and AIDS intervention activities with the help of family and community structures to reduce these social prejudices and their consequences.

Prevention of mother-to-child transmission and orphans and vulnerable children (OVC) care. Mother-to-child

transmission of HIV has become a significant route of HIV spread in Nigeria as well as other developing countries. Between one in three and one in four babies born to HIV positive women are born with HIV themselves. As a result of this PMTCT has become a major component of both prevention and care and support programmes on HIV and AIDS. PMTCT should include high-quality antenatal care for mothers, follow-up for HIV-positive women, and helping HIV-negative women avoid risk of infection. The introduction of PMTCT services has rekindled interest in the importance of high-quality care, however most ANC centres in Nigeria are yet to be fully equipped with materials and personnel skill, for this challenge. Also, a referral system is yet to be fully developed.

Promoting HIV prevention in uninfected mothers is critical because infections still do occur commonly after the initial sero-negative HIV test, as most programmes tend not to focus on that group. Generally, PMTCT is achieved in three ways, namely, by:

- preventing the mother from being infected;
- ensuring that women have the right and are enabled to choose whether or not they wish to have children; and
- reducing the risk of passing on the infection from mother to child: if the mother is infected during late pregnancy (by using ARVs to prevent the baby from becoming infected); during labour/delivery by modifying obstetric practices to reduce risk of passing on the infection, such as avoiding premature rupture of membranes, avoiding unnecessary use of instruments, and planned Caesarean sections when these can be done safely; and avoiding breastfeeding where feasible, by providing safe, sustainable and acceptable alternatives to breastfeeding, so that babies who are not infected at birth will not be infected through breastfeeding.

BOX 4. 5

The Golden Rules of Healthy Eating for PLWHA

Eat **whole** (unrefined) foods.
Eat **natural** (unprocessed) foods.
Eat indigenous (not imported) foods and foods that are **in season** (fresh foods that have not been stored for a long time).
Drink **clean** water (boiled for ten minutes or filtered).
Eat **little** and **often**— five times daily (every three hours). This applies especially to people with appetite loss or weight loss.

A healthy plate must look like this:

Whole grain (50 per cent) — Grains should be whole, even if ground for thick porridge. For example, sorghum, millet, whole ground maize, whole wheat bread made from whole-wheat flour, brown (unpolished) rice, barley, oat porridge, brekweet, or maltabella.

Vegetables (30 per cent) — Combine yellow (pumpkin, butternut, carrots, and sweet potato) with white (onions, leeks, cabbage, cauliflower) and green vegetables (spinach, rape, broccoli, okra, pumpkin leaves). Eat lots of vegetables every day.

Pulses (15 per cent) — Pulses should make up the majority of protein in the diet: lentils, peas, nuts, dry beans, peanut butter, chickpeas, beans, and soya (soya mince or TVP). Soya and round nuts are “perfect proteins”. Just like meat, all the others must be combined with whole grains to make 100 per cent protein.

Side dish (5 per cent) —This group should make up no more than 5 per cent of the total amount eaten. It includes:

- *Fruits:* eat when fresh and when in season. Avocados, tomatoes and peppers are also in this group.
- *Meat:* little or no meat is recommended. Fish and chicken are best. If meat is desired, eat liver, kidney or heart, as they are high in iron.
- *Dairy:* milk; cheese milk products should be eaten very sparingly. Don’t eat any dairy at all when you have diarrhoea, except yoghurt and lacto, which are good at all times. Eggs are good occasionally.

Foods to avoid

- Sugar and all foods containing sugar. This includes cool drinks, cakes, sweets and cookies.
- Tinned, processed and refined foods.
- Strong tea and coffee. Herbal tea, bush tea and decaffeinated coffee can be good substitutes.
- Alcohol and tobacco.
- Red meat and pork: liver and kidney are best if you crave red meat.

Cooking oil − except olive oil or cold pressed oils. Heating oil to cook with it destroys any goodness. Use it for salads only. Fats (dairy products) should be used sparingly and not at all when you have diarrhoea.

PLWHA have medical needs, psychological needs, socio-economic needs, and human rights and legal needs.

Orphans and Vulnerable Children (OVC) also require adequate attention in order to reduce the impact of the epidemic on them and also reduce their susceptibility and vulnerability to HIV and AIDS. The growing HIV and AIDS epidemic in Nigeria has rendered almost 1 million children orphans, thereby increasing the burden of the epidemic on the country (see Appendix 4.8).

Family support and community involvement in care and support of PLWHA and PABA are still at the lowest level in most parts of the country. Only a few families accept a PLWHA with a sense of responsibility for their care, especially if they still have a dependant status in the family.

Through family and community support, coupled with well-organized home-based care programmes, provision of basic materials to the most needy PLWHA and PABA can be met. Also, economic support through skill acquisition, training and financing income-generating activities can be provided as part of C&S programmes for PLWHA and PABA.

The needs of PLWHA and their families can be categorized into four interrelated domains: *medical needs*, such as information and treatment; *psychological needs*, such as emotional support; *socio-economic needs*, such as welfare provisions, help in the household, and orphan support; and *human rights and legal needs*, including access to care and protection against violence and discrimination.

Other challenges to community involvement at different levels across the country, are inadequate mobilization and capacity building by the relevant stakeholders to stimulate and facilitate the communities to respond to the challenges of the epidemic, inadequate information on specific roles for the communities, and lack of organized and willing leadership in many places.

The presence and proliferation of CSOs and CBOs in the country, the involvement of most Nigerians in one religious activity or the other, increasing establishment of support groups, and the LACA structures, coupled with the increasing dispossession of the members of the public of socially prejudicial behaviours against PLWHA, all provide windows of opportunities for scaling up C&S activities at the home and community levels in the country.

Workplace Policies on HIV and AIDS

In Nigeria, various stakeholders including as the Federal Ministry of Labour and Productivity, ILO, AED, NLC and other trade unions are working on preventing HIV and AIDS spread as well as mitigating its impact in the workplace.

The following are among the key recommendations of the International Labour Organization (ILO) in this regard:

- *Workplace policy*. In consultation with workers and their representatives, employers should develop and implement an appropriate policy for their workplace. The policy should be designed to prevent the spread of the infection and protect all workers from discrimination related to the disease;
- *National, sectoral/enterprise agreements*. Employers should adhere to national law practice in relation to negotiating terms and conditions of employment about HIV and AIDS

issues with workers and their representatives, and endeavour to include provisions on HIV and AIDS protection and prevention in national, sectoral and workplace/enterprise agreement;

- *Education and training*. In consultation with workers and their representatives, employers and their organization should initiate and support programmes at their workplaces to inform, educate and train workers about HIV and AIDS prevention, care and support and the enterprise's policy on HIV and AIDS, including measures to reduce discrimination against people infected or affected by HIV and AIDS and specific staff benefits and entitlements;
- *Reasonable accommodation*. Employers, in consultation with the worker(s) and their representatives, should take measures to reasonably accommodate the worker(s) with HIV-related illnesses. These could include rearrangement of working time, special equipment, opportunities for rest breaks, time off for medical appointments, flexible sick leave, part-time work and return to work arrangements; and
- *International partnerships*. Employers and their organizations should contribute appropriately to international partnerships in the fight against HIV and AIDS.

Following these recommendations of the ILO, the Nigerian government has formulated its own National Policy and Programmes on HIV and AIDS in the Workplace. The key elements of the policy are as follows.

Policies

Sectoral HIV and AIDS workplace policy

The Federal Ministry of Labour and Productivity in collaboration with the most representative employers and workers associations shall ensure that HIV and AIDS Workplace Policies are put in place in all workplaces in Nigeria. The Policy shall define the position of the enterprise in relation to HIV and AIDS and provide the basis for HIV and AIDS prevention care/support and solidarity with HIV and AIDS persons in the workplace and around the community of the enterprise.

HIV prevention

HIV infection is preventable through adjustment in sexual behaviour, education/information, treatment and elimination of stigma and discrimination against HIV persons. The workplace provides an excellent opportunity and environment for HIV prevention.

Prevention and control of the spread of HIV and AIDS through education and information. Effective workplace HIV and AIDS prevention, education should be provided to all persons in the workplace to enhance the capacity of workers to protect themselves and their families against HIV infection. Workplace HIV and AIDS prevention education should address all other issues, such as stigma, discrimination, care and support for infected and affected persons, raised by HIV and AIDS at the workplace and, where reasonably practicable, in the surrounding community. HIV and AIDS education programmes should to the extent possible be developed in collaboration with employers and workers representatives.

The contents of HIV and AIDS information and education should

HIV infection is preventable through adjustment in sexual behaviour. The workplace provides an excellent opportunity and environment for HIV prevention.

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be cultural-, sex-, age-, and gender-sensitive to enlist the fullest participation of all persons in and around the workplace. To the extent possible, consideration should be given to implementing educational programmes during paid working hours and integrating HIV and AIDS prevention and education into the curriculum of the normal workplace capacity development programmes.

Key programmes/activities

Information/education. Training of personnel; occupational safety and health protection; training in compulsory use of personal protective equipment in all workplaces; training in fitting and compulsory use of seat belts in all vehicles; compulsory use of helmets for motorcycle riders; prohibition of substance abuse; access to disposable syringes and needles; and access to high quality condoms and femidoms in free, simple and discreet manner and should be given with instruction on their correct usage.

Others include *re-organization of work pattern and conservation of the family.* The peculiar work arrangement of employees in isolated work locations, confined areas, and work away from home, including long distance drivers, should be factored into the HIV prevention programme. To the extent practicable, work patterns should be organized to preserve family cohesion and minimize working away from spouse. Housing and accommodation arrangements, which place spouses in separated housing location, should be discouraged.

Care and support. As part of the comprehensive care support and solidarity with workers infected and affected by HIV and AIDS, voluntary counselling shall be provided at no cost to the employee and should include post-test, nutritional, ARV, and other relevant forms of counselling where relevant.

Training in HIV and AIDS care, counselling and support provided by the Federal Ministry of Labour HIV and AIDS Response, Federal Ministry of Health and other recognized training organizations. Voluntary anonymous testing with pre-test and post-test counselling should be made available to all employees and their families.

Protection of the right of job seekers and employment prospects. The only medical criterion for entry to employment is fitness to work; HIV infection does not in itself constitute a lack of fitness to work and nothing in the pre-employment examination should be considered as obliging any candidate to declare his or her HIV status. HIV screening should not be required for job recruitment; and where AIDS is clinically suspected HIV testing can only be carried out with the specific and informed consent of the candidate. For job placement in a country (outside Nigeria), which requires HIV testing for placement and residence, the requirement must appear in the vacancy announcement or advertisement for appropriate action by the Federal Ministry of Labour and Productivity and Ministry of Foreign Affairs.

Continuation of employment relationship

HIV infection or AIDS does not provide a basis for termination of employment relationship. Where fitness to work is compromised by

Box 4. 6: A Workplace Policy Best Practice in Nigeria: Unilever Nigeria Plc

Unilever Nigeria PLC is committed to providing a healthy and safe work environment for all employees in accordance with its SHE *policies and in compliance with current medical standards, public health regulations and international requirements as they relate to HIV and AIDS.*

The Company is concerned about the HIV and AIDS pandemic and its HIV and AIDS policy and programme are intended to ensure that staff have sufficient awareness of the causes, consequences and prevention of the disease to adequately protect themselves and others. Employees with HIV and AIDS shall also work freely in a non-discriminatory environment and will be assisted to seek appropriate medical help as currently available.

Policy Statement

Non-Discrimination

- The Company shall not discriminate against a qualified individual with HIV and AIDS with regards to job application, recruitment, advancement, training, compensation, discharge or other terms, conditions or privileges of employment.
- The Company shall accommodate employees with HIV and AIDS as with any other illness as long as they meet acceptable standards of performance and do not pose a health and safety threat to other employees.
- Release on medical grounds shall be managed in the same way for HIV and AIDS as for any other medical condition.

Protection

- The Company shall ensure that in its medical and other facilities, necessary precautions are taken to prevent the transmission or spread of HIV to other patients and medical staff.
- Staff travelling to areas where sterility of needles cannot be guaranteed and company designated hospitals are unavailable may be provided with sterile syringes and needles which shall be accounted for on their return.
- All medical waste and potentially infected materials shall be handled and disposed of in a safe and secure manner to contain the spread of the infection.
- Employees and dependants have a duty to endeavour to take all necessary precautions to avoid contracting HIV.

Testing

- Testing for HIV shall not be done as a condition for employment or routinely on staff.
- Screening shall be carried out with individual informed consent.
- Adequate pre- and post-test counselling shall be provided when tests are carried out.
- Tests shall be conducted in reliable centres with guaranteed quality assurance and positive test results shall be confirmed in an official test centres.
- Test results are confidential and shall not be disclosed to a third party without the prior consent of the patient.

Awareness

- The Company shall institute and sustain HIV and AIDS awareness and prevention campaigns by actively providing information and facilities to staff on the various aspects of HIV and AIDS with the aim of prevention and maximum containment of the spread of the disease.
- The Company shall offer regular programme of education about HIV and AIDS and shall provide formal prevention training sessions and access to informal educators and counsellors.
- Supervisors and Managers shall be adequately educated to ensure that the principles of the HIV and AIDS policy are adhered to.
- Counsellors shall be trained to provide education and support to employees, dependants and HIV and AIDS victims.
- Condoms are an effective barrier to sexually transmitted diseases and HIV transmission. The Company shall provide condoms for employees free in the rest rooms, clinics, etc.

Workplace Behaviour

The Company recognizes that HIV and AIDS is not transmitted through routine, casual personal contact under normal working conditions; therefore, there shall be no grounds for refusal to share a workplace with an HIV carrier. Co-workers shall be expected to maintain normal working relationships with any employee with HIV and AIDS and appropriate disciplinary action shall be considered in cases of such refusal.

- The Company shall make such reasonable adjustment in the workplace or process for employees with HIV and AIDS as are necessary to keep them in employment for as long as it is medically and functionally feasible.
- The Company shall be sensitive and responsive to co-workers, concerns and shall emphasize appropriate education of all employees.

Support

- Employees with HIV and AIDS shall continue to receive medical treatment and care in Company facilities and third party institutions.
- The Company shall offer counselling and support services to help employees and their families cope with social, emotional and other concerns associated with HIV and AIDS.
- The Company shall assist employees with HIV and AIDS to obtain proper medical care and supervision of their condition within the scope of its existing health policy.

Confidentiality

Strict confidentiality shall be maintained during testing and when medical, counselling and support services are extended to employees with HIV and AIDS and their families.

Where disclosure to non-medical staff is imperative, as in supervisions needing to modify workplace or process to accommodate an HIV and AIDS patient, it shall be with the prior informed consent of the employee.

Such consent is, however, not mandatory where there exists an overriding threat to the health of other employees, customers or the general public and the affected individual fails to comply with stipulated precautions/preventive measures.

Policy Review

This policy shall be subject to periodic annual reviews in keeping with developments in the understanding of the spread, behaviour, treatment and legislation on HIV and AIDS.

HIV and AIDS related-illness reasonable accommodation should be provided.

Protection from stigma and discrimination. There shall be no obligation placed on the employee to reveal his or her HIV and AIDS status to the employer. Workers infected by HIV and AIDS should be protected from stigmatization and discrimination by co-workers, union members, employers, clients, family members, health professionals and state officials/ establishments. Employees living with HIV and AIDS should not be denied statutory or social security benefits and occupationally related welfare schemes.

Health insurance coverage should be made available to employees regardless of HIV sero-status and no HIV test should be imposed as a condition for any health insurance scheme. Disagreement from work attributed to HIV sero-status shall be notified to the Federal Ministry of Labour and Productivity who shall take appropriate action in consultation with the Attorney General and Minister of Justice.

Sexually transmitted infections (STIs). There is a clear linkage between STIs and transmission of HIV. Tripartite social partners in collaboration with the Federal Ministry of Health and other relevant stakeholders shall provide access to effective treatment and management of STIs as a strategy to reduce HIV infection and transmission.

A changed trend

The active involvement of the ILO, US Labour Solidarity, AED (Smartwork) and the NLC, among others, in HIV and AIDS programmes have changed the trend in interventions in the workplace in the country. Many more firms are getting requisite information about HIV and AIDS across to their workforce and relations, and are also putting more far-reaching interventions and policies in place to deal with the epidemic.

Also there is a growing trend in collaboration between the private sector and the other sectors and policy makers on HIV and AIDS.

However, a lot of work is still required in sensitizing the majority of the workplaces that are still complacent to the challenges of the epidemic. This, of necessity, should include many government establishments that are yet to start HIV and AIDS programmes in their workplaces.

Commonly, poor health-seeking behaviour, poor information/ education, poor reporting system and poor social security for the labour force in the informal sector have been identified as challenges to HIV and AIDS interventions. Others include inadequate enlightenment of the work places management of their roles; low response and commitment from the top of the personnel; minimal to low budgeting; lack of health or HIV and AIDS policy; poor implementation of international conventions and national laws on employment and labour; human rights violations; and poor enforcement of occupational safety and health regulations (such as Universal Precautions For Health Care Providers). High mobility, indecent remuneration and inadequate welfare package for ill workers have all been seen as challenges to HIV

and AIDS interventions in the workplace.

Opportunities to explore in establishing and/or scaling up programmes in the workplace include existing networking among organizations and companies, existing social groups within the workplaces, corporate social responsibility plans of the organizations, existence of health care systems in many workplaces, training programmes, and presence of capable CSOs in the communities of the workplaces. See Appendix 4.9 for more information.

Workers and their organization

- *Information and education*. Workers and their organizations should use existing union structures and other structures and facilities to provide information on HIV and AIDS in the workplace, and develop educational materials and activities appropriate for workers' rights and benefits.
- *Training*. Worker's organizations should develop and carry out training course for their representatives on workplace issues raised by the epidemic, on appropriate responses, and on the general needs of people living with HIV and AIDS and their caregivers.
- *Vulnerability*. Workers and their organization should ensure that increase in the risk of infection for certain groups of workers are addressed in consultation with employers.

International partnership. Workers' organizations should build solidarity across national borders by using sectoral, regional and international groupings to highlight HIV and AIDS and the world of work, and to include it in worker' rights campaigns.

Networks for Care and Support

The rationale for networking

- The overriding rationale for networking is to improve the outcomes of programmes in response to HIV and AIDS, measured in terms of quantifiable reductions in the incidence of HIV, adequate care for persons living with HIV and AIDS and the mitigation of impacts on individuals, households and countries.
- By developing capacity, improving knowledge, providing technical support and sharing approaches and best practices, the networks have both enhanced HIV prevention efforts on the ground and influenced policy development at the regional and national levels.

Networks in Nigeria assist in building local technical capacity and national and regional advocacy, sharing of information, peer support and facilitating collective action. They create influential coalitions among programmes, giving them the critical mass needed to respond to HIV and AIDS at the global, regional and national levels. At the regional level, they help to address cross-border issues that may drive or be the result of the HIV and AIDS epidemic and at the local level, networks can be highly effective for sharing skills, information, resources and peer support.

Most importantly, networks can actually foster the development of new programmes and policies. Thus,

BOX 4. 7

Contributions of Networks to Care and Support Programmes

Networks and networking contribute to:

Capacity building

- Acting as a resource on different aspects of response to HIV and AIDS
- Strengthening the ability of local communities and programmes to respond to HIV and AIDS, thus reducing reliance on outside assistance
- Sharing global and regional expertise with partners at the country level.

Solidarity and advocacy

- Reducing isolation of members and providing support
- Strengthening responses in important but poorly addressed areas of HIV and AIDS.

Information sharing

- Promoting the exchange of ideas, insights, experience and skills
- Exchanging and documenting best practices from global, regional and national experience.

Resource mobilization

- Mobilizing and using financial resources for maximum impact.
- Providing of other types of resources

they can help to reduce a region's reliance on direct external assistance. This, in turn, builds capacity and enhances the network's functioning.

The Civil Society Consultative Group on HIV and AIDS in Nigeria (CiSCGHAN) is the umbrella organization for the NGOs, CBOs, FBOs and Support Groups of PLWHA that are involved in HIV and AIDS interventions in Nigeria. Broadly speaking, only a few of the CSOs in the country are involved in different aspects of C&S such as voluntary counselling, advocacy for care and support, and access to drugs, national support, micro-credit programmes, OVC care and home-based care. Most CSOs in Nigeria still work in the area of prevention programmes, and there is poor decentralization of activities.

With the adoption of a multi-sectoral approach, significant opportunities now exist for the CBOs in the country through effective collaboration with the government, development partners and the private sectors. Also, better opportunities exist for the CSOs in the areas of funding technical assistance and capacity building for their programmes.

The Network of people living with HIV and AIDS in Nigeria (NEPWHAN) dates back to 1997. It became more organized and active with the emergence of the National Action Committee on AIDS in 1999. NEPWHAN facilitates the formation of support groups of PLWHA in the country, co-ordinates their activities, builds the capacity of the support groups, mobilizes resources for support groups, and advocates improved quality of life for PLWHA with respect to access to drugs, human rights protection and GIPA in relevant programmes.

Support groups are known to be useful in the control of HIV and AIDS epidemic impacts on PLWHA in many ways such as:

- Giving information and referral to members who need such;
- Campaigning against AIDS, counselling and advising members and the public;
- Helping in fund-raising for research and other services;
- Rendering public and professional services;
- Involving themselves in political and social activities that may be beneficial to the entire public;
- Providing ancillary health care services under professional guidance;
- Providing mutual supportive activities for their members; and
- Serving as a mechanism for affected individuals to overcome the stigma of AIDS

The number of support groups who are members of NEPWHAN is increasing steadily with the support of government and donor agencies (see Appendix 4.11). The support groups in Nigeria are actively involved in care and support as well as prevention activities in the country. The Network of People Living with HIV and AIDS in Nigeria still requires comprehensive capacity building and improved funding for it to be able to perform its functions effectively, especially in the areas of care and support, advocacy for drug access, anti-discrimination campaigns, and general public enlightenment on HIV transmission and prevention. Some of the organizations that have provided support to NEPWHAN

include NACA, UNDP, UNAIDS, Ford Foundation, FMOH, APIN, and Policy Project, to mention a few. NEPWHAN still requires an extensive membership drive across the country in other to encourage many PLWHA to join the network. The acceleration of national-level efforts to expand the response to the HIV and AIDS epidemic has resulted in a substantially increased demand for technical resources (both information and expertise) in a widening array of programme areas. At the same time, effective programme approaches are often specific to cultural, resource and political environments. Individual agencies have made, and continue to make, substantial contributions in specific areas of HIV prevention and care. But it is also increasingly evident that single institutions, whether government departments, UN agencies, non-governmental organizations (NGOs), or groups of people living with HIV and AIDS, do not have the capacity to deal with the multiple determinants of HIV on their own. The need to act is simultaneously and synergistically in a number of areas – such as targeted interventions, health services, communications, legal reform, education, rural development and the status of women – requires that a range of technical issues must be addressed at the same time. This has further increased the need within countries for access to current technical information and expertise.

Challenges

Some of the major challenges that are still being faced by networks in the country include building trust among members of the network, reaching consensus of opinions and ideas on programmes and policies, establishing a common focus, maintaining a unified voice, ensuring equity in benefit sharing amongst the constituency, establishing a generally acceptable code of conduct/guiding principles, assigning tasks and monitoring its implementation, and mobilizing resources for networking. At the individual support group level, the problems range from incompetent managerial capabilities to ineffective organizational structure, low interest in not-for-profit/charity work, poor programming skills, inadequate funding, and poor record keeping.

Conclusion

The national response to the spread of HIV and AIDS in the country has been evolutionary – from initial denial through half-hearted initiatives under the various military leaders to a pro-active response under President Obasanjo. The President chose to lead the fight personally through his Presidential Committee on AIDS (PCA), and established the National Council on AIDS (NACA) to ensure the multi-sector and multi-level participation. The latter effort led to the emergence of SACA in all the states and LACA in all the local governments of the federation.

To fulfill the multi-sectoral objective, NACA developed a National Policy on AIDS and backed it up with the development of HEAP, a programmatic framework for the national response whose twin components are creation of an enabling environment, and specific HIV and AIDS intervention. The document identified over 200 activities conceived as short-

term (2001-2004), high-impact interventions.

Among the achievements of the above measures are:

- sustained improvement in establishing and documenting the magnitude, trend and future projections of the HIV and AIDS/STDs epidemic, which serve as a formidable tool for advocacy and effective planning;
- high-level advocacy to policy-makers and opinion leaders which has resulted in the recent increase in political commitment and increased funding of the national response;
- acceptance of the reality and an increased level of awareness about the HIV and AIDS epidemic by the general population;
- more openness in discussing the disease in Nigeria;
- production of an Interim Action Plan (IAP) – HEAP, in collaboration with relevant sectors and stakeholders as a preparatory stage towards a comprehensive Strategic National Plan;
- significant mobilization of financial and technical resources from within and external sources;
- increased tempo of activities by local and foreign NGOs, resulting in substantial community-based innovative projects;
- broad-based consultative and participatory planning process and the increasing mainstreaming of HIV and AIDS into all facets of national life.

On resource mobilization, the commitment of President Obasanjo to the fight against AIDS has widened the partnership, and by implication, the resource base of the fight to a truly global level. In the absence of a National Health Account for HIV and AIDS, it has been estimated that Nigeria garnered over US$ 300 million to prosecute the war in the country. To demonstrate its commitment, government contributed about US$ 56 million from its own coffers. It is with this funding support that government was able to implement its HAART programme which placed some 15,000 PLWHA on ARV drugs at over 70 per cent subsidy rate.

Another aspect of the national response which was not given due attention in the past is care and support (C&S) for people infected or affected by HIV and AIDS. But because this has a telling effect on the economy – decreasing productivity, food insecurity, depleting skills, increased absenteeism, etc. – the stakeholders in Nigeria are becoming increasingly aware that the relegation of C&S of PLWHA and PABA will put all other interventions at a risk of failure. Hence stakeholders have recognized the need to use C&S to deal with DSD at home, in the public and in the workplace. Community and family support for C&S is still very low in Nigeria, hence the PLWHA have organized themselves into effective networks for mutual support with the backing of CSOs and the government which also fashioned a workplace policy in line with ILO recommendations.

Despite these efforts, however, the national response to HIV and AIDS still has many challenges to contend with. For instance, good as the HEAP document appears to be,

it is yet to be technically estimated and is thus left to the various actors to take on whatever they can. The document lacks a legal and institutional framework to operate; sectoral roles are poorly defined and co-ordinated, and there are policy gaps and contradictions needing to be addressed. For instance, in view PMTCT, what should be done with exclusive breastfeeding campaign, family planning, and antenatal and delivery services?

Also, there are major and immediate challenges to expand VCT, provide drugs and treatment, build infrastructure in response to the outcomes of VCT and other awareness programmes, provide safety nets for the poor, especially through access to drugs, nutrition, counselling follow-up and assistance to help orphans stay in school. As many as 300, 000 people die every year from AIDS-related diseases. If the programmes do not expand rapidly enough health personnel and facilities will be inadequate to cope.

It has been well documented that the resources available for the national response is inadequate. In 2002, the HEAP was grossly underfunded: against the US$ 190 million which the programme was estimated to cost in year 2000, it is suggested that Nigeria will require not less than US$ 500 million (Appendix 4.3). This is partly the result of over-dependence on foreign donors. State and local government hardly make allocations to fight the disease. Apart from the Federal Ministry of Health other ministries lack the capacity to prepare intervention programmes, hence their programmes have been in gestation for a long period; the police which has a very large at-risk population has no specific response programme and private sector commitment to the AIDS war is but recent. All these suggest that the war is still not being fought multi-sectorally.

Recommendations

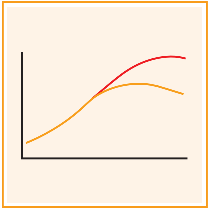
Undoubtedly, HIV and AIDS presents a major challenge to human development in Nigeria and the exact cost of the epidemic might be difficult to calculate. As the death toll increases, skills shortage in all sectors becomes apparent, wearing down the gains of economic growth and human development. AIDS is indeed devastating Nigerian communities, and poses a real threat to poverty reduction efforts and the achievement of the UN Millennium Development Goals (MDGs).

It is important that HIV and AIDS is now widely accepted as a development issue and not just a health issue. A sustained proactive multi-sectoral approach towards prevention and mitigation of its effects is necessary to stop and begin to reverse its impacts on human development in Nigeria. To achieve this, a number of measures have to be taken, among them the following:

- Much more financial, technical and political resources should be invested to ensure the effective and rapid implementation of the HEAP and sustain the effort to develop a National Strategic Plan.
- Access to HIV prevention interventions should be provided for all, along with appropriate care and support for persons infected and affected by AIDS.
- Affordable treatment options,

including access to generic ARV drugs, should be made available to all PLWHA. That is why it is strongly recommended that government should go into the manufacture ARV drugs.

- The commitment of stakeholders at all levels of government and all segments of the society should be sustained in order to achieve effective community mobilization and involvement in the prevention and management of HIV and AIDS control.
- The legal and policy frameworks relating to HIV and AIDS control should be harmonized.
- The social conditions of the people should be greatly improved to minimize vulnerability to high-risk behaviour.



Chapter Five

The Way Forward

Hitherto, in this discourse, our object has been to explain the overwhelming presence of HIV and AIDS in Nigeria, the reasons for such high prevalence and spread, and the national response to contain it. In this chapter, the aim is to indicate the way forward so that Nigeria can move fast and still the gathering storm.

As earlier discussed, Nigerians overwhelmingly denied the presence of HIV in the country until 1986 when the first case was reported. The implication is that Nigeria did not recognize the enemy when it came through the door. And now that the enemy has taken root, it is uprooting everything in the way. Unfortunately, after two decades of its onslaught in the country and with an official prevalence rate of 3.5 million, 1.5 million AIDS orphans and over 300,000 deaths annually, many Nigerians still doubt the presence of the epidemic and, thus, still continue with their high-risk behaviour. Naturally, having crossed the 5 per cent consequential benchmark in 1999, the epidemic is well on course into the explosive phase, with significantly increased probability of new infection resulting from every episode of sexual intercourse with an infected partner.

The population of infected Nigerians is projected to increase very significantly over the next 10 years from a low-scenario of about 4.85 million people (by 2005) to a high-scenario of about 8.0 million infected Nigerian by 2012! These figures under-score the in-built momentum of a disease burden of immense proportions, and does not include large numbers of Nigerians who would have died of AIDS during this period. It would appear that the worst of the epidemic is yet to come. Under the high-prevalence scenario, should HIV and AIDS prevalence rate reach 9 per cent by 2012, the cumulative number of deaths by that year would be as high as 6.95 million Nigerians! Even from the unlikely possibility of halting the spread of the disease, the in-built momentum of the 3.5 million infected Nigerians would assure that these many Nigerians

are certain to die from the disease, given the absence of a curative treatment. Consequently, in addition to continuing a vigorous preventive and awareness campaigns and interventions, there is equally a need to expand care and support interventions for those living with the disease and to mitigate the social and economic impacts on those affected by it.

What is the way forward, and how do we give hope to the millions of people who are torn apart by the reality of AIDS in their lives and those of their loved ones? From all that has been said in the previous chapters, the way forward consists in addressing six clear issues in the spirit of a national emergency which the epidemic deserves. These issues are:

- The policy environment
- Poverty
- Socio-economic and cultural traps
- The sociology of sexual networking in Nigeria
- Social re-engineering, and
- Exploring existing windows of opportunity

The Policy Environment

It has been acknowledged generally that the policy environment in the country has improved drastically since the advent of civilian regime of President Olusegun Obasanjo in May 1999. Before then, budgetary allocations to fight AIDS either did not exist or were among the poorest in the world. But with President Obasanjo personally leading the national challenge, the level of political commitment has heightened dramatically and this has made it possible to obtain over US$ 300 million from the donor community.

The federal government's commitment to the AIDS cause has resulted in a deluge of local and international partnerships, the development of a national policy on AIDS, as embodied in the HEAP document, the creation of an elaborate institutional framework at the three levels of government for preventive as well as care and support interventions.

Although the policy environment for AIDS and other STIs has kept on improving, it is still not sufficiently conducive any meaningful impact on the incidence and prevalence of the disease. The noticeable commitment at the federal level has not been matched at the state and local government level. Thus, while the federal authorities could contribute US$ 56 million from its own coffers to swell its receipts from the donor community, the other tiers had no budget for AIDS hence both SACA and LACA depend on the federal purse for 95 per cent of their resources.

Buoyed up with resources from donors, the federal authorities placed 10,000 adults and 5,000 children on ARV treatment, which is subsidized by over 70 per cent. At the estimated cost of N45, 000.00 per annum per patient, this is a heavy burden on government, however compares the 15,000 who are placed on life-supporting ARV under the HAART programme with the over 300,000 who die annually and the 1.5 million AIDS orphans, the whole impact is like a drop in the ocean. This calls for a more radical approach.

To improve the environment, a vigorous preventive awareness campaign should be mounted like never before. This should be so enriched with cases and statistics to compel a positive change in the behaviour of the target populations and the message should be disseminated consistently and sustainably to the remotest corner of the country. The policy environmental score conducted in 2002 shows that the weakest points in the AIDS campaign in Nigeria are legal/regulations, resources and programme components. It is not possible to arrest the spread of AIDS with these limitations.

The large presence of PLWHA in the country is enough for government to mobilize its strategic partners to begin immediate manufacture of AIDS treatment drugs in Nigeria. If the African Union is slow in deciding on this, Nigeria cannot afford to delay. Local manufacture of the drugs will bring the cost down considerably, facilitate unlimited access to them and create employment locally.

Also, care and support interventions should be expanded drastically in all the four areas of need – medical, psychological, socio-economic, and human rights and legal.

There is an urgent need to provide the present multi-sectoral approach to HIV and AIDS with an enduring legal and institutional framework through which to operate, with clearly specified sectoral roles and responsibilities. Statutory location of programming and service delivery should remain at or near the highest political structure, that is the Presidency and the offices of Governors and LGA Chairmen at the other tiers of government. Political support at the highest level of government gives high profile, visibility, as well as facilitates the implementation of programmes. The Uganda success story is based on this approach and Nigeria could embrace the example. It is necessary to expand the number of service-centres, including home-based care that actively supports PLWHA and orphans.

The National HIV and AIDS response needs to be continuously assessed, to provide all stakeholders with constant feedback on progress with implementation, by identifying actual or potential successes and problems so as to facilitate timely adjustment to implementation. An effective management information system with clear statements of measurable objectives should be established as an indispensable tool to assess and improve performance.

Everything should be done in the process of intervention to tackle the stigma that makes life an ordeal for PLWHA. The social stigmatization associated with HIV and AIDS remains a formidable barrier in Nigeria. Fear and discrimination prevent many people from disclosure or seeking to find out about their status, and hence continue to infect other people, unaware of their status. The challenge is to change attitudes in community and break the silence in order to encourage PLWHA to seek help. There is no gainsaying that success in tackling DSD will automatically promote VCT, which prevents 70 per cent of Nigerians from knowing (or wanting to know) their sero-status. If DSD were effectively tackled, a major breakthrough would have been

Therefore, for the war on AIDS to succeed, poverty must be the first target of attack. No war can succeed where people are hungry, malnourished, sickly, and patently insecure. The good thing, however, is that government has some control over the situation. It can switch public expenditure pattern and priorities in favour of poverty alleviation/eradication strategies. It can formulate specific women-empowerment schemes; it can target the youth,

recorded in the AIDS fight. It is now widely acknowledged that available regimes of medicines and treatment therapies would permit most HIV and AIDS positive individuals to live normal and productive lives.

Furthermore, the national HIV and AIDS response can only make sense within an overall national development framework, which is now defined as the National Economic Empowerment and Development Strategy – NEEDS. NEEDS aim to reduce poverty, generate employment and create wealth, through the transformation of the country into a sustainable modern, competitive and prosperous economy. Because of the consequences of HIV and AIDS for development, it is necessary to mainstream the national response into the NEEDS framework to ensure that the anticipated gains of NEEDS are not reversed by the looming devastation of the socio-economic consequences of HIV and AIDS for national development.

Poverty

The extreme poverty of Nigerians is one of the greatest hindrances in the fight against AIDS. Although the country is one of the most endowed in the world, yet a corrupt elite that maintains a stranglehold on political power has reduced its citizens to destitution. Consequently, Nigerians who ordinarily resent any form of slavery are only too eager now to go and slave in Western countries for hard currencies. Poverty is so deeply etched on the faces and in the psychology of the people that it can be truly regarded as the major underlying factor for the moral turpitude that other people so readily point to in Nigerians. In its full manifestation – material, moral, intellectual and psychological – poverty has created millions of professional prostitutes (CSWs) and circumstantial prostitutes who use unlikely places such as their stall, offices and student hostel.

Therefore, for the war on AIDS to succeed, poverty must be the first target of attack. No war can succeed where people are hungry, malnourished, sickly, and patently insecure. The good thing, however, is that government has some control over the situation. It can switch public expenditure pattern and priorities in favour of poverty alleviation/eradication strategies. It can formulate specific women-empowerment schemes; it can target the youth, give them hope, good education and jobs. If it plays the right music, the people will dance. A lot of money will be needed to do all these; but more than just money, there is need for creative invention of resources in government and the creative use of them. The pillars of public education, health care and other social services, which were pulled down a long while ago, have to be rebuilt for those sectors to play their natural role in arresting the march of HIV and AIDS.

Socio-Economic and Cultural Traps

All cultural practices that help the spread of HIV should be eschewed. Very dangerous practices, such as, polygamy, wife exchange among siblings, wife hospitality, cult prostitution, scarification, use of unsterilized sharp objects

and needles, etc., can be fought successfully with excellently packaged preventive awareness campaigns. To stop the spread of HIV resulting from unintended consequences of rapid urbanization and modernization requires new social planning of public institutions, policies, and urban development. The urban chaos that Nigerians are forced to endure is a product of their legendary planlessness. AIDS has created new challenges that cannot be managed with the same traditional approach that has been in use for so long.

Sociology of Sexual Networking

If, as research has borne out, 80 per cent of HIV infections is attributable to sexual intercourse, then this is the strongest point to deal with. Although, sex talk is culturally prohibited, its practice has continued nevertheless to dominate social relations. With the existing knowledge of sexual networking, all the contributory factors should be carefully analysed with a view to adjusting social policy to make people less vulnerable. A great deal of resources will be required to promote safe sex and other wholesome sexual practices among the general public and the high-risk population.

Social Re-Engineering

As HIV and AIDS has challenged the foundations of existing social order, it would take a complete social re-engineering to re-assess official policies, social norms and values. For instance, with 1.3 million Nigerian children living with HIV and AIDS, which they contracted from their mothers through breastfeeding or during childbirth, is it still necessary to insist on exclusive breastfeeding? Similarly, if the education and health sectors which traditionally play a most useful role in the total development of each individual have been allowed to deteriorate so badly, they cannot be looked up to for solutions in their present state. What this means is that we must re-plan and re-build the foundations of education, health care and other social services to make them bear the weight of new realities.

One of the reasons why unemployment is rampart in the country is because the knowledge acquired at every stage of the Nigerian education system is theoretical; it is very weak in practical knowledge and application. Moreover, the system thrives on the acquisition of certificates and academic learning rather than imparting essential skills that are needed in the job market. Most graduates do not fit into the labour market because there is a mismatch between the two. It is a systemic problem that has to be tackled by policy reformulation and planning. What is said of education is applicable to all other sectors of the economy. If people have good quality education they would stand on their own rather than remain on the queue for years, waiting for non-existent white-collar jobs.

In the social re-engineering plan such as is advocated here, special care must be taken to protect and empower women, the girl-child, and youths in general. The protection and empowerment should encompass statutory and

legal avenues to promote women education and advancement; it should include promotion of financial independence through entrepreneurship and leadership training and complete eradication of those cultural practices that reduce women to commodities to be purchased, abused and dispossessed of their fundamental rights. It is only when a woman has lost every sense of self-respect, direction and stability that she takes to commercial sex work. When the same happens to a man, he takes to crime and becomes a security risk. To avoid the greater risk of HIV spread to the yet uninfected, the re-engineering plan must eliminate the factors that make people vulnerable to infection.

Windows of Opportunity

There are existing windows of opportunity to explore as a way forward in the AIDS war. Even though mass poverty, inequality, dispossession of the vulnerable groups, and such other measures have seen Nigeria to the top of the world suffering index, Nigerians are about the most obedient people to the first law of nature – self-preservation. No matter how hellish things might be, Nigerians don't want to lose their lives for any reason. Another thing Nigerians fear more than death itself is to die with ignominy. To die of AIDS, in the Nigerian mentality, is to die with ignominy. That is why DSD is very common. The fear of dying with ignominy makes the average Nigerian to completely abandon an HIV carrier and treat him like a ghost.

The thing to do in this case is to convert this fear to advantage: The people don't want to die, and AIDS is sure death. The point, therefore, is to rub in the Pro-Life message in the preventive awareness campaign. The kind of campaign required is not the intermittent, selective radio and TV message. If we have the right understanding of the disaster coming, then it is not out of place for Nigeria to dominate the public discourse for the next two years with HIV and AIDS. The message should be beamed aloud to the remotest part of the country that AIDS is real, that it kills in millions, and that unless every individual takes a decisive step to prevent being infected, he will be one of the projected 9-15 million carriers of this disease which has no known cure. If this message goes on air it will get instant attention everywhere and if it is repeated every thirty minutes on all radio and TV stations across the land for two full years, Nigeria will save itself a lot of agony and unnecessary expenses. And it is quite possible. Virtually 95 per cent of the electronic media in Nigeria belong to government; even the independent press can be relied upon to give this cause the greatest support.

Also, given that the youth are the most vulnerable group, the intervention programmes must target them. The programmes must be properly packaged to influence students in the secondary schools and tertiary institutions, artisans in the various trades, the stream of sexually active unemployed people who constantly migrate in search of work. Other high-risk populations like women, young girls, CSWs/FSWs, etc., must be specifically targeted with creative preventive

and C&S programmes. Another layer of intervention for them is for the social planning system to expand avenues for work, recreation, further education, etc.

The large network of CBOs, NGOs and CSOs offer another veritable window of opportunity that should be maximized. Reports indicate that the 500 officially registered groups are not representative of the absolute number and that they are unevenly distributed across the states. All stakeholders (including the government) should ensure that the whole country is effectively covered in the number and diversity of intervention. The capacity of the support groups should be built to achieve the goal of the intervention.

Additionally, the public-private partnership should be solidified. The private sector should be encouraged to play a more active role in the fight against AIDS given its potential to mobilize abundant human, technical and financial resources. The sector should establish its own workplace programmes for HIV and AIDS, to include advocacy, counselling, access and support for treatment, and bereavement assistance to staff affected by AIDS-related deaths. Given the financial constraints and the non-availability of certain expertise in government, it is desirable to establish a formal, mutually-beneficial, business arrangement of long-term nature, between the government institutions, and private partners involving shared rewards and risks and share governance and accountability as an important component in mobilizing resources for the national response.

An example is the establishment of HIV and AIDS treatment centres that would provide low cost clinical and pharmaceutical care, service and treatment. This would further ensure that those in need of medications obtain them so that HIV and AIDS pharmaceutical integrity.

The partnership must be all-embracing; LACA, SACA, state and local governments and all CSOs must play their part alongside the federal government and the private sector. The existing political commitment should translate to positive results; for it to be meaningful. This is one war Nigeria cannot win by throwing money at it. But with deft management of donor assistance, excellent co-ordination of programme execution and special care and empowerment of the vulnerable groups, Nigeria can and will stop the clock of AIDS and turn the tide against it in the country.