

HIV/AIDS in Nigeria

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Nigeria is Africa's most populous nation with a population estimated at well over 120million in 2002. The adult HIV prevalence has increased from 1.8% in 1991 to 4.5% in 1996 to 5.8% in 2001. Estimates indicate that more than 3.5 million Nigerians were living with the virus in 2002. The epidemic in Nigeria has extended beyond the commonly classified "high-risk groups" and has now entered the generalized phase. With the adult prevalence rate at 5.8 percent in 2001, the nation is now threatened by an exponential and explosive growth of the epidemic.



Factors Underlying the Spread of HIV in Nigeria

In Nigeria, the underlying factors constituting the leading driving forces for the spread of the HIV infection include low level of education and high level of ignorance, cultural practices such as polygyny and wife-hospitality, high level and crippling effect of poverty and lack of access to appropriate reproductive health services and information particularly for young people. The practice and use of traditional medicine is also an important socio-cultural factor in this respect, as practice of traditional surgery such as uvulectomy and blood-letting procedures with unsterilised instruments, non-observance of infection control procedures by traditional birth attendants who are still heavily patronized in Nigeria may all result in HIV transmission.

Ignorance: In Nigeria the level of awareness of HIV/AIDS has steadily but slowly increased among the general population. The 1999 NDHS indicated that 90 per cent of men, but only 74 per cent of women above the age of 15 years have ever heard of AIDS. The awareness is highest among 20 to 24 years old (93.8 per cent) with a slight urban/rural variation of 95.3 to 89.6 per cent. The knowledge varies widely between the zones, with the lowest level recorded in the North West where less than 50 per cent of women are aware of the disease (Figure 9.8). As Figure 9.9 shows, knowledge about ways of preventing AIDS is generally low. Keeping to one partner was mentioned by 52 per cent of women and 43 per cent of men, while 15 per cent and 25 per cent of women and men respectively mentioned abstinence from sex. Only 29.9 per cent of respondents mentioned the use of condoms in this regard. Overall, 26 per cent of women and 14 per cent of men indicated that they did not know any way of avoiding AIDS. Adolescents, in the 15 to 19 age group showed less knowledge of HIV prevention compared to older people.

Cultural factors: whereas some cultural values are highly desirable and beneficial to AIDS prevention and control, some are detrimental and further compound the situation. In Nigeria, some of the positive cultural factors include the promotion of the preservation of virginity and chastity before marriage, mutual fidelity within marriage and the extended family safety net systems.

On the other hand, some cultural practices tolerate or even enhance the transmission of HIV. The traditional stance that views discussion on sexuality or reproductive health issues as a taboo exposes young people to considerable risks based on ignorance and misinformation by peers. Traditional practices that exist in certain communities such as wife inheritance and offering the wife to a visitor as part of hospitality have grave implications for increased HIV transmission. Culturally-based gender discrimination that promotes female subjugation and low status of women reduce the negotiation and assertiveness skills of women with regards to sexual activities and adoption of safer sex practices. Lower level of education of females increases the possibility of ignorance about HIV and its prevention and thus put them at greater risk of being infected.

Fear and stigmatization of people living with HIV: Stigmatization and neglect of PLWH discourage open disclosure about one's status. Thus, affected people, particularly at the early phases of their infection hide their identities and may still be engaging in sexual practices with others. Fear also prevents many from undertaking

voluntary testing to detect their sero-positivity status. Thus, infected people, unaware of their status, may be spreading the disease to other through sexual contacts.

Social and Economic Conditions: Poverty has the potential of increasing the risk of HIV as economically disadvantaged people may and do engage in commercial sex work for survival. Poor people also have less access to education, thereby being rendered more ignorant about diseases, and may be less able or willing to pay for condoms. The large-scale and sudden movement of civil servants to the new Federal Capital Territory, Abuja, without adequate attention to their accommodation led to separation of couples; co-habitation of sexes and the formation of new relationship and sexual networking. In all the tertiary institutions, even in the high schools, the girls have resorted to generational relationships for survival while the men continue to take advantage of the situation.

Key challenges to effective HIV/AIDS control efforts in Nigeria, at present, include the following:

- Ensuring political willingness at all levels and adequate funding of the programme on a continuous basis
- Strengthened policy formulation to involve relevant stakeholders, including states and CSOs. Among others, existing gaps and contradictions in the policy realm need to be addressed. These include the development of clear regulatory frame work and mechanism in relation to announcement and verification of RIV cures. and reviewing the breastfeeding policy to ensure its continued appropriateness in an age of spreading HIV/AIDS
- Monitoring media outputs to ensure that, despite their commercialization, they do not become instruments for misinformation of the public about the nature and claims about HI V/AIDS cure, as well as ensuring that prevention messages are culturally appropriate and sensitive
- Effective and transparent programme management at various levels of government
- Continued information, education, and communication to sustain and improve level of awareness of HIV/AIDS
- Ensuring continued regular availability of modern family planning commodities, in public sector facilities and other outlets
- Active promotion of appropriate reproductive health information to young people in Nigeria through both in-school and out-of-school programmes including curricula (population and family life education) approaches, and in creasing access to adolescent-friendly health services, including counseling and clinical services
- Adequately addressing the various driving forces of the HIV/AIDS epidemics in Nigeria, including poverty and provision of housing for civil servants
- The response, while having focused a lot on prevention, had done very little for people living with HIV/AIDS (PLWA) and people affected with HIV/AIDS (PABA)
- Increasing access to voluntary HIV counseling and testing geographically, culturally and economically
- Providing appropriate support and care for PLWAs and PABA, including counseling and legal support for the enforcement of their human rights and access to good quality health care including retro-viral drugs
- Prevention of MTCT through proper education of the populace and health workers, and availability of retro-viral drugs and nutritional substitutes and supplements for babies of PLWAs under appropriate policy
- Ensuring adequate coordination of a multi-level and multi-sectoral programme within the Nigerian environment

The table below summarizes in general, the HIV/AIDS control efforts in Nigeria.

Year	Key Event
1986 - 92	The era of Denial and Tentative Actions
1986	Official reporting of the first two cases of HIV AIDS Establishment of Expert
1986	Advisory Committee on AIDS (NEACA)
1987	Technical Service Agreement (TSA) signed with WHO under the Global Programme on AIDS (now defunct and succeeded by UNAIDS).
1988	National AIDS Control Program NACP set up as national coordination/implementation unit within the FMOH, and replaced NEACA
1988	National AIDS Committee (NAC) and five Technical Advisory Committees (TACs) established as advisory bodies to the NACP.
1988	States AIDS Control Programs (SACPs) and the States AIDS Committees established in all States of the Federation and Federal Capital Territory Abuja.
1988/ 1989	Implementation of the Short Term Plan, which focused mainly on Blood Safety and General Awareness.
1990 to 1992	Medium Term Plan I, Focused on decentralisation of implementation of control efforts to LGAs AIDS integrated into PHC system Merging of AIDS Control Programme with STDs Control Programme to create the National AIDS and STD Control Programme (NASCP) Military President launched National War Against AIDS (1991) CSOs' involvement in control programme commenced 1 st HIV Sentinel Survey conducted (1991). Nigeria initiated an OAU agenda on AIDS (1992).
1993 - 98	The Era of Increased Awareness
1993 to 1998	Medium Term Plan II, focused on Multi-sector involvement and increased Awareness Inadequate funding of response and withdrawal of International Donor support due to sanctions on Nigeria Increased Donors' support for CSOs' activities and resultant increased prominence and outputs of CSOs The HIV related death of Fela Anikulapo Kuti, one of Nigeria's greatest Musical artiste in 1997 brought the reality of HIV/AIDS nearer home to many Nigerians.
1999 - date	The Era of Strategic Expansion
1998/1999	Bridging Plan: Focused on Expanded National Response to AIDS (Multisector/Multi-sector/multi-disciplinary), Comprehensive Data Gathering and Analysis, Intensive Advocacy at High Political and General levels, Intensive General and Targeted Education Sustained High Performance by Civil Society Organizations (NGOs/ CBOs) The new democratic government identified HIV/AIDS control as one of the priorities in national development, and the President showed indication to personally be involved in the control effort nationally and internationally.
2000-2005	Presidential Committee on AIDS (PCA) and National Action Committee on AIDS (NACA) established to improve response and ensure multi-sector and multi-level participation Increased collaboration among development partners Three year Interim Action Plan developed More resources allocated/ mobilized

Subsidized HIV Treatment Sites in Nigeria

1. Nigeria Institute of Medical Research (NAIMA) Yaba, Lagos
2. Creek Hospital, Lagos, Lagos Island
3. Lagos State University Teaching Hospital (LUTH), Idi-Araba, Lagos
4. Nigerian Institute of Pharmaceutical Research And Development, Idu , Abuja
5. National Hospital, Abuja
6. Directorate of State Services Clinic, Abuja
7. National Intelligence Agency Clinic, Abuja
8. State House Clinic, Abuja
9. Gwagwalada Specialist Hospital, Abuja
10. Central Bank Clinic, Abuja
11. Jos University Teaching Hospital, Plateau State
12. University College Hospital, Ibadan, Oyo State
13. Abu Teaching Hospital, Zaria/Kaduna
14. University of Maiduguri Teaching Hospital, Borno State
15. Nnamdi Azikwe Teaching Hospital, Nnewi
16. University of Nigeria Teaching Hospital, Enugu State
17. University of Benin Teaching Hospital, Benin, Edo State
18. University of Ilorin Teaching Hospital, Ilorin Kwara State
19. University of Port Harcourt Teaching Hospital, P/Harcourt, Rivers State
20. Usman Dan Fodio University Teaching Hospital, Sokoto, Sokoto State
21. Aminu Kano Teaching Hospital, Kano, Kano State
22. Federal Medical Centre, Uyo, Akwa-Ibom State
23. Federal Medical Centre, Gombe, Gombe State
24. Federal Medical Centre, Markurdi, Benue State
25. Federal Medical Centre, Owerri
26. General Hospital, Lagos Island(MSF)
27. Island Maternity(PMTCT), Lagos Island
28. Massey Children Hospital(Pediatric)Lagos State
29. Mainland Hospital, Yaba, Lagos State
30. St. Charles Borromeo Hospital, Onitsha
31. General Hospital, Calabar, Cross River State
32. Central Hospital, Benin, Edo State
33. Wuse General Hospital, Abuja
34. Murtala Mohammed Specialist Hospital IDH, Kano
35. Federal Medical Centre, Nguru, Yobe State
36. Federal Medical Centre, Azare, Bauchi State
37. Bauchi State Specialist Hospital, Bauchi
38. Gede Foundation Abuja
39. Federal Medical Centre, Nassarawa State
40. Federal Medical Centre, Yola , Adamawa State
41. Government House Clinic, Taraba, Jalingo States

Additional materials sourced from Nigeria Common Country Assessment 2001.