

Nigeria's Response To HIV/AIDS

The Problem

The Acquired Immune Deficiency Syndrome (AIDS) is a serious public health concern and a major cause of death in many parts of the world, including Nigeria. In Nigeria, the first case of the Acquired Immune Deficiency Syndrome (AIDS) was reported in 1986, which thereby established the existence of the epidemic in Nigeria. Since then, infection with Human Immunodeficiency Virus (HIV) has spread to become a generalised epidemic affecting all population groups and sparing no geo-political zone in Nigeria.

Several factors have contributed to the rapid spread of HIV/AIDS in Nigeria. These include sexual networking practices such as polygamy, a high prevalence of untreated sexually transmitted infections (STIs), low condom use, poverty, low literacy, poor health status, low status of women, stigmatization, and denial of the existence of HIV by vulnerable groups. Mother-to-child transmission and transfusion of infected blood and blood products are common routes of infection, each accounting for almost 10% of infections. Other modes of transmission, particularly intravenous drug use (IDU) and same-sex intercourse, are slowly growing in occurrence. The drivers of the HIV epidemic in Nigeria include: low risk perception, multiple concurrent partners, informal transactional and inter-generational sex, lack of effective services for sexually transmitted infections (STIs), and poor quality of health services. Gender inequalities, poverty and HIV/AIDS-related stigma and discrimination also contribute to the continuing spread of the infection.

In many African countries, the impact of HIV/ AIDS on public life has been significant, in some cases even threatening economic growth and GDP. HIV/AIDS constitutes a leading development challenge and a major threat to the general advancement of the country, and the Continent's ability to achieve the Millennium Development Goals (MDGs). Most significantly, HIV/AIDS decimates the most productive segments of the population particularly women and men between the ages of 20 and 49 years. Consequences of HIV/AIDs include reduced productivity, lower life expectancy, increasing dependency on family members, reduced economic activity and lower GDP growth, increasing poverty, rising infant and child mortality, and an increase in the number of child orphans.

Given Nigeria's large population, a large proportion of which is within the sexually active age group, it was important that Nigeria tackles the problem of HIV/AIDs to ensure that it does not hamper the country's development.

The Reform Action

The return of democratic governance in Nigeria 1999 brought about the first real signs of a strengthened national response to the incidence of HIV/AIDS in the country. Data from the 1999 Seroprevalence survey was presented to the Obasanjo Administration, who immediately formed a Presidential Commission on AIDS (PCA) comprising Ministers from all sectors, with the President serving as Chairperson of the Commission. In 2000, the Obasanjo Administration established the National Action Committee on AIDS (NACA), whose strategy was to emphasise a multi-sectoral approach to AIDS. Membership of NACA included representatives from relevant Ministries, private sector, Non-Governmental Organizations (NGOs) and networks of persons living with HIV/AIDS. State and Local Action

Committees on AIDS (SACA and LACA) were also established to spearhead the local multi-sectoral response to HIV/AIDS.

The National Action Committee on AIDS prepared Nigeria's first HIV/AIDS Emergency Action Plan and this was approved in 2001 for a 3-year period. The primary objectives of the HIV/AIDS Emergency Action Plan are to:

- Increase awareness and sensitization of the general population and key stakeholders;
- Promote behaviour change in both low-risk and high-risk populations;
- Ensure that communities and individuals are empowered to design and initiate community-specific action plans;
- Ensure that laws and policies encourage the mitigation of HIV/AIDS;
- Institutionalize best practices in care and support for people living with HIV/AIDS;
- Mitigate the effect of the disease on people living with HIV/AIDS, orphans and other affected groups;
- Create networks of people living with HIV/AIDS and others affected by AIDS;
- Establish an effective HIV/AIDS surveillance system; and
- Stimulate research on HIV/AIDS.

As a follow-up to the agreement reached at the 36th Ordinary Session of the Organization of African Unity (OAU) in Lome, Togo from 10th to 12th July 2000, the Obasanjo Administration hosted the Organisation of African Unity's first African Summit on HIV/AIDS, Tuberculosis, and Other Related Infectious Diseases in Abuja, Nigeria from 26th to 27 April 2001. The summit undertook a critical review and assessment of the situation and the consequences of the afore-mentioned diseases in Africa. It reflected on how to strengthen current successful interventions and develop new and more appropriate policies, practical strategies, effective implementation mechanisms and concrete monitoring structures at national, regional and continental levels. The intention was to ensure adequate and effective control of HIV/AIDS, Tuberculosis and Other Related Infectious Diseases in Africa.

Following this, in 2002, the Federal Government introduced the "Antiretroviral Treatment Programme", which was aimed at supplying 10,000 adults and 5,000 children with antiretroviral drugs within one year. An initial \$3.5 million worth of ARVs was to be imported from India and delivered at a subsidised monthly cost of \$7 per person. The programme was announced as 'Africa's largest antiretroviral treatment programme'. By 2004 the programme had suffered a major setback as too many patients were being identified without a sufficient supply of drugs to hand out. This resulted in an expanding waiting list and not enough drugs to supply the high demand. The patients who had already started the treatment then had to wait for up to three months for more drugs, which not only reversed the progress the drugs had already made but also increased the possibility of HIV drug resistance. Eventually, another \$3.8 million worth of drugs were ordered and the programme resumed.

Despite the increased and concerted efforts made by the Federal Government to control the spread of the disease, by 2006 it was estimated that just 10% of HIV-infected women and men were receiving antiretroviral therapy and only 7% of pregnant women were receiving treatment to reduce the risk of mother-to-child transmission of HIV. As a result, in 2006 Nigeria opened up 41 new AIDS treatment centres and started handing out free ARVs to those who needed them. By 2007, the number of people being treated had gone up appreciably, rising from 81,000 people (15 % of those in need) to 198,000 (26%) by the end of 2007.

In 2011, Nigeria joined other countries to pledge the United Nations Political Declaration on HIV and AIDs. This pledge, amongst others, identified the urgent need to significantly scale up efforts towards the goal of universal access to comprehensive prevention programmes, treatment, care and support. It also committed countries to redouble efforts to achieve universal access to HIV prevention, treatment, care and support by 2015. In 2012 a United Nation report identified Nigeria has having the second highest number of HIV infections in the world. Consequently, in December, 2012 a systemic review of the national response to HIV/AIDS was carried out. The review identified key challenges which revolved around limited domestic financing of the response, weak coordination at the Federal and State levels, inadequate State Government contribution, challenges with human resources for the health sector, weak supply chain management systems, limited service delivery capacity and limited access to HIV service.

Based on the premise of the global declaration and the identified continuing challenges to universal access to HIV/AIDS services in Nigeria, the Jonathan Administration developed the **“Presidential Comprehensive Response Plan for HIV/AIDS in Nigeria (PCRP): 2013-2015”**. The primary aim of PCRP is to accelerate the implementation of key interventions areas over a two (2) year period to bridge the existing service gaps, address key financial areas, health systems and coordination challenges and promote greater responsibility for the HIV response at the Federal and State levels. Specifically, the PCRP aims to avail 80 million men and women aged from 15 years with an opportunity to know their HIV status; enrol an additional 600,000 eligible adults and children on ART; provide ART for 244,000 HIV pregnant women for PMTCT; provide access to combination prevention service for 500,000 Most-At-Risk Populations (MARPS) and 4 million young person’s; and activate 2,000 new PMTCT and 2,000 ART service delivery points across the country. At the presentation of the PCRP, President Jonathan declared that no Nigerian citizen must be allowed to die from HIV henceforth. As part of the PCRP implementation strategy, the sum of N179 billion domestic investment funds was required. Out of this, 99% % was to be used to accelerate the implementation of HIV prevention, care and treatment services of HIV/AIDS, while the remaining 1% was to be used to improve coordination and strengthen national response systems. The PCRP would focus on the 12 States that had the greater burden of the scourge. The PCRP identified areas were very specific and ambitious delivery.

In July 2013, Nigeria hosted the special African Union Summit on HIV/AIDS, Tuberculosis, and Malaria tagged “Abuja +12”. The meeting afforded the African leaders the opportunity to take stock of the progress that has been made over the years and to make new commitments to the eradication of the three infectious diseases. At the summit, the Joint United Nations Programme on HIV/AIDS (UNAIDS), launched a new framework to accelerate action to reach 15 million people with antiretroviral treatment by 2015, aimed at reducing new infections and ensuring a healthy generation. The framework, with the themed, "Treatment 2015" is expected to afford counties the opportunity to expand and upscale HIV testing and treatment which has been proven to reduce the rate of infection, prevent new infections and enable a healthy generation. The framework reveals that the foundations for ending the AIDS epidemic are being established by scaling up HIV treatment combined with expanding access to other essential programmatic activities. At the end, the African Heads of State concluded their meeting with a consensus from member States that the region would look beyond 2015 to eradicate HIV/AIDS, malaria and tuberculosis, while sustaining the progress made so far.

Main Achievements

The HIV Prevalence Rate in Nigeria has dropped from 5.4% in 1999 to 3.4% in 2013. This represents a drop of 37%, which is very significant.

As a demonstration of its commitment to addressing the HIV/AIDS epidemic in Nigeria, the Government has established an elaborate multi-sector response that focuses on prevention, treatment, and intervention. It established the Presidential Council on AIDS and the National Action Committee on AIDS (NACA), the latter comprised representatives from the Presidency, Federal Ministry of Health, Federal Ministry of Education, Federal Ministry of Youths and Sports, Federal Ministry of Finance, and other relevant Federal, State, and local Parastatals, NGOs, and international organizations working on HIV/AIDS in Nigeria. The HIV/AIDS Emergency Action Plan, coordinated by the National Action Committee on AIDS, is the country's current HIV/AIDS policy. Most importantly, is the development of a Presidential Comprehensive Response Plan for HIV/AIDS in Nigeria (PCRPP) to accelerate the implementation of key interventions areas over a two year period (2013-2015) to bridge existing service gaps, address key financial areas, health systems and coordination challenges and promote greater responsibility for HIV/AIDS response at the Federal and State levels.

Other key achievements include:

- Strengthening of institutional capacities of the coordinating entities of the HIV response. This includes capacity assessment and development of institutional capacity building plans by the entities, transformation of the National Action Committee on AIDS into a full-fledged agency; similar upgrade of State Action Committees on AIDS (SACA) to agencies and establishment of LACAs in local government councils where they do not exist. To date, SACAs in all the states have transformed to agencies, with about 73% established Boards. To enhance interventions, relevant Technical Working Groups (TWGs) have also been established. These include 97% TWG for M&E, 83% TWG for prevention, and 30% TWG for care and support.
- The majority of HIV services providers providing HIV services in the country have been trained in HIV services. The number of trained health workers increased from 2466 in 2010 to 8686 in 2013, while the number providing HIV services increased from 4294 in 2010 to 10407 in 2013.
- Increased engagement and collaboration with various stakeholders and development partners in meaningful partnership has expanded HIV response funding and activities to all states.
- Enactment of a number of laws and policies to guide the multi-sectoral response to HIV/AIDS. The policies have been well articulated and include the:
 - ✓ National Policy on HIV/AIDS developed in 2009 by the National Agency for the Control of AIDS. This policy document provide regulations and guiding principles on topics ranging from prevention of new infections and behaviour change, treatment, care and support for infected and affected persons, institutional architecture and resourcing, advocacy, legal issues and human rights, monitoring and evaluation, research and knowledge management and policy implementation by the various stakeholders in the national response;
 - ✓ The 1999 Constitution of the Federal Republic of Nigeria, which affirms the national philosophy of social justice and guarantees the fundamental right of every citizen to life and to freedom from discrimination;
 - ✓ Complementary government policy documents which provide the framework for the National HIV policy, including the NACA Act, Medium Term Strategy, Transformation Agenda;
 - ✓ The Abuja Declaration and Framework for Action for the Fight Against HIV/AIDS, Tuberculosis and other related diseases in Africa (2001) and the

United Nations General Assembly Special Session on HIV/AIDS (UNGASS) (2001); and

- ✓ Nigeria's Commitment to Universal Access and to comprehensive HIV prevention, treatment, care and support as enunciated in the following: the 2005 Gleneagles G8 Universal Access Targets, the 2006 United Nations Political Declaration on HIV/AIDS, the African Union's Abuja call for Accelerated Action towards Universal Access for HIV/AIDS (2006), and the Brazzaville Commitment on scaling up towards Universal Access to HIV and AIDS prevention, treatment, care and support services in Africa by 2010, etc.
- Development of a costed multisectoral National Strategic Plan (NSP) 2010-2015 at Federal Level and state strategic plans at the state level with HIV/AIDS prevention as the overarching priority. The NSP is derived from the architecture of the National Strategic Framework 2010-15 (NSF II) and has targets to halt and begin to reverse the spread of HIV infection, as well as mitigate the impact of HIV/AIDS, by 2015. The NSF II was developed to provide direction and ensure consistency in the development of the strategic plans by all stakeholders including all the 36 states of the Federation and the Federal Capital Territory (FCT); MDAs; and the constituent coordinating entities of Civil Society Organization (CSOs) Networks. The NSF II, is linked to Universal and MDG targets and Vision 20:2020. Surveys and surveillances among pregnant women; most at risk population and general population have been strengthened and sustained for effective monitoring and coordination of the response.
- Development of a National HIV/AIDS Research Agenda to improve coordination of research efforts and to improve evidence base and research towards understanding the dynamics of the epidemic for a better and more effective response.
- Development and launch of a national HIV/AIDS vaccine plan. The Plan is a roadmap that will advance Nigeria's capacity to contribute to HIV vaccine research and development.
- Implementation of a uniform electronic data collection and reporting platform District Health Information System 2 (DHIS 2.0) including a mobile phone component for all health facilities providing HIV/AIDS services in Nigeria.
- Establishment of an electronic patient record management system to allow health care workers access all of the clients' care history even when they transfer from one hospital to another, collaboration with community based organizations to create awareness and demand for HIV services and reach orphans and vulnerable children within the communities with care;
- In terms of service delivery outlets, the number of ART, HCT and PMTCT sites has been on the increase from 2006 to 2013. In particular, PMTCT sites increased from 33 in 2005 to 5,622 in 2013. ART sites increased from 34 in 2005 to 842 as at 2013. HCT sites increased from 226 in 2006 to 5191 in 2013. The increase in PMTCT sites is no doubt a result of government prioritization and expansion of PMTCT services, and decentralization of PMTCT programming with assistance from development partners and donors. The availability and use of cost-effective anti-retroviral drugs for treatment of HIV/AIDS (ART) has increased with ART service provision increasing from 51 persons per 1000 population in 2005 to 639 persons per 1000 population in 2013.
- A new Global Report by UNAIDS (2014) revealed that the new HIV infections have declined by 35% in the past three years in Nigeria. The UNAIDS also revealed that new infections showed signs of decline while about 640,000 people in Nigeria were on antiretroviral therapy in 2013. Also the Gap Report (16th July, 2014) released in Geneva, Switzerland also showed that Nigeria is one of the countries in the world

that realised a rapid increase in the number of people living with HIV that are accessing antiretroviral therapy. The UNAIDS report further showed that despite the improvement, there is need for much work to be done in the country in order to eliminate HIV by 2030. The decline in new infection is a clear sign that the Federal Government is steering the HIV response in the right direction and much progress can be reached if more resources are committed to the disease.

- The increased number of HCT service outlets has resulted in more persons counselled, tested and receiving their results. The annual number of persons, who were counselled, tested and received results increased from 2,056,578 in 2011, to 2,792,611 persons in 2012 and 4,077,663 in 2013.
- The proportion of pregnant women who received antiretroviral medicines to reduce the risk of mother to child transmission (MTCT) of HIV has been on the increase from 5.25% in 2007 to 30% in 2013.
- Increased role of HIV/AIDS-focused Non-Governmental Organisations in complimenting management oversight, as well as donor engagement in order to enhance the integrity and perception of how Nigeria manages donor assistance in arresting the spread of the HIV pandemic;
- Launching of a number of initiatives in the country to educate the public on HIV/AIDS. Among these are combination prevention programmes, considered to be the most effective initiative, the abstinence, be faithful, and use of a condom campaign;
- Development of a Family Life Health Education (FLHE) curriculum by the Federal Ministry of Education in collaboration with other government agencies, NGOs, and UN agencies. The FLHE curriculum is deemed critical in helping young people acquire adequate knowledge, skills, and responsible attitudes, needed to prevent sexually transmitted infections, including HIV/AIDS;
- Introduction of Peer Education Programme titled “Empowering Youth through Young People” by the National Youth Service Corps (NYSC) in collaboration with UNICEF. The objective of this program is to reach new graduates of university programs serving the one-year compulsory NYSC program with reproductive health and HIV/AIDS messages, train some to be trainers themselves, and for all to act as ‘peer educators’ in and out of school; and
- Many NGOs, faith-based organizations, and educational institutions have been active in outreach programs, setting up youth counselling centres, promotion of behaviour change via radio and television programming, peer education, discussions, awareness, etc.

Key Challenges

Although Government has demonstrated a lot of commitment to address the HIV/AIDS epidemic in the country, the HIV/AIDS epidemic still faces some challenges. These include:

- Insufficient funding by national state and local governments, given the scale and complexity of Nigeria’s epidemic and in line with the partnership framework signed by the country that Nigeria will provide 50% of the funding for HIV by 2015;
- The current funding from government is 21.3% thus the HIV/AIDS response is still heavily dependent on donor funding.
- The current data on number of person living with HIV, number of new infection and HIV related death on the basis of which country impact data are calculated are estimated from the national HIV sentinel and general population survey(ANC and

NARHS). The country is currently in the process of rebasing its prevalence rate and redefining its epidemic

- Weak coordination capacity among local NGOs;
- Low perception of risk among policymakers and the general population; Many citizens and government officials in Nigeria are reluctant to acknowledge the spread of the disease owing to strong social cultural norms and stigmatization of people living with HIV/AIDS. HIV/AIDS is still associated with behaviours widely considered taboo, including prostitution, drug use, and homosexuality. HIV-positive people often do not seek testing and treatment because they fear being ostracized by their families, neighbours and friends and losing their jobs or access to public services. Up till date the societies, culture and religions have not learnt to accept people living with HIV and show love, care and support to them. Stigmatization of people living with HIV/AIDS arising from fear, ignorance and socio-cultural factors is a big challenge to the control of HIV eradication of the syndrome in Nigeria.
- Weak Sexual Transmitted Infections (STIs) interventions and surveillance systems;
- Lack of supportive legislation for HIV/AIDS programme;
- Conservative social values, and regional religious and cultural differences;
- Poverty and low status of women;
- Inability to address human rights and legal issues surrounding HIV/AIDS. This is mainly due to the fact that, in Nigeria, official policy documents do not constitute law and cannot be enforced in the courts of law. They constitute merely administrative tools and guidelines that provide direction for governmental action. However, these policy documents can and may elaborate and specify the goals, values, and standards to which existing laws aspire and may be useful in interpreting the latter as well as guiding programmatic interventions by the government. The problem is that, at the moment, there are no HIV/AIDS specific laws on the statutes. Due to the delay in the progress of legal reforms and the absence of the backing of the law, government policy documents can only serve to inspire an effective national HIV/AIDS response that respects the rights of People Living with HIV/AIDS (PLHIV);
- HIV/AIDS knowledge though increasing is still low in the general population, and across all sub-populations.
- Most services are still facility based, mostly located at tertiary and secondary facility level and in urban centres. These all provide access challenges to the community and the hard-to-reach populations with increased risk for HIV infection.
- Although there has been significant increase in annual number of persons accessing HCT services the overall uptake of HCT service is still low and the national targets have not been met.
- There are still gaps in PMTCT coverage. A significant proportion of HIV exposed infants do not get early infant diagnosis (EID) services and ARV prophylaxis.
- Workplace stigma and employment discrimination against PLHIV remains a major challenge in private sector settings.
- Other challenges include weak procurement and supply chain management of essential commodities and products resulting in stock outs and expired drugs and commodities, high prevalence of stigma and discrimination, violation of the human rights of people living with HIV/AIDS (PLWHA), inadequate monitoring of the quality of intervention, challenges in program coordination (National HIV response analysis, 2009) as well as the limited involvement of the private sector in HIV/AIDS funding, planning and implementation of HIV/AIDS programmes;

Assessment of Reform Initiative

Assessed against the 10 criteria for judging the success of government reform initiatives, it is clear that the fight against the HIV/AIDS disease has recorded some successes:

S/No.	Assessment Criteria	Result of Assessment
1.	Has the fight against HIV/AIDS improved the quality and quantity of public services?	The improved response to HIV/AIDS means that the Nigerian workforce is more able to deliver public services to citizens.
2.	Do more people now have access to services, including disadvantaged groups such as women, young persons and people with disabilities?	More people including the disadvantaged groups and those with disability are now accessing antiretroviral therapy and services related to the prevention and treatment of HIV/AIDS.
3.	Has the HIV/AIDS reform reduced the cost of governance?	It has not reduced the cost of governance. However, government funding for HIV/AIDS is negligible. This may be due to the fact that the majority of funding for HIV programs is donor driven. For instance, Nigeria contributes only an estimated 5% of the funds for antiretroviral therapy programmes.
4.	Has the HIV/AIDS reform made the service more affordable for citizens?	The free HIV/AIDS policy as part of government reforms has made access to retroviral therapy affordable to citizens.
5.	Has the HIV/AIDS reforms reduced corruption?	Yes procurement of good and services strictly comply with the national and donor procurement policy. Regular evaluation and Joint review of programme effectiveness and efficiency has improved transparency and accountability.
6.	Has the HIV/AIDS reduced unnecessary bureaucracy and red tape?	The establishment of NACA and strengthening/streamlining of its systems and operations and adoption of performance based approach has reduced unnecessary bureaucracy and red tape.
7.	Is HIV/AIDS reform likely to lead to improved development outcomes?	The improved response to HIV/AIDS as being currently observed will lead to improved development outcomes and Nigeria's capacity to achieve the Millennium Development Goals (MDGs).
8.	Are things improving, staying the same or getting worse?	Things are improving because there is substantial decline in the prevalence rate in both children and adults and significant

		increase in access to prevention and treatment services .
9.	Where things are improving, will those improvements endure?	Improvements are likely to endure because government and some faith-based organisations have launched a number of initiatives in the country aimed at educating the public on HIV/AIDS. Among these are combination-prevention programmes, considered to be the
10.	Where things are not improving, what should be done?	NACA reviews its operations regularly and adopt innovative strategies where there are challenges.

Proposed Next Steps

Nigeria has made positive strides in her fight against HIV/AIDS syndrome and there is still a need for more concerted efforts to address the scourge of HIV/AIDS. These include:

- i. The commitment of senior political leadership to persist in the struggle against HIV/AIDS has been a very key variable in the few successful programs around the world. The Federal Government, therefore, needs to maintain and sustain priority and high-level interest to reduce the spread of the disease;
- ii. Evidence has shown that the impact of HIV/AIDS has been enormous particularly on women and children. While gender has been mainstreamed into the national response in Nigeria, there is clearly still a lot more to be done in this area. It is particularly sad that Nigeria records annual HIV-positive births of 56,681. There is the need for all stakeholders to speak with one voice and declare that this trend as unacceptable. There is need to strongly advocate for the scale up of both the access and quality of all HIV/AIDS services. These include HCT, PMTCT as well as other prevention, treatment, care and support services, especially for those disadvantaged due to location, income or gender;
- iii. There is the need to strengthen technical, financial and management capacity not just at NACA but at the SACAs and LACAs;
- iv. There is a greater need for Prevention programs to be at the heart of the HIV/AIDS response. This need is reinforced by the declining difference in the proportion of people with an awareness of HIV/AIDS compared to those with a comprehensive knowledge of HIV/AIDS. There is a further decline in the proportion of the latter group with the awareness of where to get tested. While treatment, care and support programs are indispensable, there is the need for a scale up of prevention programs to cater to the over 95% of the population that are currently HIV negative.
- v. While donors should be praised for the huge financial and human resources they have committed to the HIV/AIDS response, there is the need for country

- ownership as well as the alignment and harmonization of donor priorities in line with country plans and strategies; and
- vi. There is need for the Federal Government to put in place policies that would protect people living with HIV/AIDS from stigmatization in places of employment and schools.