TABLE OF CONTENTS

Acronyms
Acknowledgements
Foreword By NACA Chairperson
Executive Summary

1.0 Introduction and Background
1.1 HIV/AIDS in Nigeria
1.2 NACA and HIV/AIDS Emergency Action Plan (HEAP)

2.0 Overview of the National Response Review (NRR) Process
2.1 Goals and Objectives of the NRR
2.2 Methodology of the NRR
2.3 Review Team
2.4 Organisation of Report

3.0 Gender Analysis of HEAP, National HIV/AIDS Policy and NNRIMS
3.1 Executive Summary
3.2 Contextual Background
3.3 Goals and Objectives
3.4 Strategies and Guidelines
3.5 Monitoring and Evaluation

4.0 Prevention and Behaviour Change
4.1 Progress to Date
4.2 Constraints
4.3 Emerging Issues
4.4 Recommendations

5.0 Care Support and Treatment
5.1 Progress to Date
5.2 Constraints
5.3 Emerging Issues
5.4 Recommendations

6.0 Socio-Economic Impact
6.1 Progress to Date
6.2 Constraints
6.3 Emerging Issues
6.4 Recommendations

7.0 Regional Programmes, and New Technologies

7.1 Uniform Personnel
7.2 New Technologies
7.3 Regional Programmes

8.0 Policy, Advocacy, Legal and Human Rights Issues

8.1 Policy
8.2 Advocacy
8.3 Legal Issues

9.0 Resource Mobilisation and Management

9.1 Progress to Date
9.2 Constraints
9.3 Recommendations

10.0 Coordination and Institutional Arrangements

10.1 Progress to Date
10.2 Constraints
10.3 Emerging Issues
10.4 Recommendations

11.0 Monitoring and Evaluation

11.1 Monitoring and Evaluation
11.2 Research

12.0 Conclusion and way forward

Annexes
<table>
<thead>
<tr>
<th>ACRONYMS</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFPAC Armed Forces Programme on AIDS Control</td>
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<tr>
<td>AFRICASO Africa Network of AIDS serving organization</td>
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<td>AIDS Acquired Immune deficiency Syndrome</td>
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<td>AIDS Acquired Immunodeficiency Syndrome</td>
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<td>ANC Ante-Natal Clinics</td>
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<td>APIN AIDS Prevention Initiative in Nigeria</td>
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<td>ARFH Association for Reproductive and Family Health</td>
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<td>ARH Adolescent Reproductive Health</td>
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<td>ART Anti-Retroviral Therapy</td>
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<td>ART Antiretroviral Therapy</td>
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<td>ARV Anti-Retroviral</td>
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<tr>
<td>BCC Behavioural Change Communication</td>
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<td>BSS Behaviour Sentinel Survey</td>
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<td>CAFOD Catholic Agency for Oversea Development</td>
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<tr>
<td>CBOs Community Based Organizations</td>
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<tr>
<td>CCE Consultative Constituent Entities</td>
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<td>CCM Country Coordination Mechanism</td>
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<td>CDC Centre for Disease Control and Prevention (US)</td>
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<td>CEDAW Convention on the Elimination of Discrimination Against Women</td>
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<td>CEDPA Centre for Development and Population Activities</td>
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<td>CHAN Christian Health Association of Nigeria</td>
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<td>CHBC Community and Home Based Care</td>
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<td>CIDA Canadian International Development Agency</td>
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<td>CiSNHAN Civil Society Network on HIV/AIDS in Nigeria</td>
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<td>CLP Community Life Project</td>
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<td>CRA Child Rights Act</td>
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<td>CSOs Civil Society Organizations</td>
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<td>CSW Commercial Sex workers</td>
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<td>DFID Department for International Development (UK)</td>
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<td>ECOMOG ECOWAS Monitoring Group</td>
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<td>ECWA: Evangelical Church of West Africa</td>
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<td>ETI Ecobank Transnational Incorporated</td>
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<td>FBOs Faith Based Organisations</td>
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<td>FCT Federal Capital Territory</td>
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<td>FGN Federal Government of Nigeria</td>
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<td>FHI Family Health International</td>
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<td>FLE Family Life Education Curriculum</td>
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<td>FMOH Federal Ministry of Health</td>
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<td>FMOL: Federal Ministry of Labour</td>
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<td>FMOWA: Federal Ministry of Women Affairs</td>
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<tr>
<td>FRCN Federal Radio Corporation of Nigeria</td>
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<td>FRN Federal Republic of Nigeria</td>
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<td>FY Financial Year</td>
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<td>GDP Gross Domestic Product</td>
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<td>GFATM Global Fund to fight AIDS, Tuberculosis and Malaria</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>GIPA</td>
<td>Greater Involvement of People Living With HIV/AIDS</td>
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<td>HAART</td>
<td>Highly Active Anti-Retroviral Therapy</td>
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<td>HAF</td>
<td>HIV/AIDS Fund</td>
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<td>HEAP</td>
<td>HIV/AIDS Emergency Action Plan</td>
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<td>HIV</td>
<td>Human Immuno-deficiency Virus</td>
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<td>ICCPR:</td>
<td>International Convention on Civil and Political Rights</td>
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<td>ICESCR:</td>
<td>International Convention on Economics, Social and Cultural Rights</td>
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<td>IDA</td>
<td>International Development Association</td>
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<td>IDU</td>
<td>Intravenous rug users</td>
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<td>IEC</td>
<td>Information Education and Communication</td>
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<td>ILO</td>
<td>International Labour Organization</td>
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<td>ITD</td>
<td>International Theatre Day</td>
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<td>JAAIDS</td>
<td>Journalist Against AIDS</td>
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<td>LACA</td>
<td>Local Government Action Committee on AIDS</td>
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<td>LACA:</td>
<td>Local Government Committee on AIDS</td>
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<td>LATH</td>
<td>Liverpool Associates for Tropical Health</td>
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<td>LDDs</td>
<td>Long Distance Drivers</td>
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<td>LGA</td>
<td>Local Government Area</td>
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<td>M &amp; E</td>
<td>Monitoring and Evaluation</td>
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<td>MARPs</td>
<td>Most at Risk Persons</td>
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<td>MIPA:</td>
<td>Meaningful Involvement of PLWHAs</td>
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<td>MSM:</td>
<td>Men having Sex with Men</td>
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<td>NACA</td>
<td>National Action Committee on AIDS</td>
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<td>NACA:</td>
<td>National Action Committee on AIDS</td>
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<td>NAFCDC</td>
<td>National Agency for Food and Drug Administration and Control</td>
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<td>NANTAP</td>
<td>National Association of Nigerian Theatre Arts Practitioners</td>
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<td>NARHS</td>
<td>National Adolescent and Reproductive Health Survey</td>
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<td>NASCP</td>
<td>National HIV/AIDS and Sexually Transmitted Infection Control Programme</td>
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<td>NBCC</td>
<td>National HIV and AIDS Behavior Change Communication Strategy</td>
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<td>NDHS</td>
<td>National Demographic and Health Survey</td>
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<td>NEEDS</td>
<td>National Economic Empowerment and Development Strategy.</td>
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<td>NEPAD</td>
<td>New Economic Partnership for Africa Development</td>
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<td>NEPHWAN</td>
<td>Network of People living With HIV and AIDS in Nigeria</td>
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<td>NERB</td>
<td>National Ethical Review Board</td>
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<td>NGO:</td>
<td>Non-Governmental Organization</td>
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<td>NGOs</td>
<td>Non Governmental Organizations</td>
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<td>NHIS:</td>
<td>National Health Insurance Scheme</td>
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<td>NHVMAG</td>
<td>Nigeria HIV Vaccine and Microbicide Advocacy Group</td>
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<td>NIBUCAA</td>
<td>Nigerian Business Coalition Against AIDS</td>
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<td>NIMR</td>
<td>Nigerian Institute of Medical Research</td>
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<td>NIPRD</td>
<td>National Institute for Pharmaceutical Research and Development</td>
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<td>NNIRMS</td>
<td>Nigeria National Response Information Management System</td>
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<td>NNIRMS:</td>
<td>Nigerian National Information Management System for HIV/AIDS</td>
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<td>NRCS</td>
<td>Nigerian Red Cross Society</td>
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<td>NRR</td>
<td>National Response Review</td>
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<td>Abbreviation</td>
<td>Full Form</td>
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<td>NSF</td>
<td>National Strategic Framework</td>
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<td>NURTW</td>
<td>Nigerian Union of Road Transport Workers</td>
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<td>NYAP</td>
<td>Nigeria Youth AIDS Program</td>
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<td>NYNetHA</td>
<td>Nigerian Youth Children</td>
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<td>OI</td>
<td>Opportunistic Infections</td>
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<tr>
<td>OIs</td>
<td>Opportunistic Infections</td>
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<td>OSIWA:</td>
<td>Open Society Initiative for West Africa</td>
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<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
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<td>OVC:</td>
<td>Orphan and Vulnerable Children</td>
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<td>PABA</td>
<td>People affected by AIDS</td>
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<td>PAC</td>
<td>Presidential AIDS Committee</td>
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<td>PACC</td>
<td>Police AIDS Control Committee</td>
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<td>PEP</td>
<td>Post Exposure prophylaxis</td>
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<td>PEP</td>
<td>Poverty Eradication Programme</td>
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<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
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<td>PESSP:</td>
<td>People Engaged in Same Sex Practice</td>
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<tr>
<td>PESSPs</td>
<td>Persons engaged in same sex practice</td>
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<td>PLWHA</td>
<td>People Living with HIV/AIDS</td>
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<td>PLWHA:</td>
<td>People living with HIV/AIDS</td>
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<td>PMAN</td>
<td>Performing Musicians Association of Nigeria</td>
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<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
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<td>PSI/SFH</td>
<td>Population Services International/Society for Health</td>
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<td>PSSP</td>
<td>Persons with Same Sex Partners</td>
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<td>REHRAC:</td>
<td>Reproductive Health and Rights Research and Advocacy Centre</td>
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<td>SACA</td>
<td>State Action Committee on AIDS</td>
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<td>SACA:</td>
<td>State Action Committee on AIDS</td>
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<td>SFH</td>
<td>Society for Family Health</td>
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<td>SGF</td>
<td>Secretary to the Government of the Federation Network on HIV and AIDS</td>
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<td>SNR</td>
<td>Strengthening National Response</td>
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<td>STI:</td>
<td>Sexually Transmitted Infections</td>
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<td>STIs</td>
<td>Sexually Transmitted Infections</td>
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<td>SW</td>
<td>Sex Workers</td>
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<td>SWAAN</td>
<td>Society for Women and AIDS in Africa Nigeria</td>
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<tr>
<td>TB-DOTS</td>
<td>Tuberculosis Direct Observation Treatment Scheme</td>
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<td>TWG</td>
<td>Technical Working Groups</td>
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<td>U.N.</td>
<td>United Nations</td>
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<tr>
<td>UBE</td>
<td>Universal Basic Education</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on AIDS</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
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<td>UNFPA</td>
<td>United Nations Fund for Population Activities</td>
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<td>UNFPA:</td>
<td>United Nation Fund for Population Activities</td>
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<td>UNGASS</td>
<td>United Nations General Assembly</td>
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<td>UNICEF</td>
<td>United Nations Children Fund</td>
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<td>UNICEF:</td>
<td>United Nations International Children Education Funds</td>
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<td>UNIFEM</td>
<td>United Nations Development Fund for Women</td>
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<td>Acronym</td>
<td>Full Name</td>
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<tr>
<td>UNODC</td>
<td>United Nations Office on Drugs and Crimes</td>
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<td>USAID</td>
<td>United State Agency for International Development</td>
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<tr>
<td>USAID:</td>
<td>United State Assistance for International Development</td>
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<td>VCCT:</td>
<td>Voluntary Confidential Counseling and Testing</td>
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<td>VCT</td>
<td>Voluntary Confidential Counseling and Testing</td>
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<td>WANASO</td>
<td>West African Network AIDS Serving Organization</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WSW:</td>
<td>Women having Sex with Women</td>
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<td>YBSS</td>
<td>Youth Behavioural Sentinel Survey</td>
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Acknowledgements
The National Response Review of the HIV and AIDS in Nigeria (NRR) in 2001 to 2004, is an end product of combined effort and support of various organizations and individuals. The NRR provided the basis for the development of the National Strategic Framework for HIV and AIDS (NSF) in Nigeria 2005 to 2009. While it is difficult to acknowledge all groups involved, the following deserve mention.

NACA acknowledges the important role played by the members of the coordinating Team (CT) under the able leadership of the Chairperson of NACA, Professor Babatunde Osotimehin, for driving the process, providing oversight and linkages to the coordinating committees, mobilizing resources and facilitating the NRR and NSF process. Special thanks are extended to the members of the Coordinating Committee (CC), for serving as an advocacy and consultative committee for the national process. The 25 member secretariat lead by the NACA Directors of Policy Strategy and Communication, Alex Ogundipe, and UNAIDS Deputy Representative, Dr Alti Zwandor and NACA Director of Response Monitoring Dr Kayode Ogungbemi, is acknowledged for providing technical and administrative coordination of the entire NRR and NSF process.

NACA acknowledges with thanks the important role played by members of the Gender Technical Committee (GTC) for ensuring that gender was mainstreamed in both the NRR and NSF. Particular thanks go to members of the GTC namely CIDA, UNIFEM and UNFPA for providing financial and technical support for the five gender consultants who participated in the process.

The review of national response to HIV and AIDS was based on documents and reports submitted to NACA from a broad range of stakeholders, in government, civil society and support groups and development partners. NACA appreciates their invaluable contributions. The entire NRR and NSF team of consultants who reviewed and analysed the national response must be commended. This report would not have been possible without for their dedication and team work. The consultants include; Gender Consultants: Dennis Ityavyar, Ifeoma Isiugo-Abanihe, Nkechi- Onah, Izekuwa Briggs and Neddy Matshalaga, Facilitators: Ugochukwu Amanyeije-Adaka, Nnenna Mba-Oduwusu, Umaru Pate, A.M. SA-AD, Christopher Oluwadare, Morenike Ukpong and Timi Owolabi and Technical Assistants: Cyril Ojeonu, Kufre J. Okop, Bashiru Akande, Ufon Udofia, Aminatu Aremo, Ijeoma Nnaji, Adebayo Solomon and Simon NA-ALLAH. NACA would like to extend special thanks to Tayo Fagbenro, co-lead international consultant, Neddy Matshalaga, lead international gender consultant and Folarin Olowu, lead national consultant who together provided overall technical, management and leadership of the NRR and NSF process.

The development of the NRR benefited immensely from the contributions of the two consultative processes involving Technical Thematic Working Group (TWG) members and Constituency Coordinating Entities (CCE) members. NACA acknowledges with thanks the members of the TWG whose representation was drawn from; Civil Society Organisations (CSOs), Faith Based Organisations (FBOs), Youth Organisations, NEPWHAN, Federal Ministries of Government and Parastatals,
Development Partners, Private Sector, NACA management, and other technical experts. Special thanks goes to members of the Constituency Coordinating Entities (CCE) drawn from; Civil Society Network of HIV in Nigeria (CiSNHAN), International Non Governmental Organisations (INGOs), Federal Line Ministries, Network of People Living with HIV and AIDS in Nigeria (NEPWHAN), Nigeria AIDS Research Network (NARN), FBOs, State Action Committee on HIV and AIDS (SACAs), Private Sector, Development Partners, Media, Arts and Entertainment and Women and Youths Groups.

The Government of Nigeria and NACA acknowledge the financial, technical and logistical support provided the following institutions; United Nations Systems in Nigeria, DFID, CIDA.
EXECUTIVE SUMMARY

In responding to the HIV/AIDS epidemic, Nigeria developed the HIV/AIDS Emergency Action Plan (HEAP), covering the period 2001 to 2004. The HEAP, a multisectoral plan, focused on three major areas; removal of socio cultural, informational and systematic barriers to community-based responses, prevention, and care and support. The expiry of HEAP in 2004 provided an opportunity for the review of the national HIV/AIDS response (NRR), which informed the development of the new strategic framework for HIV and AIDS in Nigeria (NSF) in the next five years.

The National Action Committee on HIV and AIDS (NACA) worked closely with a wide range of development partners in Nigeria, in driving the NRR and NSF process. Different coordinating structures were put in place to coordinate the process. The coordinating Committee (CC) made up of NACA, representation from federal ministries and development partners, served as an advocacy consultative committee for the process. The secretariat, chaired by NACA senior management with representation of development partners, provided technical and administrative coordination of the process. The Gender Technical Committee (GTC) was tasked with mainstreaming gender into both the NRR and NSF process and outputs. A team of 20 consultants made up of 8
facilitators, 8 technical assistants and four gender consultants worked on the 8 thematic areas on the NRR and NSF. A lead international, national and a lead international gender consultant provided the technical leadership to the team and oversaw the production of NRR and NSF. Two consultative processes, involving about 200 members of the Technical Thematic Working Groups and over 150 members of Constituent Coordinating Entities (CCE) provided feedback, strengthened the outputs and validated the NRR and NSF.

Key Findings

Prevention: The young people especially women below the age of 24 years are among the most vulnerable groups with HIV prevalence rates of 6%, higher the national average of 5%. The community youth AIDS education programmes were an effective prevention strategy. More males (70%) than females (54%) are knowledgeable about condoms. This knowledge has unfortunately not translated into increased condom use. Only 23% of males compared to 8% of females are reported to be using condoms. The Inter faith Coalition on HIV/AIDS was formed in 2002 to spearhead prevention efforts in this sector. Faith-based organization are reported to have integrated HIV/AIDS in their activities. Civil society organizations play an important role in HIV prevention efforts. More than 700 NGOs working in HIV and AIDS focus on community mobilization, prevention and behaviour change communication. Many traditional rulers across the country were sensitized to address the socio-cultural factors of HIV prevention and control. Nigeria has initiated Prevention of Mother to Child Transmission (PMTCT) of HIV with 12 operational sites in 10 states and the federal capital. Male support and involvement in such programmes remain a major challenge. The network of people living with HIV and AIDS in Nigeria (NEPWHAN) established in 1998, has contributed to prevention efforts. A wide range of traditional, religious and socio-cultural factors continue to put young women and girls at risk of HIV infection.

Care and Support: Through the implementation of HEAP, there was an increase in government and development partner support for care, support and treatment activities. In 2002, the government initiated an anti-retroviral (ARV) programme targeting 10 000 adults and 5000 children. Many treatment centers, have exceeded current quotas and about 17 000 people are currently receiving ARVs. Unectodotal information point to the fact that efforts have been put in place to ensure gender equity in access to ARVs in most centers. Community-based care and psychological support activities targeted at PLWHA and OVCs are provided by CSOs, with increased participation of religious organizations. Women constitute bulk of support providers in this area. In February 2004, a national conference on OVCs was conducted to facilitate the development of a national OVC policy.

Socio-cultural Impact: Gender inequalities and poverty, worsens the socio-economic impact of the HIV and AIDS on the Nigerian society. OVCs present a major development challenge, particularly in education, health food security and employment opportunities. Lack of comprehensive sector studies on the impact of the epidemic prevents a more focused and informed approach to mainstreaming gender in
development. The review revealed that HIV and AIDS threatens to have a negative impact on agricultural production, viability of the transport sector, health service provision and access to education.

Regional Programmes and New Technologies: There is significant progress in HIV and AIDS programmes targeted at Armed Forces, Police, and Immigration Personnel. With support from local NGOs and the Armed Forces Programmes on HIV/AIDS (AFPAC) has recorded a lot of success in their programmes. There exists a strong political will and commitment by the Nigerian government for the development of new technologies for HIV prevention. Nigeria has an HIV/AIDS vaccine plan making her more prepared for the international HIV vaccine research efforts.

Policy Advocacy, Legal and Human Rights: At both the state and federal level, Nigeria has a relatively rich HIV and AIDS policy environment, with many HIV/AIDS related policies having been developed. The major challenges around policies are; lack of widespread knowledge and usage of policies, gaps in policy development in some areas and more important, the inability of most policies to address the gender dimensions the HIV and AIDS epidemic. There is also need for review of some policies to ensure that they can be more supportive to the fight against HIV and AIDS. There is need for advocacy for the development of relevant legal instruments to give strategic policies (workplace, insurance coverage and more) a legal backing in cases of violation of human rights. The protection of individuals human rights in the context of HIV and AIDS is critical for an effective response to HIV and AIDS. Despite the limited knowledge on the linkages between human rights and HIV and AIDS among key stakeholders, an encouraging development is that NGO, private sector and most recently the public sector, have worked towards the development of HIV and AIDS in the workplace. The response review reported violation of individuals’ human rights in settings and women particularly those testing positive in ANC settings continue to experience stigma and discrimination.

Resource Mobilisation and Management: Resource mobilization is key to an effective national response to HIV and AIDS. The HEAP provided the context for partnership in resource mobilization. The review period registered promising progress. At national level, over US$300 million was raised towards the national response in the last four years from a wide range of key stakeholder which included government, development partners, private sector, the Global Fund, World Bank, United Nations System, United States and United Kingdom Governments and others. The end of the HEAP, was marked by the launch of the United States Presidential Emergency Plan for AIDS Relief (PEPFAR), from which the country expects to receive US$1 billion between 2004 and 2009. However, during the period under review, over-dependency on donor funding has restrained the responsiveness of indigenous resource mobilization. The Private sector is currently not adequately involved. Both religious bodies and communities are not sufficiently motivated.

Coordination and Institutional Arrangements: Effective coordination and institutional management is at the center of an effective national response to the epidemic. The development of the HEAP was a coordination achievement in itself. The national
response in Nigeria is coordinated through a three tier system of National Action Committee on HIV and AIDS (NACA), State Action Committee on HIV/AIDS (SACA), and the Local Government Action Committee on HIV and AIDS (LACA). NACA has succeeded in raising awareness of HIV/AIDS among the general population. Despite some impressive responses in some states, not all states have effectively SACAs and LACAs. While NACA is a federal coordinating body, the current legal provisions are such that NACA is not able to have full control of coordinating SACA and LACA HIV and AIDS activities. SACA and their respective LACAs have some degree of autonomy which does not bind them to follow though NACA coordination requirements. While NACA has a strong multi-sectoral representation and participation in HIV and AIDS planning and activities, this approach is not reflected effectively at the SACA and LACA levels. The capacity of all coordinating bodies still needs to be strengthened to ensure an effective management and dissemination of the direction of the epidemic in Nigeria.

Monitoring and Evaluation: The launch of the Nigeria National Response Information Management System (NNRIMS) is one of the key achievements in Nigeria. The system was designed in alignment with global monitoring and evaluation needs and has been agreed upon by major stakeholders as the core system. The review revealed that Nigeria had accomplished some of the HEAP-set goals for M&E which included periodic update of data through HIV/AIDS syphilis sero-prevalence, conducting a situational analysis of OVCs and establishing the NNRIMS. The major challenges in this area included: lack of gender sensitivity in the system, failure of NNRIMS to address programme evaluation. NNRIMS though a good structure, is still in its early stages of implementation. NNRIMS was based on the HEAP, which had a narrow focus on HIV/AIDS responses and thus needs to be reviewed to be in harmony with the thematic areas in the new NSF.

1.0 INTRODUCTION AND BACKGROUND

1.1 HIV/AIDS in Nigeria

Since the first case of AIDS in Nigeria was reported in 1986, the epidemic has expanded rapidly. The adult HIV prevalence rate has increased from 1.8% in 1991 to 4.5% in 1996 and 5.0% in 2003. Estimates using the 2003 HIV/Syphilis sero-prevalence sentinel survey among women attending antenatal clinics indicate that between 3.2 and 3.8 million Nigerians aged 15-49 years may be infected with the virus. The epidemic in Nigeria has extended beyond the commonly classified high-risk groups and is now common in the general population. With the adult prevalence rate at 5.0% in 2003, the nation is at the threshold of an exponential growth of the epidemic.

While some parts of the country are worse affected, no state is unaffected. In some sites of the survey, the prevalence rate was higher than 10%. All the states of the country have general epidemics of over 1%. There was marked difference in HIV prevalence between major urban areas and sites outside urban areas. The infection cuts across both sexes and all age groups. However, youths between the ages 20 and 29 years are more affected.
An increasing number of children are now being either infected with the virus, through mother-to-child transmission, or are losing both parents to the disease. By all indications, the HIV and AIDS epidemic has continued to grow largely through heterosexual relationships, mother-to-child transmission and contaminated blood and blood products.

The HIV and AIDS crisis has worsened the subordinate status of women and girls. In sub-Saharan Africa, women and girls account for more than half (58 percent) of those living with HIV and AIDS, and infection rates are rising rapidly among young women in many parts of the world including Nigeria. In the worst-affected countries in South Africa, HIV prevalence among girls aged 15-19 is four to seven times higher than among boys their age, a disparity linked to the widespread sexual abuse, coercion, early marriage, discrimination and impoverishment.

**Gender and HIV/AIDS**

In Nigeria, the epidemic’s disproportionate impact on women and girls has risen to a startling new reality: the feminization of the epidemic, rooted in their economic dependency, stigmatisation and the denial of their rights.

The AIDS epidemic poses severe challenges to the human rights of young women and girls. 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 difficult to seek care and to fight 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.

**Mobile Populations, Conflicts and HIV/AIDS**

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 Nigeria’s borders. Movement of professional groups characterized by mobility, for instance, of uniformed personnel, truck drivers, traders, etc., contribute to mobility.

Of increasing significance also is the number of internal conflicts 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 part 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; floods in Bayelsa, Niger, and Bauchi, and explosions in Lagos.
So far no study has given specific 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 programs 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/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 rights to information and education, freedom of expression and association, the right to liberty and securing freedom from inhuman or degrading treatment, the right to privacy and confidentiality and the right to health. In its declaration of commitment on HIV and AIDS, the UN General Assembly acknowledged the important connection between HIV and AIDS and human rights.

*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.*

UN General Assembly Declaration on HIV/AIDS 2001

Although anti-discrimination measures have formed 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 workplace. 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 PLWHA themselves provide incontrovertible anecdotal evidence.

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 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 and AIDS will infect as many as 10-15 million Nigerians by 2010. This number will constitute about 15 to 25% 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% in some hard hit communities.
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% are under 15 years of age) and (ii) the age of the first sexual intercourse (more than 25% 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.

1.2 NACA and HIV/AIDS Emergency Action Plan (HEAP)

In 1999, after the transition to democracy, the new government instituted vigorous response to the AIDS epidemic. The key element of the response was a decentralized approach, with comparable programs at local, state and national levels. Furthermore, the government has undertaken a multi-sectoral approach to mitigate the impact of the epidemic, collaborating closely with the private sector, community-based organizations, faith-based organizations, development partners and other stakeholders.

An inter-ministerial Presidential Committee on AIDS (PCA), chaired by the president, was established, forming the multi-sectoral, multi-disciplinary, National Action Committee on AIDS (NACA), State Action Committee on AIDS (SACA) and Local Action Committee on AIDS (LACA). The National Action Committee (NACA), coordinates the entire national response to HIV and AIDS through the relevant agencies, partners, programs and projects.

The HEAP is the programmatic framework for the national response to HIV and AIDS in Nigeria.
<table>
<thead>
<tr>
<th>SN</th>
<th>Strategies (Areas of Work)</th>
<th>Objectives</th>
<th>Target Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Creation of an Enabling Environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Removal of socio-cultural barriers</td>
<td>To mobilize key influential groups and the general public to respond to HIV and AIDS</td>
<td>Political opinion leaders, General Public</td>
</tr>
<tr>
<td>2.</td>
<td>Removal of information barriers</td>
<td>To develop and maintain an information base to permit policy makers, program managers and the general public to design and implement proactive interventions for the prevention and mitigation of HIV and AIDS</td>
<td>Program Managers, Policy Makers, General Public</td>
</tr>
<tr>
<td>3.</td>
<td>Removal of systemic barriers</td>
<td>To develop National Program management capacity to successfully implement the HEAP</td>
<td>Line Ministries, NACA, SACA, LACA, Private Sector, NGOs</td>
</tr>
<tr>
<td>4.</td>
<td>Catalyzing community-based responses</td>
<td>To mobilize communities to respond to HIV and AIDS</td>
<td>Community-Based Populations</td>
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<tr>
<td>B.</td>
<td>Specific HIV and AIDS Interventions</td>
<td></td>
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<tr>
<td>5.</td>
<td>Preventive interventions targeted at high-risk populations:</td>
<td>To reduce HIV transmission among youths</td>
<td>Young people aged 10 – 24 years</td>
</tr>
<tr>
<td>6.</td>
<td>• Youths: high-risk &amp; non-high-risk youth population</td>
<td></td>
<td></td>
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<tr>
<td>7.</td>
<td>Preventive interventions targeted at high-risk populations:</td>
<td>To empower women and girls to negotiate safer sex</td>
<td>Women, Girls</td>
</tr>
<tr>
<td>8.</td>
<td>• Empowerment of women to negotiate safer sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Preventive interventions targeted at high-risk populations:</td>
<td>To reduce HIV transmission amongst personnel of the Armed Forces and the Police</td>
<td>Armed Forces, Police personnel</td>
</tr>
<tr>
<td>10.</td>
<td>• HIV and AIDS intervention with the armed forces and the police</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Preventive interventions targeted at high-risk populations:</td>
<td>To prevent mother-to-child transmission of HIV</td>
<td>Women of reproductive age and children</td>
</tr>
<tr>
<td>12.</td>
<td>• Prevention of infection through MTCT</td>
<td></td>
<td></td>
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<tr>
<td>13.</td>
<td>Preventive interventions targeted at high-risk populations:</td>
<td>To integrate participatory mapping, peer counseling and promotion of condom use by CSWs</td>
<td>CSWs, Partners, Clients</td>
</tr>
<tr>
<td>14.</td>
<td>• Commercial sex workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>Preventive interventions targeted at high-risk populations:</td>
<td>To reduce the rate of infection amongst prison population and staff and immigration</td>
<td>Prisoners, Prison Staff, Immigration Personnel</td>
</tr>
<tr>
<td>16.</td>
<td>• HIV and AIDS intervention in prisons system and immigration service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>Preventive interventions targeted at high-risk populations:</td>
<td>To prevent HIV infection and provide care and support for workers infected and affected through the initiation of workplace policies and programs</td>
<td>Workers in the public and private sector workplaces, including the informal sector workers</td>
</tr>
<tr>
<td>18.</td>
<td>• Workplace policies and programs related to HIV and AIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>Preventive interventions targeted at high-risk populations:</td>
<td>To reduce the rate of transmission amongst LDDs, touts, seafarers</td>
<td>LDDs, Touts, Seafarers</td>
</tr>
<tr>
<td>20.</td>
<td>• HIV and AIDS interventions for Transportation-related workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>Preventive interventions targeted at high-risk populations:</td>
<td>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 counseling and testing (VCCT)</td>
<td>Health Care Providers, General Public, PLWHA</td>
</tr>
<tr>
<td></td>
<td>Care and support for persons infected with HIV and AIDS</td>
<td>To provide care and support for persons infected with HIV and AIDS</td>
<td>PLWHA</td>
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<tr>
<td>14.</td>
<td>Care and support for persons affected by HIV and AIDS</td>
<td>To provide care and support for persons affected by HIV and AIDS</td>
<td>AIDS orphans, widows, guardians, affected families, affected communities</td>
</tr>
</tbody>
</table>
2.0 OVERVIEW OF THE NATIONAL RESPONSE REVIEW (NRR) PROCESS

2.1 Goal and Objectives of the NRR

Goal
• To review the National Response based on HEAP 2001-4

Objectives of the NRR
• To conduct a situation and response review of the National HIV/AIDS Response in 8 thematic areas through:
  ➢ Review of progress towards delivering the HEAP
  ➢ Review the objectives, targets and expected outcomes based on the indicators in the NNRIMS
  ➢ Identify and share strategic information about the National Response
  ➢ Document & share local best practices on the prevention and control of the HIV/AIDS epidemic
  ➢ Incorporate emerging issues in the response to the epidemic
  ➢ Identify and agree on main priorities & milestones for the next two years FY 2005/6

2.2 Methodology of the NRR

The guiding principles of the methodology of national response review are; participation of stakeholders, consultation with key actors, inclusion of all sectors, wide geographic representation and involvement of all tiers of government and the private sector.

The Process

The process involved definition of the scope of work and establishment of the review coordination structures, including identification of constituent coordination entities. Next was definition of thematic group work plan which consisted of desk review, field visits, interviews with key informants and technical working group meetings. The process was concluded by validation of the NRR by the constituent consultative entities as established in the HIV/AIDS Partnership Forum

Thematic Grouping of NRR

The NRR was conducted under eight thematic areas as indicated in the following table.
### Table X. Technical Thematic Working Groups

<table>
<thead>
<tr>
<th>TWG</th>
<th>Technical group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Prevention, Behavioral Change</td>
</tr>
<tr>
<td>2</td>
<td>Care, Treatment and support</td>
</tr>
<tr>
<td>3</td>
<td>Socio-economic impact of the epidemic</td>
</tr>
<tr>
<td>4</td>
<td>Regional programmes and emerging issues</td>
</tr>
<tr>
<td>5</td>
<td>Policy, Advocacy, legal issues and human rights</td>
</tr>
<tr>
<td>6</td>
<td>Resource Mobilization and Management</td>
</tr>
<tr>
<td>7</td>
<td>Coordination, Institutional arrangements, Capacity decentralization and local responses &amp; social support</td>
</tr>
<tr>
<td>8</td>
<td>Monitoring and Evaluation, research and surveillance</td>
</tr>
</tbody>
</table>

#### 2.3 Review Consultants Team

To be included later

#### 2.4 Organisation of the Findings

The findings of the NRR in the eight thematic areas, are presented in such a way that they highlight the following components:

- Progress to date
- Constraints
- Emerging Issues and
- Recommendations
3.0 GENDER ANALYSIS OF THE HEAP, NATIONAL HIV/AIDS POLICY AND NNRIMS

The HEAP, National HIV/AIDS policy and the NNRIMS are three key federal policy documents. Against the background that gender inequalities fuel the HIV epidemic, such federal policy documents, which provide a roadmap for a national response to HIV and AIDS, should as much as possible address the gender issues in HIV and AIDS in their provisions. This section of the report analyses the degree to which gender is mainstreamed in the three policy documents. The analysis will be based on the key components of policy documents namely; the executive summary, the contextual background, goals and objectives, strategies and monitoring and evaluation.

3.1 Executive Summary:

The Executive Summary of the HEAP mentions gender in passing without providing contextual evidence necessitating the mainstreaming of gender into the document. It recognizes that a proactive and aggressive response to gender issues is critical but states this in general terms with no follow-up gender sensitive goal, objectives or strategies. There is no mention of gender in any form as part of the guiding principles for the document. The National policy on HIV/AIDS and STIs recognizes the subjugation and subordination of women as a constraint to realizing the full impact of the national response. However, the policy goal, objectives and strategies are gender neutral, focusing attention on controlling the spread of HIV/AIDS and mitigating its impact on a seemingly monolithic Nigerian people. The NNRIMS is without an executive summary. The first chapter which discusses the situation of HIV and AIDS in Nigeria does not discuss the gender dimensions of the Nigerian epidemic, and expectedly the goals, objectives and strategies are gender blind.

Statistics show that women are increasingly more infected with the virus. Factors that affect the spread of the epidemic, like socio-cultural, religious and economic factors all have gender undertones and the whole spectrum of the HIV/AIDS epidemic from prevention to impact affect boys and girls, men and women differently therefore, it is important in all policy documents to highlight the main gender issues as they pertain to HIV and AIDS in the executive summary.

3.2 Contextual Background/Situation Analysis/Introduction

The situation analysis in the HEAP does not provide a comprehensive analysis of the determinants of the HIV/AIDS epidemic. It does not take into consideration the high vulnerability of women and girls to sexually transmitted infections due to their biological construct, nor does it discuss the implications for young girls married off to older men
with multiple sex partners. The analysis is silent on polygamous relationships or seemingly monogamous partnerships with an unfaithful spouse. Cultural factors that are discriminatory against women and aid the propagation of the epidemic is not discussed, neither is the role of poverty, especially in women, in the transmission, infection, care, treatment, support and impact mitigation highlighted in the document. The National HIV/AIDS policy also does not provide gender disaggregated data when discussing the HIV prevalence. The document highlights the particular risk of young people between the ages 15 to 24 years but is silent on the peculiarities for young girls with a risk more than 2 times higher than their male counterparts in the same age group. In discussing the impact of HIV the policy fails to highlight the differences in impact on men and women, girls and boys within the various sectors of health, social and economic. Expectedly, since the problem diagnosis was lacking in gender analysis, the implementation strategies proposed were also gender insensitive. Although there is a mention of interventions for female sex workers, the policy did not take into account the fact that Nigeria’s epidemic is mature and therefore in the general population with monogamous ‘faithful wives’ becoming increasingly more infected with HIV. The situation analysis in the NNRIMS seems to be guided by the HEAP and National HIV/AIDS Policy. The same issues apply with gender blindness in terms of data and vulnerability in the discussions of the HIV/AIDS situation in Nigeria.

3.3 Goals and Objectives

A few objectives in the HEAP were targeted at women- the objectives on PMTCT and that on female sex workers and negotiation of condom use. The fact that women are more infected than men, and that the epidemic impacts heavier in women than in men is not evident in the formulation of the HEAP’s objectives. The HEAP does not clearly show that the HIV/AIDS epidemic is different in women and in men in terms of transmission, prevention, care, support, and impact, and therefore strategies emanating from these objectives are not gender responsive. The goal of the HIV/AIDS policy is gender neutral. Though one of the policy’s guiding principles is based on human rights, social justice and equity, the policy does not seem to have taken the differential impact of the epidemic on boys, girls, women and men into consideration. None of the twelve objectives in the policy indicated how the particular needs of women and girls would be addressed. The role of gender in vulnerability to HIV infection, access to information and services, provision of care, etc is conspicuously absent from the policy document. The NNRIMS is a good first start in the process of engendering Nigeria’s response to the HIV/AIDS epidemic. There are a few gender indicators in the document but work still needs to be done to highlight the special needs of men and women for effective programming.

3.4 Strategies and Guidelines

It is not surprising that the strategies in the HEAP and the National HIV/AIDS Policy are not engendered as the strategies were developed based on the contextual issues and the situation analysis, which were devoid of gender in the HEAP document. In the development of strategies for prevention, the low status of women and their inability to make choices or seek care, including those related to their sexual and reproductive health
were not taken into cognizance. The socio-cultural factors that affect the spread of the epidemic, including violence against women, wife inheritance and hospitality, polygamy, low literacy levels, myths about having sex with a virgin to cure AIDS, etc were not addressed. The strategy to promote safer sex behaviour addresses the empowerment of women through education and legislation to protect them from unsafe sex. It is however silent on the education of men, who sometimes would not seek knowledge. Where men take the lead in the negotiation of safer sex efforts usually yield better results, especially where they are able to respect women when they say no. The sub-strategy on condom use is limited to male condoms and value will be added if expanded to include the female condom and other female controlled methods like microbicides. The sub-strategy on blood safety should take into account the frequent blood transmissions in pregnant women due to anaemia, strategies for ensuring the rational use of blood would be beneficial. While the sub-strategy for VCCT and PMTCT address women rightly, strategies to address the benefits of men accompanying their spouses to ANC and enrolling in VCCT programmes are articulated. This would reduce the stigma of the women for being the first to be diagnosed in the family and would ensure support for breast feeding options for the mother and father if positive. The opportunity of both the father and mother to be enrolled in an ARV programme will also be an advantage for the family and future of potential orphans. Under the strategy for adolescents and Youth, the particular needs of young girls and married adolescents at high risk of infection are not taken into consideration. Prevention strategies for high-risk groups, highlights uniformed forces, police, commercial sex workers and prison and migration border control. Strategies for addressing MSM should also be added. Strategies for care and support promotes the protection of human rights for People Living with AIDS and advocates for the national HIV/AIDS policy to advocate for the creation of supportive environment for orphans, girls and boys infected by HIV/AIDS to enroll in school. It also deals with Home Based Care. Strategies to protect women carers from getting the infection due to lack of information are necessary. Research into the particular opportunistic infections for women would be beneficial to determine the appropriate drugs for these infections. Guidelines for equitable access to ARVs and ensuring availability of these drugs at community levels where the majority of women live would also be beneficial. Widows should be included in the sub-strategy addressing support to PLWHAs. Some Nigerian laws that contribute to the vulnerability of young women, girls men and boys to HIV should be reviewed so that the National HIV/AIDS Policy would be in synchrony with these laws.

3.5 Monitoring and Evaluation

The HEAP recognizes the place of gender in its guiding principles and also discusses the need to review and modify policies to reflect gender equality relating to HIV and AIDS. Gender is not adequately mainstreamed in the document however as evident by baseline studies, activities and indicators. The guidelines for the formation of NACA, SACAs and LACAs are devoid of any gender considerations. Within the NNRIMS document none of the sources and methods of data collection mention gender as an important aspect of the data. The indicators within the document however are clearly gender disaggregated and
will give relevant information on how men and women respond to HIV/AIDS. There will be value added to include an annual publication on women and HIV/AIDS.

It is hoped that a review of gender mainstreaming in the current three key policy documents, will provide a window of opportunity for the gender mainstreaming in the future development and review of similar policy documents.

4.0 PREVENTION AND BEHAVIOR CHANGE

This thematic area addresses interventions to raise HIV/AIDS awareness, increase knowledge, and achieve behavior change. The HEAP strategies focused on increasing awareness and sensitization of general population and key stakeholders promoting behavior change in both low-risk and high-risk population; and removal of socio-cultural barriers.

Prevention and behavior change communications constituted over 70% of the interventions during the period. Behavior change communication programs, targeted at-risk, high-prevalence groups, including youth, sex workers, and the uniformed services with activities that included development and distribution of IEC materials, training of peer educators, focus group discussions, condom promotion, media programming and outreach programs channeled through religious groups, schools, unions, community-based organizations, and the workplace. As a result of these efforts, cumulative data from production of IEC materials indicated that materials reached more than 20 million people, most of whom are in urban areas.

Currently, there exists a generalized awareness about the disease. The 2003 National HIV and AIDS Reproductive Health survey (NARHS)\(^1\) conducted revealed that 8 out of 10 adults have heard of HIV and AIDS, but fewer are knowledgeable about it. The findings indicated little knowledge of the primary modes of HIV transmission, inconsistent condom use in high-risk situations, and low estimations of personal risk.

4.1 Progress to Date

4.1.1 Youth

Young people especially women; 20-24 years old are increasingly becoming vulnerable. It is estimated that up to half of new infections occur among them. In the 1999 sero-prevalence survey, the youths had the highest rate of 6%. This figure declined to 5.2% by 2003, but it is still higher than the national median rate of 5%.\(^2\)

Within the context of the HEAP\(^3\), one of the issues identified that could limit the impact of the national response was the low participation of young people. In addressing this, a National Youth Consultative meeting was facilitated by NACA and the UN system. In attendance were 50 youth representatives drawn from the six geopolitical zones. This was

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\(^1\) 2003 National HIV and AIDS Reproductive Health survey
\(^2\) National HIV/AIDS/Syphilis Sero-Prevalence Sentinel Survey
\(^3\) HIV/AIDS Emergency Action Plan
followed by the National Youth Forum which drew 250 young people from 36 states and the FCT. The purpose of these meetings was to facilitate the establishment of a viable youth network as a key strategy for ensuring effective youth participation in the national response. The participation of youths in conferences, both national and internationally supported by donor agencies are evidence of increasing commitment to build the capacities of youth in program policy formulation, development and implementation of sustainable youth-friendly interventions.

Schools have traditionally been readily available communication sites for reaching the in-school youths, thus training of peer educators through the National Youth Service Corps and by youth-serving NGOs, and formulation of anti-AIDS clubs in secondary schools were common approaches used to educate youth and for condom distribution. The community youth AIDS educational programs targeted to reach youth particularly out-of-school youths utilized entertainment through organization of musical concerts and dramas. This approach was effective in reaching a wider audience, and is believed to have led to a high awareness among youth and relative reduction in STIs, though the impact of this has not been properly documented.

The adoption and introduction of the Family Life Education Curriculum (FLE) into primary and secondary schools, and the introduction of the mandatory HIV/AIDS course by all post secondary school students are strides to increase knowledge and to change high-risk behavior.

Through the John Hopkins University Center for Communication Programs, USAID supported an HIV/AIDS telephone hotline for youths in Lagos area, and the “Caring and Understanding Partners” media campaign, which used prominent football players to convey HIV/AIDS prevention messages through commercials and personal testimonies. Similarly, through CEDPA, assistance was provided to several women’s and church based organizations to raise awareness and increase use of reproductive health services, including HIV/AIDS services for young women. The “Zip Up” and similar campaigns from SFH were also conducted.

Through a public private partnership between NACA, the University of Port-Harcourt and Ecobank Transnational Incorporated (ETI), a youth-friendly center was established at the University of Port-Harcourt. The youth-friendly center model is designed to provide health, educational and recreational services including VCT and treatment of STIs for youths in tertiary institutions.

4.1.2 National Behavior Change Communication Strategy

The effectiveness of any campaign is dependent on the specificity of the strategy to the targeted audience. The development of the National HIV and AIDS Behavior Change Communication Strategy (NBCC)\textsuperscript{4} as a framework for effective target programming demonstrates the commitment to increase the knowledge of the prevention of HIV/AIDS;

\textsuperscript{4} National HIV and AIDS Behavior Change Communication Strategy
reduce the rate of new infections, and to enhance a coherent, and comprehensive response from every sector of the society. The NBCC plan recommends that a substantial part of the national and stakeholders efforts and resources be directed to prevention strategies. When fully implemented, Nigeria will achieve remarkable success in behavior change communications globally.

Despite the emphasis placed on promoting abstinence among the public, there seems to be less visible result considering the number of youths who are increasingly becoming vulnerable to HIV/AIDS. Perhaps, because of the secrecy surrounding the subject of sex, it has been difficult getting accurate data on the proportion of persons, particularly the youth, who practice abstinence. On the use of condoms, NARHS survey found that knowledge about condoms is higher in males than in females; (70% and 54%). There are also huge differences between urban and rural areas, 54% in rural as opposed to 86% in urban areas. While the majority of both female and male respondents feel that condoms are accessible and affordable, only 23% of male and 8% female respondent ever used or are using it.

4.1.3 Civil Society Organizations

There has been an increasing presence and visibility of NGOs in AIDS related activities. More than 700 NGOs working in the area of HIV/AIDS have been identified and mobilized to form a coalition known as CISNHAN. An evaluation of NGOs supported through the World Bank HIV/AIDS Fund (HAF) and mapping of CSOs in target states revealed that many of these organizations focused on community mobilization, prevention, and behavior change communications.

Religious institutions wield enormous influence in shaping the values, morals and behavior of their members, and as such they influence acceptance or rejection of messages on HIV/AIDS. Recognizing the potential of religious groups, an Interfaith Coalition on HIV/AIDS was formed in 2002. The coalition operates through a membership network, with 51 member institutions, out of which 41 are national and 10 are regional groups representing Christians and Muslims.

Faith-Based organizations are now increasingly involved in AIDS prevention, care and support. Most FBOs have integrated HIV/AIDS messages into their sermons thus creating opportunities to reach a large percentage of the general population. During the period, the Interfaith Coalition conducted needs assessment in 9 states, developed a joint action plan by member institutions, endorsed a statement of commitment on stigma and discrimination; provided training for 80 zonal coordinators in two geopolitical zones in the country.

5 National Reproductive Health Survey 2003
6 ActionAid Mapping of Civil Society Organisations January 17th 2005
7 Personal discussion with the National Coordinator of Interfaith Coalition
Encouragement of HIV testing among potential marital partners by some religious bodies has contributed to increase in the awareness among the vulnerable population on needs for prevention and being faithful.

### 4.1.4 Traditional Rulers

Traditional rulers are instrumental in prevention and behavior change communications. During the period under review, many traditional rulers across the country were sensitized in order to address the socio-cultural barriers.

### 4.1.5 Mass Media, Theatre and Entertainment

The mass media and other multi-channels of information dissemination like the Theatre, Arts and entertainment have played active roles in creating public awareness and understanding about HIV/AIDS and mobilizing support for policy changes and involvement of the government and the public towards prevention and behaviour change as part of HIV/AIDS control. The media produces variety of programmes and engages in numerous coverage on the subject. In addition, media based NGOs like JAAIDS, Devcom, and Internews, have engaged in series of capacity building activities for media personnel and opened resource centres.

The Theatre and Entertainment have also engaged in enter-educate activities like stage plays, video shows and musical performances in different locations. For example, National Association of Nigerian Theatre Arts Practitioners (NANTAP) dedicated the International Theatre Day (ITD) to HIV/AIDS in 2002 and has also conducted series of grass root HIV/AIDS awareness programme through its ‘AIDS-GRIP’ programme (World Bank Assisted). Members of Performing Musicians Association of Nigeria (PMAN) had waxed musical records and videos that promote HIV/AIDS prevention and behaviour change.

### 4.1.6 Most at Risk Population (MARP)

Most At Risk Persons are defined as those with a higher chance of contracting or transmitting HIV either because of their level of involvement in high-risk behaviors. The population consists of sex workers, long distance drivers, and uniformed personnel. General awareness about HIV/AIDS is high among these target groups with increasing level of involvement and participation in HIV/AIDS activities. Prior to HEAP, in 1999, Family Health International (FHI) and the National AIDS and STDs Control Program (NASCP) carried out a limited behavioral surveillance survey in selected states among high-risk groups including sex workers, and male truck drivers.8

In 2001, Population Services International/Society for Health (PSI/SFH) carried out another survey on risk perception of HIV/AIDS and safe sex practices among sex workers.

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8 Family Health International (FHI) and the National AIDS and STDs Control Program (NASCP) Behavioural surveillance survey 1999
workers in selected sites in the six geopolitical zones. The survey found out that whereas nearly 100% of sex workers have heard of HIV/AIDS, and 80% knew that HIV is transmitted through sex, less than 40% knew that non-condom use increases risk.\textsuperscript{9} Condom usage is an important variable that needs to be tracked in order to measure behavioral change among MARPs. A mapping of junction towns/hot spots and services delivery points was conducted in 2003. Sensitization rallies and carnivals were conducted by the Nigerian Union of Road Transport Workers (NURTW) in Kano, Lagos, Ibadan, Okigwe, Jalingo, and Onitsha.

The Armed Forces Programs on AIDS Control (AFPAC) had been in existence since 1987. Its HIV/AIDS control activities reflect a multi-sectoral approach by treating HIV/AIDS as a welfare issue and not just a health problem. Consequently, all interest groups in the military communities are involved in the prevention and care efforts with strong emphasis on behavioral change interventions. In 2002, AFPAC, trained 1,800 armed forces personnel as peer educators and reached more than 50,000 personnel with HIV/AIDS information and counseling\textsuperscript{10}.

AFPAC have set up counseling centers in many units across the country, and provided training for peer health educators in military schools and in every command unit for effective dissemination of IEC materials. AFPAC has also set up outlets in all officers’ mess where condoms are accessible. Also, efforts are being made to ensure armed forces personnel living with HIV benefit from the ARV program of the Federal Government. The Police AIDS Control Committee (PACC) and local NGOs through support form various local and international partners are implementing HIV/AIDS prevention services among armed and allied forces.

Increasing number of NGOs and FBOs are focusing on effective interventions among prison inmates with Ministry of Internal Affairs working to enhance the creation of an enabling environment.

4.1.7. Prevention of Mother to Child Transmission (PMTCT)/VCT

In line with the resolutions of the African governments to stem the tide of mother-to-child transmission of HIV/AIDS, the Federal Ministry of Health commenced the development of a national Prevention of Mother-to-Child Transmission (PMTCT) of HIV/AIDS program in 2001.

Currently PMTCT sites are available in 12 tertiary health sites located in 10 states and Federal Capital Territory. A national PMTCT Communication Strategy was developed with commencement of implementation in 2002 to foster advocacy, social mobilization and behaviour change.

Voluntary counseling and testing services are linked to the PMTCT program located in the ante-natal clinics of the 12 tertiary health facilities. While there is a strong

\textsuperscript{9} Population Services International/Society for Health (PSI/SFH) 2001
\textsuperscript{10} USAID-Nigeria HIV/AIDS Strategy Assessment Report, April 2002
commitment to meet the demand for VCT, the services outside the government-run programs are unregulated and many do not conform to standard protocols.

As a result of training of health care providers, there is an increasing willingness by people to be tested.

4.1.8 People Living with HIV/AIDS (PLWHA)

The Network of People living with HIV/AIDS in Nigeria (NEPWHAN) is the umbrella organisation that coordinates support groups of PLWHA. NEPWHAN was established in 1998 with activities and achievement ranging from; formation of new support groups and strengthening of the existing ones through institutional capacity building; capacity building of members; provision of food supplements; representation at ARV centres; as well as advocacy to government, traditional rulers, trade unions and other stakeholders.

The support provided by the Ford Foundation to AIDS Alliance to provide care and support, including voluntary counselling has yielded significant results, by bringing about the visibility of PLWHA. Through the support of UNDP, the capacity of coordinators of support groups was built on advocacy, prevention, VCT and community home-based care.

Through the support of development partners, PLWHAs have been able to contribute to HIV/AIDS prevention and behaviour change program. Also, during the period there has been an increase in number of people who have openly declared their status and are coming together to form support groups. The involvement of trained PLWHA counsellors in strategic ways is tremendously helping to demystify HIV/AIDS and build commitment of support groups in promoting HIV prevention and behaviour change.

4.1.9 Innovative Prevention and Behavior Change Communication Strategies

Thousands of people get infected with HIV daily in spite of the various approaches by government and non-governmental organizations to educate people on HIV/AIDS prevention and control measures. This necessitates the need for innovative intervention strategies in the area of HIV/AIDS prevention and control. One approach successfully used by Community Life Project (CLP) to address HIV/AIDS within Isolo, a low to medium residential area in the city of Lagos, is the use of participatory approach in the design and implementation of its programs.

Another strategy used by the Nigeria Youth AIDS Program (NYAP) is blending learning with amusement, leisure or hobby. NYAP explored the use of football as a tool for HIV/AIDS education, community mobilization, participation and empowerment. It organizes the NYAP super cup tournament involving all home teams in a local government area. A selection criterion for the tournament that enhances HIV/AIDS prevention is the need for team members and referees to participate in an HIV/AIDS prevention education workshop. The half time is also used to educate spectators about
HIV/AIDS through organized quiz sessions between selected members of the playing teams, distribution of IEC materials and a talk on basic facts on HIV/AIDS.

Another strategy adopted by Association for Reproductive and Family Health (ARFH) is the use of market agents as conduits of change in attitudes and behaviors. In October 2002, the Nigerian Ministry of Labor and Productivity set up hotlines for PLWHA in the Nigerian Civil service that are being threatened with or discriminated against in their place of work. The hot line services have been used by over 50 persons.

The Federal Government, through some ministries, is working towards providing people oriented programs at the grass-root level. Several media houses like the ASO Radio, Nigerian Television Authority (NTA) and FRCN have produced programmes on different aspects of HIV/AIDS.

4.2 Constraints

Non-Involvement of Traditional Rulers: In certain African societies, certain individuals are identified as agents of social control, thereby, invariably determining the flow of information or materials in society. These individuals are referred to as gatekeepers; they are known, respected and influential. In developing IEC materials and behavior change communication campaigns, there is the need to critically understand the important role that gatekeepers play in determining the efficacy of campaign messages on target audience. This would enhance targeted communication campaigns without offending social values, norms and belief systems.

The non-involvement of traditional rulers in the planning and implementation of AIDS programs has been identified as a major gap that has limited the effectiveness of past interventions. Risky practices deeply imbedded in the socio-cultural milieu of communities are unlikely to change by outside imposition of programs. Mobilizing and using traditional leaders to redress negative socio-cultural practices is more likely to be successful. The limited contribution and ownership of intervention programs by the traditional rulers and their communities are major limitations. The modest involvement of traditional rulers in the current HIV/AIDS activities appears not to be organized and coordinated.

Socio-cultural barriers: Strong views have been expressed that most HIV/AIDS control activities have been carried out at the expense of socio-cultural, religious, family and personal values, the transgression of which can only lead to increasing resistance from gatekeepers of those norms traditional and religious leaders.11

HEAP’s approach to supporting local interventions: NACA recognized that, given the decentralized nature of the nation’s political environment, mobilization of local communities is critical for HIV/AIDS control. It therefore included a separate strategy for catalyzing local responses in the HEAP. The strategy’s main thrust is the creation of a

community-based fund to ensure unobstructed flow of resources to local communities. The fund will support community mobilization, selection and training of community volunteers, and the design and implementation of Community Action Plans. LACA will provide technical support to local communities in the development of their action plans while funds will flow directly to communities whose plans are approved by SACA. Unfortunately, the structures through which community supports are to be received are presently not in place. Most states do not have functioning SACA or LACA. Community based activities are often spearheaded and supported by NGOs who in turn, are donor dependent. Some organizations have therefore evolved ways of reaching out and working effectively with communities.

**Spread and capacity of NGOs:** Most of the youth services are provided by NGOs and FBOs. The NGO culture is comparatively young in northern part of Nigeria. There is an inequitable distribution of NGO services with the majority of them located in the south, especially the southwestern part of the country. Recent literature noted the linkage between prevention, care, treatment and support as an effective delivery mode for HIV/AIDS control. The current national response is limited by lack of technical assistance and capacity enhancement for NGOs responses to youth and most at-risk persons. There is limited context-specific IEC materials and training of peer educators to enhance outreach.

**Condom efficacy and Sex Workers (SW):** There is negative perception of condom efficacy. This was promoted by the attitude of men and lack of negotiation skills by SWs, inaccessibility of condoms in rural areas and unavailability of female condoms. Difficulties in reaching SWs due to fear of stigmatization and harassment by the police, insufficient VCT centers and attitude of health care workers to SWs, as well as lack of information on VCT sites.

**Monitoring and evaluation of BCC:** There is a lack of effective monitoring and scientific evaluation of BCC and other prevention activities.

**Willingness to test:** The cost attached to VCT outside the PMTCT and the lack of regulation hinders the willingness for testing services.

### 4.3 Emerging Issues

- While the need to reach MARPs is being increasingly acknowledged, it is equally important to recognize that distribution of condoms is not sufficient.

- Prevention is usually considered to most as commonly involving education and the promotion of safer sexual practices. However, food and livelihood insecurity often leads people into behaviors and strategies that increase their risk of infection, such as migration and prostitution.
Improving livelihoods, especially among the most vulnerable groups in society, can provide a concrete way to tackle one of the most fundamental issues behind prevention and behavior change.

4.4 Recommendations

- **Institutional Leadership**: There is an urgent need to empower the line ministries especially Information Ministry and National Orientation Agency with technical assistance from health communication experts to take the lead in coordinating the BCC aspects of the national HIV and AIDS response.

- There should be full involvement and participation of the media, both private and public and the commissions. Efforts should be made to ensure that female journalists and media professionals participate at all levels of the media sector response.

- **National 5 year BCC Strategic framework on HIV and AIDS**: There must be a coordinated approach to institutionalise the use of the document to design, implement and evaluate BCC programs. This document should be incorporated into the broader National Strategic Response Framework and coordination mechanisms well defined at national, zonal, state, LGA and community levels to drive the process.

- **Youth Friendly Strategies and Interventions**: This should be promoted among young people, especially abstinence, and delay of sexual debut. Consistent condom use should be promoted among young people who are sexually active. It is critical to utilise existing youth organizations (and promote the establishment of female -led youth organisations) for intervention strategies on Adolescent Reproductive Health (ARH) particularly for out-of-school males and females.

- **Gender Mainstreaming**: It is critical that BCC and prevention programs and actions take into cognizance the disproportionate impact of HIV and AIDS on women and girls. BCC and prevention efforts must actively target and involve these groups in planning, implementing and evaluating responses to mitigate HIV and AIDS.

- **PMTCT**: There is an urgent need for a campaign to change the attitude of mothers and young females towards testing for HIV. It also becomes critical to enlighten those already infected on their chances of preventing the vertical transmission of the virus to their babies. There is also a need to equitably institutionalize comprehensive PMTCT -Plus programs that will cover care of HIV positive women, their male partners and children nationwide. PMTCT is still very low in Nigeria. There is a need to strengthen existing centres and rapidly scale up services to include comprehensive care, treatment and support.

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12 National 5 year BCC Strategic framework on HIV and AIDS 2004
components that addresses the needs of the HIV positive mother and her immediate family beyond the postnatal period.

- **Advocacy**: No strategy will be successful without a strong coalition of supporters and key stakeholders who are willing and able to approach all the relevant leaders and gatekeepers and to hold those leaders accountable for specific deliverables. There is a need for more open, gender-equitable policies and increased allocation of resources and funds to address HIV/AIDS prevention.

- **Stigma**: It drives the HIV/AIDS epidemic, and as such it needs to be addressed from the outset as an underlying and consistent BCC theme, until surveys show it is no longer a major factor.

- **Information, education and communication**: Provide accurate and culturally sensitive prevention education and services that also promote gender equality and safety in sexual relationships, and the respect of human rights.

**Others**

- Reduce harassment of female sex workers by sensitizing all cadres of the uniform personnel in HIV/AIDS prevention activities.
- Promote sex workers friendly services for treatment of STIs by training health workers
- Increase advocacy among brothel owners through regular meetings and consultations and provide capacity building towards effective negotiation skills for SWs, utilizing SWs as facilitators
- Increase the capacity of the media, arts and entertainment to respond adequately to HIV/AIDS prevention and control.
- Engage long distance drivers in interpersonal communications to develop campaigns and provide information booths and IEC/BCC materials on health and HIV/AIDS at motor parks and junction towns
- Improve access to treatment of STIs within health services sector.
- Promote Parent-To –Child communication among the general public
- Utilize mobile communication units at hotspots, junction towns and in uniform services settings (police/army/prison barracks).
- Adopt communication strategies for different gatekeeper around the country e.g. Parent Teacher Association (PTA), Media, Arts and Entertainment, etc.
- Encourage government officials and celebrities to access VCT services in order to serve as role models for other to emulate.
5.0 CARE, SUPPORT AND TREATMENT

Government recognizes its responsibility to provide access to Care, Treatment and Support to all persons living with HIV and affected by AIDS. Given that no curative therapy currently exists for AIDS, effective management must include emphasis on compassion and support for the persons infected and affected by HIV/AIDS. The HEAP strategies on Care, Treatment and Support were “to provide Care & Support for persons infected and affected by HIV/AIDS”\(^{13}\) while the totality of the national response to date, reveals a multi-sectoral attempt at providing comprehensive, effective, affordable and accessible treatment with the objective of reducing HIV/AIDS morbidity and mortality.

5.1 Progress to Date

The government is committed to the establishment of a network of voluntary and confidential counseling and testing (VCT) services to provide access to affordable, high quality testing and counseling. However, VCT services are presently provided in very few government centers and by Bi-lateral/Development partner-supported NGO and FBOs such as Salvation Army\(^{14}\), SWAAN, Catholic health facilities\(^{15}\) and even CBOs like Network on Ethics, Law and HIV/AIDS (NELA)\(^{16}\) Ibadan, Mother’s Welfare Group (MWG) Kaduna\(^{17}\), Lifeline plus Foundation Enugu, e.t.c. FHI supports both stand-alone or facility integrated VCT centers while Catholic centers in mainly Northern dioceses, are funded by CAFOD England and Missouri (Germany) to mention just a few among many.\(^{18}\)

All screening facilities must apply the prescribed national protocol for HIV testing provided by the Federal Ministry of Health and be certified by the government according to Federal Ministry of Health (FMOH) protocols. The FMOH provides national leadership in implementing anti-retroviral therapy programs including developing ARV treatment guidelines\(^{19}\), allocating resources and providing technical support to states and implementers. Normative technical assistance in developing these treatment policies, guidelines and strategies is provided by WHO.

In 2001, the government announced a program to provide anti-retroviral treatment to 10,000 adults and 5,000 children living with HIV/AIDS at subsidized rates within the context of the National HIV/AIDS Emergency Action Plan. Meanwhile WHO estimates of number of people requiring treatment by end of 2005 was 520,000\(^{20}\). The government program to provide anti-retroviral treatment began in 2002 with the purchase of drugs

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\(^{14}\) Activity reports outline 2001-2004 Salvation Army

\(^{15}\) Summary of activities 1990-2004 Network of Health Coordinators –Catholic North Dioceses

\(^{16}\) Activity report 2001-2004 Network on Ethics, Law and HIV/AIDS (NELA)

\(^{17}\) Activity report: 2004. Mothers Welfare Group (MWG) Kaduna

\(^{18}\) Activity reports outline 2002-2004: FHI,

\(^{19}\) ARV Guidelines FMOH 2004 and Plan to Scale-up Antiretroviral treatment for HIV or AIDS in Nigeria 2005-2009 FMOH, 2004

and test kits for 10,000 people. Treatment started in 25 tertiary institutions, with preventing mother-to-child transmission growing from six model centers to currently 11 model and 22 satellite centers. Many treatment centers have exceeded treatment quotas and about 17,000 people are currently receiving anti-retroviral therapy\textsuperscript{21}. Of these, 11,435 received treatment through the government-subsidized program. Drugs were procured through private pharmaceutical companies like Ranbaxy\textsuperscript{22} and Cipla, while Roche/Swipa, Glaxo-Smith-Kline and other pharmaceuticals companies also account for the ARV drug available in the Nigerian market.

The Center for Specialist Studies … USA, provides free anti-retroviral drugs on a monthly basis to people living with HIV/AIDS including treatment for children at the Shagamu Community Center in collaboration with the Ogun state Teaching Hospital, Shagamu, while the DFID-LATH program, provided technical support on VCT and CHBC on this project.

The AIDS Prevention Initiative in Nigeria (APIN), a project of the Harvard School of Public Health with funding from the Bill and Melinda Gates Foundation supports preventing mother-to-child transmission, diagnosing HIV/AIDS and monitoring clients on anti-retroviral therapy at two (2) sites; University College Hospital, Ibadan and Jos University Teaching Hospital\textsuperscript{23}, while the Centre for Disease control and prevention/Institute of Human Virology University of Maryland, Baltimore, in collaboration with FHI supports four (4) PMTCT sites -Aminu Kano Teaching Hospital, Kano; National Hospital, Abuja; University of Benin Teaching Hospital, Benin and Nnamdi Azikwe University Teaching Hospital, Nnewi.

UNICEF’s provided technical support for procurement and assistance in obtaining the highest quality anti-retroviral drugs at the best prices, while UNDP’s collaboration with the United Kingdom Department of International Development to spearhead the formation of support groups through the Ambassadors of Hope has led to a wide range of non-governmental organizations and networks of people living with HIV/AIDS involvement in community base care and support\textsuperscript{24}. The Christian Health Association of Nigeria (CHAN), which has a network of more than 4,000 health facilities of different levels of care across the country, is also involved in providing anti-retroviral therapy\textsuperscript{25}.

The Nigerian Red Cross (NRCS) contributed significantly to prevention care and support within the HEAP period. NRCS implemented peer education training, sensitization workshops, home-based care, counseling, anti-stigma and anti-discrimination campaigns in 24 states in the country. Through the NRCS program intervention in 2004 alone, 2,640 youth peer educators were trained, with about 1 million youths reached; 720 home-based

\textsuperscript{22} WHO: Summary Country Profile for HIV/AIDS treatment and Scale-up; July, 2004.
\textsuperscript{23} PMTCT Scale-up plan Nigeria, FMOH: 2004
\textsuperscript{25} CHAN Directory 2004
care providers trained, who rendered home-based care support to over 4,000 PLWHA; 72 counselors trained and over 10,000 people received pre and post testing counseling services. In addition 6 anti-stigma and anti-discrimination campaigns were conducted across the country and HIV/AIDS prevention, information and education was disseminated to more than 14 million people\textsuperscript{26}.

Community-based care and psycho-social support activities aimed at helping PLWHA and OVC are being provided by CSO, with increasing participation of Faith-based Organizations. Many of these FBOs contribute by providing counseling, as well as psychosocial support for members living with the virus and other people affected by HIV/AIDS. Training of health workers and caregivers in the management of HIV/AIDS and counseling was conducted in 5 local government areas per state\textsuperscript{27}.

As at December 2004, the population covered for TB-DOTS implementation was estimated at 80 million people. There were 547 microscopic centers (centers having adequately trained staff and facilities by FMOH standards, to carry out basic TB diagnoses by microscopy) in 494 of the existing 774 local government areas (LGA). Presently, 2000 treatment centers exist within the 36 states + FCT in the country, and the National Tuberculosis and Leprosy Control Program (NTBLCP) target is 5000 treatment centers by year 2007, with at least one microscopic center and 2 treatment centers per LGA. Presently at least 8 LGAs are implementing TB-DOTS in each state\textsuperscript{28}.

A rapid assessment was conducted on the needs of orphans and vulnerable children (OVC) affected by HIV/AIDS\textsuperscript{29}. In February 2004, a national conference on OVC was conducted to facilitate the development of a national policy on OVC. Nutritional supplement in the form of breast milk alternatives was initiated with the support of UNICEF.

5.2 Constraints

Despite the laudable efforts and commitment to treatment, the national response did not give due attention to care and support for people living with HIV or those affected by AIDS.

Some major constraints being faced in the areas of care, support and treatment include;

- NEPWHAN requires an extensive membership drive across the country in order to encourage many PLWHA to join the network.
- NEPWHAN as well as other support groups of PLWHA, requires comprehensive capacity building and increased funding for them to be able to perform their functions effectively, especially in the areas of care and support, advocacy for

\textsuperscript{26} Nigerian Red Cross Activity Report 2004
\textsuperscript{27} FMOH Health Sector Response Report 2004
\textsuperscript{28} National Tuberculosis and Leprosy Control Program (NTBLCP): Summary TB program desk report 2004 (as presented at the NRR-TWG)
\textsuperscript{29} On overview of orphans and vulnerable children in Nigeria, Policy commission USAID February 2004
access to treatment, anti-discrimination campaigns and general public enlightenment on HIV transmission and prevention.

- Family support and community-based interventions for OVC are very low in most part of the country.

- OVC requires adequate attention and welfare provisions in order to reduce the impact of the epidemic on them and also reduce the susceptibility and vulnerability to HIV/AIDS.

- Gross inadequate nutritional support strategies for PLWHA in terms of coverage and quality.

- Flawed logistics of the alternative to breast milk initiative led to disruption of supplies of breast milk supplements.

- Conflicting messages on breastfeeding for positive mothers

- Most ANC centers lack equipment, material and skilled personnel to meet the demand for HIV-related services, particularly for the provision and when available the very high cost of elective caesarian session services for HIV positive pregnant women

- Inadequate coverage, accessibility and affordability of ARV drugs (specifically inadequate provision of HAART) at existing centers; there is also inadequate storage facilities for the ARV drugs at most existing centers.

- Inadequate capacity for palliative treatment and end of life care for PLWHA.

- Lack of reliable national data on OVC and no institutionalized guidelines for welfare support (nutrition, health, education and psychosocial care) for OVC.

- 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 measure.

- Inadequate data disaggregating, monitoring and evaluation at all levels of care, treatment and support interventions.

- Low capacities of most stakeholders involved in care, treatment and support.

- Lack of commitment to the principle of GIPA by stakeholders

- Lack of Treatment Education/Drug literacy in Government ARV centers.

- Lack of a national framework for Care, Treatment and Support

- Stigma is still very prevalent among health care workers

5.3 **Emerging Issues**

- On the ARV therapy guidelines, training of non-clinical personnel in ARV drugs distribution and adherence/literacy (for home and community care providers as well as counselors), must be addressed as a means of scaling-up and attaining wide coverage for the ARV program.

- Other ARV issues include; post exposure prophylaxis for all caregivers; increase access for pediatric formulation of ARVs; side effects, adverse reactions and development of resistance to ARV drugs requires critical attention.
• Specific care and support initiatives appropriate for Persons with Same Sex Partners (PSSP); intravenous drug users (IDUs) and prison inmates need to be addressed by identifying gaps and fostering interventions.
• Psychosocial support and care guidelines in the workplace need to be reviewed to meet gender specific needs, particularly of females/widows and single person head of families in all sectors of labor and productivity.
• Strict implementation of workplace based support and care policies are necessary to eradicate stigma in the workplace.
• Inclusion of lab technicians for VCT training
• Use of multiple therapy for PMTCT (HAART) as against mono therapy

5.4 Recommendations

_Anti-Retroviral Therapy_

• Scale-up and decentralize distribution, by rapid implementation of ART scale-up plan
• Train both health care providers and home/community based care givers on ART delivery to facilitate scale-up.
• FGN must make commitment to support significantly the scaling-up process financially to ascertain its sustainability and ownership.
• Scale-up ART into all levels of ANC and VCT services.
• Provision of free ARV drugs to children infected, OVCs and positive mothers as part of PMTCT.
• Ensure adequate training in adherence and use of ARV drugs is given to care providers and PLWHA to reduce risk of resistant strains.
• Qualified Faith-Based groups should be included in subsidized ART programs as part of scale-up and decentralization
• ART treatment and PMTCT guidelines, VCT protocols and policies should be made available by widely disseminating published copies to relevant FBOs and CSOs who have difficulty accessing them.

_Treatment of Opportunistic Infections_

• Free opportunistic infection drugs available and administered at all service delivery centers.
• Integrate the TB-DOTS/ART/VCCT interventions for more impact and effective services.
• Mandatory inclusion of all OI drugs on the essential drug list.
• Train non-clinical care givers on OI treatment protocols.
• PEP mandatory in all health care centers and guidelines established.
• PEP made available for rape victims and accessible in VCCT centers.
Orphans and Vulnerable Children (OVCs) and PABAs

- Communities with high proportion of orphans identified as requiring urgent assistance and collaboration of all stakeholders.
- Strengthen the capacity of the extended family and single parent head of families to cope with the unique challenges of HIV/AIDS in the family.
- Free primary and secondary education for OVC.
- Teaching of life-building skills.
- Integrating of life skills oriented learning to the educational curricula.
- National guidelines that address OVC social and unique needs, care and support.
- Specific needs of the most vulnerable PABAs addressed in a gender sensitive policy on support of PABAs.

Others

- The capacity of family members, people living with HIV, community health workers and volunteers should be built to provide home based care and support.
- To help reduce discrimination and stigma, there is need to increase special training in interpersonal communications and integrate basic training in psychosocial care and support in curricular for training all levels of health care providers.
- Mobilize the community to combat Stigma and discrimination through education and information.
- Best Practice Models on VCT, CHBC, M&E etc, should be documented, published and widely disseminated, taking example from the DFID-LATH supported Benue state project.
6.0. SOCIO-ECONOMIC IMPACT

The socio-economic impact of HIV and AIDS is driven by poverty and gender issues. HIV/AIDS affect virtually all aspects of human development and has unprecedented devastating impact on demographic, social and economic aspects of development. Hence in Nigeria the response to the epidemic has shifted from purely health response to that of multi-sectoral development issue. The key areas of impact include the family/household, formal labour sector, food production, transport, rural communities, education and the health sector and the gender dimensions of the impact on each of the sectors is enormous.

The greatest impact of HIV/AIDS on the family is the generation of spiral levels of social problems including loss of financial status, increasing number of orphans, female headed households and other psychosocial burdens which are shouldered mainly by women and girls. The major economic cost in the formal labour sector can be classified into labour supply and financial cost to organizations and the nation at large. According to the National Policy on HIV and AIDS (2003), the epidemic has increased the cost of achieving set development goals by decreasing the size of the work force since HIV and AIDS affect the economically productive adults in their prime (15-49 years)\(^{30}\).

In Oni and Opatola (2002), the epidemic also impacts significantly on the expenditure pattern thus reducing revenue accessible to the other sectors. HIV and AIDS is depleting the country of its food producers and farmers, hence weakening the agriculture labour force for generations to come. The HIV and AIDS epidemic has brought additional pressure to bear on the health sector. As the epidemic matures, there is increased demand for health care medical personnel and facilities\(^{31}\).

The cost of the epidemic is felt on the education sector in various ways including loss of personnel, increase in school drop rates and dwindling of government and household resources to support educational services. The transport sector is one of the most affected by the HIV and AIDS epidemic. There is relatively high prevalence rate along the corridors and transport routes of the country. As stated in the NEEDS document,

“HIV/AIDS is already having a disastrous impact on the social and economic development in Nigeria. If not adequately contained, the epidemic will prove to be the greatest single obstacle to reaching national poverty reduction and other targets for social and economic development.\(^{32}\)."


6.1. Progress to Date

Impact on the Household

The greatest impact of HIV/AIDS in the family is the generation of spiral levels of social problems which begins as soon as a member of the family starts to suffer from HIV and related illnesses. The impacts are both psychosocial and economic. In Nigeria the mortality due to AIDS over the years is over 300,000 and this is expected to increase annually and significantly with the attendant crises. Women and girls are the mostly impacted by the epidemic suffering from burden of care of sick husbands and orphaned children and grandchildren. In addition to the physical burden, women suffer gross poverty due to socio-economic norms that deny them access to inheritance and ownership of property. Indeed the general effect of poverty at the individual and household levels compounds and reinforces the burden of AIDS.

The economic situation of the household as impacted by AIDS can be described as follows:

- Loss of income of the patient (who may be the breadwinner), leading to poverty of the household.
- School dropout and loss of jobs, especially for daughters and wives, respectively who are forced to take time off to care for the sick person.
- Permanent loss of job as a result of death, less labour on the farm, cost of funeral and mourning costs; and the removal of children from school in order to save on educational expenses and increase household labour, resulting in severe loss of future earning potential.

The psycho-social Impact

The burden of the psychosocial impact of HIV/AIDS falls heavily upon women, orphans and vulnerable children. The following are key findings:

- Increasing number of orphans generated by the epidemic. Policy Project Report vividly describes the crisis in Nigeria concerning the increasing trends of orphans and vulnerable groups. The number of orphans from all causes was 2.6 million and orphans from all causes account for 9.6% of the population under 15 years. This trend is increasing due to the contributions of the HIV/AIDS mortality of mothers or fathers or both. Cases of HIV positive parents abandoning their neonates abound also in the cities. Implications include inadequate health care and schooling, Risk of child abuse, prostitution and other social crimes.

- Related to the aforementioned issues is the increasing case of female headed households and young widows due to the death of the spouse of HIV/AIDS.

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related complications. The Policy document of February 2004 also indicates that male death due to AIDS is more than female deaths. This shows that the burden of care for the children and the home generally falls on the female members of the household either as daughters, mothers or grandmothers.

Economic Impact

The major economic burden is on labour productivity and the cost of labour. According to the FGN National Policy on HIV/AIDS 2003, the epidemic has increased the cost of achieving set development goals by decreasing the size of the work force since it affects the economically productive adults in their prime (15-49 years). In reducing the workforce, it increases the cost of labour. There is a dearth of information from the national level but case studies are sufficient to inspire imagination about the national dimension of the epidemic on the productive age cohort and the effect on the national productivity. For instance, a study of a cement factory showed that mortality is high among HIV positive workers: 25 sero-positive workers were studied for 18 months out of which 28% died during the period and others were either hospitalized or receiving treatment at the out-patient clinic. The management was still paying sick workers for the period of the disease experience up to the point of death. The employer equally financed the treatment including ARV service. At the national level though data does not exist for Nigeria, the average lifetime cost of treatment for AIDS per case is put at over 500 US dollars in Africa.

The loss of young adults in their most productive years will affect the overall economic output. Currently, the annual mortality due to AIDS is estimated at over 50,000 concentrated in the active productive male and female population. The epidemic is also impacting significantly on the expenditure pattern thus reducing revenues accessible for capital development both at private and public sectors.

In the mining/oil sector, scanty information exists on policies addressing workers. Nevertheless, some multinationals involved in the oil industry have policies on supporting and counseling HIV/AIDS positive staff. However, the cost is enormous both at the micro and macro level considering that the mining industry is the primary source of foreign exchange for the country. Over 80% of the country’s earnings is from the oil and gas sector) but though the mining/oil industry contributes about 97% of all exports, it employs less than 2% of the labour force yet the socio economic implication can not be understated. Thus on the macro-economic level, the impact of the epidemic includes; progressive collapse of human capital and productivity, higher wages, increased domestic productive cost (Nationally) and reduction in government revenues.


37 Ajakaye and Odumosu ( 2002: 30-44) op cit
Impact on Agriculture and Rural Development

The primary source of income for the Nigerian population is agriculture, which supplies about 60 per cent of the employed labour force, and was estimated to contribute 41.5% of GDP in 2000. Although cocoa, groundnuts, palm oil and coffee are the main cash crops, they accounted for only 0.7% of total exports in 1995.\(^{38}\)

In its earlier stages, the HIV/AIDS epidemic was predominantly an urban problem affecting more men than women, and those with relatively higher incomes. Now, the epidemic has rapidly moved into the rural areas, hitting those who are least equipped to deal with its consequences.\(^{39}\) People living with HIV/AIDS in the terminal stage in the cities are often relocated to the rural areas where they are abandoned and left to pass away. The impact on production and food security is difficult to estimate hence the challenge is to develop food security interventions and farming practices that adapt to the reality of HIV/AIDS affected environments.

In corollary, the government’s program of accelerated rural development may open up the hitherto shielded communities to risk of HIV infection especially between the local girls and visiting workers. Cases of these are the activities of road construction workers, oil depot workers, factory workers etc. The relationship between rural livelihood and HIV/AIDS is well documented in the Benue Report. This remains the only documentation available for the impact and relationship between agriculture, rural livelihood and HIV epidemic in Nigeria.\(^{40}\) Also the Federal Ministry of Agriculture and Rural Development started programming HIV/AIDS intervention in its food security and rural development activities. Examples are the FADAMA projects and the rural road rehabilitation projects across the states.

Impact on Health Sector

Furthermore the HIV/AIDS epidemic is bringing additional pressure to bear on the health sector. As the epidemic matures, the demand for care for those living with HIV rises, as does the toll amongst health workers. Health-care services face different levels of strain, depending on the number of people who seek services, the nature of their need, and the capacity to deliver that care. The cost and administration of Antiretroviral and related drugs and process pose a great challenge to public health system finance in all sub-Saharan African countries. The public expenditure of ARV is beyond the ability of most already impoverished nations. In a study conducted in Lagos, out of a total of 13 ARVs included in a study only six were available. Also, only three ARVs were found in

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\(^{38}\) Akande (2002) in Ajakaye and Odumosu Op cit


\(^{40}\) Benue State Agricultural & Rural Development Authority; Impacts of AIDS on Rural Livelihood in Benue State, Nigeria: Implication for Policy Makers.
health facilities sampled. In the open market, ARVs was found in one site. The study concluded that affordability was way out of the reach of an average Nigerian with a minimum wage of N6, 500 or $52.41. The Federal Ministry of Health asserted that the cost of HIV/AIDS treatment will consume a huge part of the health budget while depleting public expenditure in other critical sectors of the economy. The problem of MTCT greatly neutralizes the whole gains of PHC started since 1978. The PMTCT/VCCT is an added stress to health care delivery and health budgeting.42. Already the infant mortality rate in the country has risen to 100/1000, and child death due to AIDS is the highest contributor to child mortality in Nigeria43

Other impacts of the epidemic on health are summarized as follows: Increase demand for health care services; Reduce resources available for other health are issues; Government faces trade-off among presented three options; Spending more on treating HIV/AIDS patients; Treating HIV/AIDS patients at the expense of other illnesses; Spending for health (provision of HIV/AIDS inclusive) ignoring other objectives; Insufficient hospital beds due to occupation by people in the terminal stage of the infection; Double standards in service provision particularly by private practitioners (improper or inadequate blood screening); Risks of infection of health care providers in emergency cases; Reduction in accessibility to trained and experienced health care providers; and increased workload resulting in stress.

Impact on the Transport Sector

HIV/AIDS is now the leading cause of death in Africa though virtually unknown 20 years ago. In several nations, by striking young people, HIV/AIDS limits the pool of potential job recruits and diminishes the returns from skilled labour. The evidence is clear from several studies in southern Africa; HIV prevalence is high among some cadres of transport personnel. It has been affirmed that the distance truck drivers and itinerant hawkers (women who sell goods along the roads) play major roles in the spread of HIV. “As most transport workers (truck drivers, train and airline crews and among others are away from their homes and families for a long period, they face the risk as a result of sexual activity with casual partners: this risk is shared by the communities along highways or concentrated around some of the principal transport nodes”44 Also in an extensive study of hot spots and risk settings across Nigeria, it was shown that the prevalent rates in junction towns is approximately 2% higher than median rates for the states in which they are located.45. Transport workers are twice as likely to acquire HIV as workers in ‘low-risk’ occupations. Because of their high-risk sexual behaviour, long

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distance transport service providers have HIV infection rates as high as 30 percent. The transport operators are relatively well-paid hence the temptation to engage in risky sexual behaviour. The death of transport workers due to HIV-related illnesses can lead to serious declines in transport sector productivity, loss of earnings and attrition in skills and experience.

**Impact on the Education Sector**

About 60% of age-eligible children are enrolled in primary schools and nearly half eventually dropout before completing primary school. Of those who remain in school to the sixth grade, only 40 percent are functionally literate. Though information on the impact of HIV/AIDS on the educational sector is scarce, current infection trend shows that the supply and demand for education will be grossly affected by the epidemic. In a recent study of three states in Nigeria, though perception of the impact of the epidemic among stakeholders is low, the indicators of the impending implication are endemic. Illnesses of self, relatives, or friends and funeral constituted the major cause of teacher’s absences from schools. It was further stated that states with the highest prevalent rates also have higher cases of teacher absences due to illnesses. In the study the children affected by HIV/AIDS in schools ranges from 2.2% to 6.7%. In the wake of increasing HIV prevalence and gross nationwide poverty over the past decades, the magnitude of the impact on the impact on the educational sector and human development generally is great.

**6.2. Programme Interventions**

Over 17 sectors including health, education, women’s affairs, defense, internal affairs, agriculture, information, culture and tourism, police and labour are currently implementing various interventions in response to the epidemic.

The health sector remains the pivot of the national multi-sectoral response. Its strategic focus includes:

- Prevention of HIV and AIDS through management of sexually transmitted infection (STIs), prevention of mother-to-child transmission (PMTCT), voluntary counseling and testing (VCT) blood safety, condoms use, etc.
- Care and treatment for PLWHA and people affected by HIV and AIDS (PABA) through supportive counseling. Access to poverty eradication program (PEP), widows/ orphans and vulnerable children (OVC), care etc.
- Surveillance studies and research and
- Monitoring and evaluation.

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47 This section relies on available activity reports of specified sectors and also derived from the analysis of brief key informant interviews with officers in those institutions. See the Tables I &II.
Given the large pool of PLWHA in Nigeria and the primary concern over their welfare, a highly active anti-retroviral therapy (HAART) program was conceived in 2001 with the target of treating 10,000 PLWHA. Three generic ARVs are currently being used in 25 centers (mainly tertiary hospitals) in the federation. The three drugs which cost about N45,000 per annum per patient, are dispensed to PLWHA at a subsidized rate of N1,000 per month amounting to N12,000 per annum per patient. Treatment has been provided to over 12,000 PLWHA.  

The PMTCT program is provided in 11 sites located in tertiary hospitals across the country. No user fees are charged for the ARV drugs used in this program. HIV positive mothers are expected to enroll in the Adult ARV program while children would enroll in the Pediatric 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 PMTCT programs.

The response from other sectors especially education, defense, police etc 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 schools within the Federal Capital Territory (FCT), to be replicated in other parts of the federation. The Universal Basic Education Board which directly oversees the UBE initiative of the federal government is central to the targeting of the orphans and vulnerable children due to AIDS. The board given its statutory roles and resources available can successfully intervene through the state governments and FCT to develop an impact mitigation strategy for the nation targeting the OVCs. It has engaged in sensitization, through the production of BCC materials towards improved enrolment in schools and HIV/AIDS prevention. Also the training of states/LGAs desk officers, head teachers and supervisors have been done. This programme is supported by the World Bank. Other HIV/AIDS related programmes are also in progress supported by UNICEF. The most pertinent future plan for the Universal Basic Education (UBE) remains the targeting of the OVCs for support across the nation.

Similarly, in line with “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.

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 efforts to assist rural dwellers that are affected by the disease. Capacity building of the ministry staff both at the federal and state levels is on

going. The ministry has established a critical mass at the federal level and during the National Council on Agriculture meeting in Makurdi, 2004; states were mandated to also establish critical masses in their ministries for coordination of HIV/AIDS programmes.

The Ministry of Defense has worked through its Armed Forces Programme on AIDS Control (AFPAC) program to undertake extensive sensitization of military formations in the country, especially for troops on peace-keeping assignments under the ECOMOG and other foreign missions. New emphasis will be placed on expansion of VCT beyond military hospitals to the workplace 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 centers 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.

Other ministries that need critical level of scaling up to match the expected responses in this framework include those of communication, aviation, power and steel, works, housing and urban development, and justice. These sub sectors need some level of capacity to engage in strong activities for impact mitigation, policy development and programme coordination for their institutional staff and the public of their respective constituency.

Prolonged inadequate information and uncertainty about effects and impact of HIV and AIDS epidemic on the private sector led to 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, especially some key firms in the oil, food and beverage and banking industries both at the programming and funding levels in Nigeria. The resources – funding, technical skills, personnel and material – 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. It appears generally that the banking industry like most private sectors is not awake to reality of the threat of AIDS in terms of contingency planning and supporting or catalyzing impact mitigation programmes.

6.3. Constraints

There are currently very few reports and studies that addressed social and economic impact on the HIV/AIDS epidemic, a situation that has limited the capacity of NACA and other relevant agencies to formulate appropriate responses. The need to focus on impact
of AIDS in terms of tracking resources, economic impact and financial monitoring of the HIV/AIDS programme at both the private and private sectors cannot be overemphasized.

Poverty increases vulnerability to HIV and other STIs. Under conditions of poverty, the risk of HIV assumes a lower priority among people daily concerns. People in such circumstances are more concerned about of survival than the chances of contracting a virus whose effects do not manifest immediately. The lower income – earning power of most women is a major driving force for them to engage in sex work as part of their survival strategy. Young people in rural areas have limited access to education, and few job prospects and lack recreational facilities, thus sex becomes a means for meeting economic and recreational needs.

The private sector is not taking the HIV/AIDS issue very seriously, as there are low responses by organized private sector in particular indigenous businesses. The fact is that most private sector units do not have adequate capacity for impact assessment of HIV/AIDS.

6.4. Emerging Issues

Since poverty is a major facilitator of HIV transmission, there is need for extensive micro-credit schemes targeting the HIV positive urban poor and rural women and those affected by it in particular. Because individuals and households first feel the burden of HIV/AIDS, the first line of response should be mitigation of the social economic consequence on effected communities.

In addition to bolstering the economic recourse and income inflows of households (through access to credit and savings, micro enterprises, and linkage to markets), support is needed for creating social safety nets.

HIV/AIDS has greatly increased the dangers of trafficking and commercialized child sexual abuse, two global phenomena that profoundly violate human rights. Research, prevention, and mitigation priorities should include attention to women and children trafficked across borders.

More widows suffer economically as a result of AIDS related burden and death of spouse. Since majority of widows in the rural areas depend on their spouse’s economic support, and loss of spouses result in severe economic challenges, HIV/AIDS impact mitigation programmes should specifically address economic empowerment and basic livelihood support for widows.

Most girls drop out of school as a result of poor family finance and gender imbalance of allocation of meager family resources. Thus short and long time interventions must address the socio-economic needs of the girl-child.
6.5. **Recommendations**

- Develop appropriate plans to provide children orphaned or made vulnerable by HIV/AIDS with needed social supports, such as assistance with continued schooling, shelter, nutrition, and health and social service. Towards this the UBE programme should be used to catalyze the undeterred access of the poor OVCs to education at the same time provide economic support to them at all the tiers of government.

- Undertake an in-depth assessment/research of the social and economic impact of HIV/AIDS at the local and national levels in both private and public sectors

- Provide ongoing capacity building and empowerment interventions for volunteers, community-based organizations to mobilize resources and sustain the abilities of families and households to cope with HIV/AIDS resources.

- Involvement of poor and vulnerable groups particularly widows women and young people as resources and not beneficiaries only in stakeholders’ towards impact mitigation of HIV/AIDS. Specifically the women and youth are to be targeted for skill acquisition and micro credit facilities. These categories of people are the most impacted by HIV/AIDS.

- There is the imminent need to scale up private sector response and build their capacity to address the increasing burden of AIDS epidemic on the society. Specific areas of inputs include resource mobilization, care and support and workplace policy development and implementation.
7.0 REGIONAL PROGRAMMES, EMERGING ISSUES AND NEW TECHNOLOGIES

This thematic areas focuses mainly on prevention efforts for MARPs (uniformed personnel, PESSP, prison inmates and detainees, IDU and substance abusers), new technologies as it relates to HIV prevention methods and anti-retroviral therapy issues and emerging HIV and AIDS issues within West African sub-region of which Nigeria is part. The sub-component on regional programmes focuses mainly on transport related workers and communities. The thematic area reviews the national HIV/AIDS responses to date, analyses progress made to date, major constraints, emerging issues, lessons learnt and concludes by making recommendations.

7.1 Uniformed Personnel and prison inmates

Like any mobile aggressive force, the military and police personnel face formidable challenges of fighting the high risk of HIV infection amongst themselves and the communities they interacts with. Their involvements in peace-keeping operations and war crisis management, and civil conflicts often separate officers from their regular sex partners. Potential high risk behaviour among soldiers places them at greater risk of HIV infection while on the field. This risk of infection continues when the forces return to base, either in barracks and their residential homes as they have sexual activities with spouses, regular or new partners. Driven by poverty and other socio-economic pressures, many female members in communities surrounded by barracks engage in sex work and also increase vulnerability of HIV infection among communities.

The prisons also present its own challenges of potential risk of HIV infection. Most prison institutions are characterized by high levels of denial of rampant unprotected and risky sexual behavior among its inmates both male and female. A study in two states indicated that 15% and 8% of male prisons in Kano and Lagos respectively were engaging in unprotected sex. Rape and coercion sex by consent are common among prison inmates.

The HEAP strategy (2001-2004) addressing uniformed personnel focused on providing training for members of the armed forces, the police and their wives, establishing Voluntary Counseling and Testing (VCT) centers and promoting condom use amongst uniformed personnel. HEAP strategy addressing prison inmates and immigration border control was to ensure that this category had access to IEC materials and relevant HIV and AIDS training materials. The HEAP strategy for Sex Workers (SWs) was to undertake integrated participatory mapping, peer counseling and promotion of condom use by SWs.

7.1.1 Progress to Date

Interventions among the Armed Forces, Police, immigration border personnel and workers are on-going. Armed Forces programmes on AIDS Control (AFPAC), the Police

49 Journalists Against AIDS. Voices from the fields. Perspectives and priorities for action on HIV/AIDS in Nigeria (draft)
AIDS Control Committee (PACC) and local NGOs through support from various local and international partners are implementing HIV/AIDS prevention services among armed and allied forces. However, HIV/AIDS control programme amongst the military appear to be a step ahead of that implemented amongst other uniformed men. This may have been facilitated by the existence of an HIV/AIDS policy for the Armed Forces\(^\text{50}\). Despite this, the 2002 report on knowledge, attitudes and practices (KAP) among Armed Forces produced by Futures Project produced noted that there is a need for significant improvement in attitude and practices needed for HIV control\(^\text{51}\). Also, all the 12 divisional Headquarters have VCT centers but personnel to run these centers remain a challenge because of movement of personnel\(^\text{52}\).

With respect to prisons, an increasing number of NGOs are focusing on awareness creation among prisons inmates with Life Link and the Ministry of Internal Affairs working to enhance the creation of an enabling environment for HIV control among inmates. Sensitisation seminars for the prison staff and inmates had also been conducted in 10 states including Imo, Rivers, Benue, Katsina, Sokoto, Lagos, Akwa, Ibom and Edo. At least 50 prison inmates were reached in each state. Data on the gender composition of the inmates was not available. With the support of NACA some IEC materials for the prison community was produced and VCT centers established in all the prison clinics and 5 referral centers\(^\text{7}\).

### 7.1.2 Constraints

While some training of armed personnel on HIV/AIDS was conducted, there is need to ensure gender balance of the trained personnel and gender mainstreaming into programmes to ensure increased effectiveness of designed programmes. This is in view of the the high incidence of gender discrimination in the barracks. Also, though the AFPAC programme was properly designed, funding has however been a limiting factor. In addition, the limited number of VCT centres reduces access of armed force personnel to prevention, care and support programmes.

The entire programme in the Police was donor driven, funded and supported by FHI\(^\text{11}\) and its coverage was only in eight states in Nigeria (Lagos, Cross River, Anambra, Abia, Taraba, Edo and FCT). The sustainability of such an approach to programming is problematic. The sensitization programmes for Ministry of Internal Affairs, and staff of Prison and Border control staff has reached only 10 states. While IEC materials for the prisons were produced, they lacked the gender focus and were limited only to the ABC of prevention methods. While HEAP had the promotion of condom access through the establishment of condom outlets in clinics accessed by prison inmates, the Prisons’ policy discourages the establishment of condom outlets accessible to prison inmates.

\(^{50}\text{Armed Forces HIV/AIDS control policy guidelines. October 2003}\)
\(^{51}\text{Report from future groups}\)
\(^{52}\text{AFPAC News. 2nd edition, 2003}\)
The lack of policy guidelines on HIV/AIDS control programmes amongst Customs, Police, Road Safety, Civil Defense, Fire Brigade, and Immigration further reduces the effectiveness of addressing HIV control and impact mitigation amongst uniform personnel.

For effective programming, the difference in the operational structures of the uniform service personnel units needs to be taken into consideration in programming. It is more difficult to have effective decentralized authority. This is because the uniformed service structure is an autocratic structure. In addition, HIV/AIDS programmes programming has focused extensively on uniformed services personnel to the exclusion of members of their community who include their spouses and family members.

For prison inmates, the prison policies are presently not conducive for extensive prevention, care, treatment and support provision and services for prison inmates especially with respect to access to condoms.

7.1.3 Emerging Issues

In the majority of cases, programmes for uniformed services personnel have tended to focus more on prevention efforts. There is need for a design of gender sensitive comprehensive and integrated programmes for prevention, treatment, support and impact mitigation. It should however be noted that ARV treatment is presently being provided for some prison inmates. The challenge is the need for designing referral systems to ensure continuity of services for those inmates of treatment.

The implementation of current programmes also revealed that officers’ wives are powerful tools for mobilization of officers and their communities for HIV/AIDS interventions. The existence of a draft FMIA and Paramilitary Sector HIV policy and the Armed Force Policy guideline on AIDS control is also a step in the positive direction.

Mandatory testing as a pre-requisite for recruitment and out of station assignment is undergoing a lot of debate and criticism, with regards violation of human rights of the officers.

7.1.4 Recommendation

- To avoid too much dependence on donor-funded programmes and to scale up coverage of programmes, it is recommended that the Federal Ministry of Defense and the Nigeria Police Force allocate budget lines for HIV/AIDS programmes in the Police and armed forces. Such programmes should be as comprehensive as possible to cover all sites in Nigeria.
- In place of mandatory testing, there is need to advocate for integrating VCCT in existing health programmes for the uniformed forces.
- Develop family friendly policies for uniformed men – frequent leave, family visits.
• There is need to develop and disseminate gender sensitive BCC IEC materials for different target groups of the uniformed forces.
• There is need for policy advocacy to allow married prisoners to enjoy conjugal rights which would reduce the tendency for circumstantial homosexuality and the increased risk of HIV infection in prisons.
• There is also a need to provide for medical conditions such as AIDS as grounds for compassionate early release or diversion to alternatives other than incarceration and non-discriminatory access to facilities and privileges for HIV positive prisoners.
• Peculiar need of female inmates should be planned for such as access to male and female condoms to reduce risk of HIV infection

7.2. HIV infection in persons involved in same sex relationship
HEAP as an implementing strategic document was not comprehensive and explicit enough for this sub-activity, resulting in programmes being implemented outside the scope of the document. An example is that there were no activities addressing PESSP, refugees, displaced persons, trafficked human, intravenous drug users and substance abusers.

7.2.1 Progress to date
Men who engage in same sex practice have over the last 2 years made concerted efforts to organize themselves and advocate for their rights. They operate under the umbrella known as AIDS Alliance and have made significant progress to date in advocating for their rights. They featured prominently during the 4th National HIV/AIDS conference which held in Abuja.

7.2.2 Constraints
Not only has the Nigerian Government been slow to enact new laws relevant to HIV/AIDS mitigation and control but it has also not taken steps to revise existent laws that discriminate. The section 214 and 215 of the Nigerian Criminal Code criminalises homosexuality and commercial sex work. This limits the ability of PESSP to be open about themselves and possibly access HIV intervention programmes.

7.2.3 Recommendation
• Steps should be taken in concerted efforts with the Federal Ministry of Justice to ensure the respect, protection and fulfilment of HIV related human rights of PESSP by expunging discriminatory clauses of the Nigerian law.
• National response documents for HIV/AIDS need to address issues of HIV infection control amongst PESSP in view of the potential of many bisexual PESSP to infect partners.

7.3. HIV control in intravenous drug users and substance abusers
The Federal Government noted that practice of injectable drug use with the sharing of contaminated needles is becoming a major concern and so is the issue of alcohol abuse, marijuana and other mind altering drug use among youths. These all together increases vulnerability to HIV infection.

7.3.1 Progress to date
A number of NGO are presently working to address the issue of HIV/AIDS control amongst intravenous drug users and substance abusers. A notable example is an NGO called the Good Workers’ Movement based in Ibadan. The HIV/AIDS control effort of this organization is integrated to rehabilitation efforts in terms of discontinuation of drug use and skills acquisition for gainful employment.

7.3.2 Constraints
Presently, there are very few NGOs working to provide prevention, treatment, care, support and rehabilitation programmes for these group of individuals with high risk behaviours.

7.3.4 Recommendations
• NACA should work to encourage the funding of prevention, care and support programme for NGOs working with IDU in the country. More NGOs should also be encouraged and capacity built to enhance programme designing and implementations for IDU.

• Risk and harm reduction strategies designed as intervention programmes for this group should facilitate safer drug use behaviour knowing that drug rehabilitation programmes does not necessarily produce 100% drug use abstinence.

7.2 New HIV Technologies
In the long run, new prevention tools play a critical role in ameliorating the effects of the AIDS epidemic in the settings that are hardest hit. A growing array of public commercial and non-profit entities are engaging in the search for vaccines and microbicides to prevent HIV transmission. Historically, research and development of new health technologies was limited almost exclusively to the industrialized world and new products were licensed based on data form efficacy trials conducted mainly in Europe and the United States. This contributed to a lack of research on many global health and major delays in the delivery of new products to the developing world which is presently worst affected by the HIV epidemic. With scientifically driven, product-focuses research programmes, researchers, policy makers and communities can benefit form research efforts that bring additional resources for training, testing, and treatment. Development of new prevention technologies such as microbicides and HIV vaccines, the use of anti-retrovirals, prevention of mother to child transmission of HIV, development of new ARV drugs would offer considerable benefits if added to existing HIV prevention efforts.

HEAP strategic document focused on integrating all prevention, care and support structures into a comprehensive plan for HIV mitigation and control for the country.
However, HEAP did not make specific notes on national strategies for HIV vaccine and research and development. Despite the fact that there has been two (2) past studies on microbicides in the country (phase 1 Cellulose sulphate trial by the Centre for Right to Reproductive Health, Sagamu, N9 studies at the University of Portharcourt), and three (3) ongoing new HIV prevention technology research (phase 3 cellulose sulphate studies at LUTH and University of Port Harcourt, Phase 3 savvy studies at UCH and NIMR and phase 2/3 tenofovir study in UCH), there were however no specific plans in this areas in the HEAP. Neither did any of the national policies on HIV/AIDS make reference to microbicides. This sub-component of the thematic area, will share progress to date, constraints, emerging issues and recommendation for new technologies in Nigeria.

7.2.1 Progress to Date

The presence of a strong political will and commitment of the national Government to support HIV/AIDS issues is viewed as a positive point for the pursuit of research and development of new HIV prevention technologies relevant to Nigeria\(^\text{53}\). Nigeria has an HIV vaccine plan making her more prepared for international HIV vaccine research efforts. The country is building the capacity of field workers, policy-makers, media and community advocates who are involved in conducting, monitoring and advocating around the research. The federal government also work with the Brazilian government to develop ARV drugs and test kids locally. Nigeria already has committed institutions involved in the development of new HIV prevention technologies such as Gede Foundation, Asokoro Hospital, NIPRD and other research institutes like NIMR, LUTH, UCH and UPTH. The country has reference P1 and P2 laboratories that have the facilities to carry out HIV serology, screening and confirmation of tests. In addition, the laboratories can do CD4 counts, DNA counts and RNA (RT), PCR, viral load, STI diagnosis and management with adequate storage facilities. The laboratory in Gede foundation and JUTH has capacity for viral isolation and culture, DNA sequencing, HLA typing and facilities for the analysis of cell immune response. These laboratories located at the University of Jos, University of Ibadan and the GEDE Foundation in Abuja also maintain linkages with other international and national laboratories\(^\text{54}\).

The existence of the Nigeria HIV Vaccine and Microbicide Advocacy Group (NHVMAG) and its ability to bring stakeholders together and ensure their active participation is commendable. Its existence has enhanced the commencement of community sensitization on HIV vaccine and microbicide research thereby filling a vacuum otherwise left by the national Government. Also, the Nigeria HIV/AIDS Research Network is an umbrella body that brings together all researchers involved with HIV/AIDS research together. Its facilitation of the 4\(^\text{th}\) National HIV/AIDS conference in 2004 was a significant stride it took towards facilitating information dissemination with respect to HIV/AIDS research.

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\(^{54}\) Nigeria HIV Vaccine and Microbicide Advocacy Group. Situation Report on New HIV Prevention Technologies research and development in Nigeria (Draft)
7.2.2 **Constraints**

At the policy level, Nigeria does not explicitly address research into new technologies as part of their national strategies for combating AIDS. While the country has a National HIV Vaccine Plan (that took 3 years to develop 2001-3), the contents of this well-articulated document, which highlights the research priorities and a process for a country relevant vaccine, is not specifically referred to in the context of broader national HIV/AIDS plans and strategies. The 2003 national policy on HIV/AIDS part IV presents two paragraphs on vaccine development. However, the paragraphs made no reference to the existing National Vaccine plan and its proposed framework of activities. The national “battle plan” in the fight of HIV/AIDS the HEAP, does not make reference to national HIV vaccine plan.

Except for the reference laboratories located in Abuja, Jos, and Ibadan, the laboratories in other research institutions and public health laboratories are kept in poor conditions, with severe infrastructural problems including electricity outages, human resource shortages, and limited monetary resources. There are presently no approval processes outlined by any government agencies for trials of potential new HIV prevention technologies in the country. The key challenge is that, the National Agency for Food, Drug Administration and Control (NAFDAC), is focused on drug control and the scope of its mandate cannot address the regulation of products like microbicides. It also does not regulate clinical trials of a product not approved anywhere. Another body, the Nigerian Ethical Review Board (NERB) is a dormant national entity. It has not terms of reference, not active and has no legitimacy. Its eventual inauguration and operationalisation would be an important step in improving the ethical review structure.

7.2.3. **Emerging issue**

- Prospects for long term sustainability of ARV supplies through its manufacture, appropriate pricing through tax exemption, annexing the potentials of clinical trials to increase ARV access by PLWHA
- There is a need for a nationally defined minimum standard of care to be defined for clinical trial participants involved in HIV related clinical trials
- Facilitate the research and development of new HIV technologies through reforms of drug regulatory systems so as to enhance access to developed products; increase the involvement of local researchers in such planned clinical trials; ensure community involvement and in research design and implementation, ensure community preparedness for trials; and ensure country preparedness for such product licensing and uptake
- The country needs to start monitoring ARV drug resistance strains through the development of surveillance monitoring systems and the establishment and upgrading of laboratories for HIV strain monitoring
7.2.3 Recommendations

- There is need to incorporate new HIV prevention technologies research and development issues into all relevant national documents
- There is need to build the capacity of NAFDAC to effectively function as a regulatory body for new prevention technologies
- The Nigerian Government could possibly develop relationships and partnerships with some of the leading agencies working to develop new prevention technologies, such as the International AIDS Vaccine Initiative (IAVI) and the International Partnership for Microbicides (IPM) who are oriented explicitly to supporting product development and delivery for developing country populations.
- Establish and empower a national Working Committee on New HIV Prevention Technology which would make input into the development and reviews of a national guideline for new HIV prevention technology studies in the country as well as monitor ongoing and planned researches. It would also help to identify research priority activities related to new HIV prevention technologies for the country and help to coordinate all such related research activities.

7.3 Regional Programmes

The HIV/AIDS epidemic poses a great threat to the stability and peace of the West African – Sub-Region, which is home for one-third of the African population. Although statistics show that West Africa is relatively less affected in the AIDS epidemic when compared to Eastern and Southern Africa countries, the figures portend a looming epidemic, which could be worse than that witnessed in other parts of Africa\(^5\). This is in view of the strong inter-border. Trade and free movement within sub-regions as well as other factors that point to the potential pandemic confronting countries in West Africa. The situation calls for intensive collaboration and networking among AIDS activists, policy makers and the scientific community in the sub-region.

Presently there is no section of HEAP that identifies plans to establish and strengthen these sub-regional and international networks and efforts for controlling the epidemic. With regard to transport related workers, the HEAP strategy was reduce the rate of infection among Long Distance Drivers (LDDS), touts, seafarers through organizing stop point rallies, establishment of condom sales outlets at Stop Points and conducting sensitization activities for seafarers in Calabar, Tin Can, Oron, Warri, Port Harcourt and Lagos Ports. This sub-component of the thematic area highlights, progress to date, constraints, emerging issues, and recommendations for future programming.

7.3.1 Progress to Date

The National Action Committee on AIDS, with support from USAID and involvement of NGO/FBO/CBO operating in transit communities, is coordinating the corridor project.

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\(^5\) Verbal Discussions with Key prisons and other uniformed personnel during CCE stakeholders meeting, January, 2004
The project involves defining and implementing strategies to address cross border HIV infection mitigation and control. The corridor project provides increased access to HIV/AIDS prevention, care and support services to transport workers, underserved vulnerable groups and population living along Abidjan-Lagos transport corridor. Particular attention is given to the transport section, sex workers and the local population. The project also provides support and training for the development and implementation of IEC/BCC policy, social marketing of condoms in 8 geographical border communities, strengthening access to VCT and treatment of STIs and HIV related opportunistic infections in these areas. The project is on-going. There is also strong involvement of NGOs working in the locality.\footnote{HIV/AIDS project for Abidjan-Lagos transport corridor. File://E:\Projects-20Project%20Details-corridor.htm . Accessed 27\textsuperscript{th} November 2004}

At the regional level, there is the UNAID Inter-Country Team for North Africa, 11 countries from Central Africa and 16 countries form West Africa. Its main objectives include providing effective technical support to national efforts in HIV prevention, care and impact mitigation. Its strategies include strengthening partnership at the regional, national and local levels, promoting information exchange networks and political advocacy against HIV/AIDS.

### 7.3.2 Constraints

The HEAP did not design strategies for the implementation of Sub-regional, regional and international HIV/AIDS programmes. There is need for a clear national level strategic framework on how regional HIV/AIDS programmes will be implemented. There is also very little networking between civil society organizations and between policy makers at sub-regional and regional levels.

The Corridor project was slow incoming up, only taking off late into the epidemic and the implementation still remain very slow. The West Africa Initiative against HIV/AIDS (WAI) and the UNADS Inter-Country Team HIV/AIDS project, which were established between 1995 and 1996, are moribund projects probably due to political and financial commitments to the projects by member states. There is need however to revise such well-meaning projects.

There is poor coordination of WANASO, which is the West African network service organization, an affiliation of AFRICASO which in turn is associated with ICASO. The organisation had been in existence for over 9 years yet it still has little involvement of Angolophone countries in the sub-region.

\footnote{Social Mapping of HIV/AIDS transmission in 14 Nigerian junction towns (a study of hot spots and risky settings) by Judith-Ann Walker (PhD). Development Research and Project Centre (DRPC). April 2004}
\footnote{Developing a Comprehensive HIV/AIDS STI Program for Uniformed Service. Family Health International (FHI), 2004.}
7.3.3 Recommendations

There is significant similarity in the profile of the epidemic in the West African Sub-region and therefore, a need for highly effective network within and outside the borders of the country to ensure an effective drive towards controlling the epidemic. The following recommendations are thus suggested:

- Government networking in the sub-region, region and internationally
- NGO networking in the sub-region, region and internally
- The corroder project should be scaled up to involve more border towns within Nigeria including those in the North and Eastern parts of Nigeria
8.0 Policy, Advocacy, Legal Issues and Human Rights

This thematic area focuses on four main areas; HIV/AIDS-related policies and their role in the national response to the epidemic, advocacy issues in HIV and AIDS, the legal environment as it relates to HIV/AIDS issues, and human rights and HIV/AIDS. With regard to the national response to HIV/AIDS, the broad focus of this thematic area is to assess progress to date, constraints, emerging issues and give recommendations that can provide a basis for the development of the Nigerian National Strategic Framework.

There was no explicit coverage of policy, advocacy, legal and human rights issues in the just ended HEAP document. One however can thinly draw implications of coverage of this area in some sections of the HEAP. Strategy 2 of the HEAP focused on “Removal of information barrier”. One of the key objectives derived from this Strategy, which mentioned of policy makers, reads: “The development and maintenance of an information base, to permit policy makers to design and implement proactive interventions for prevention, and mitigation of HIV/AIDS in Nigeria”. From this section of the HEAP, it can be implied that there was a role for policy makers to play in the National HIV/AIDS response. Regardless of coverage in the HEAP, what follows is an analysis of what has happened in the HIV/AIDS Policy, Advocacy, Legal and Human Rights arena since 2001, when the HEAP was developed.

8.1 Policy

HIV/AIDS related polices, play a critical role in providing legitimacy and guidance to the various key stakeholders in their different activities all aimed at fighting the epidemic. Thus the existence and knowledge of the policy by key stakeholders is key for an effective response. Absence of a guiding policy in any sectoral response becomes a major gap, which can lead to chaos and anarchy in national responses to HIV/AIDS in any given country. For Nigeria, three types of HIV/AIDS policies can be identified. There are federal level/national HIV/AIDS policies, which provide guidance to all players in the various states on the response to HIV/AIDS. There are also State level HIV/AIDS policies, which may or may not be linked to the federal level policy. The third type of policy is the institutional policy, which can be a private sector, NGO or CBO level policies. What follows is the analysis of the HIV/AIDS-related policies in Nigeria to date (early January 2005).

8.1.1 Progress to Date

The HIV/AIDS policy environment for Nigeria is generally very rich. A number of policies at different levels have been developed. At the national level, the following are some of the key policies developed. Sexual and Reproductive Health/HIV and AIDS policy of 1997, which has been replaced by the current National Policy on HIV and AIDS and STI control of 2003; National Health Policy and Strategy; National Policy on Population for Development, Unity, Progress and Self Reliance; National Adolescent

59 HIV/AIDS Emergency Action Plan (HEAP), March 2002
Health Policy; The National Strategic Plan for Reproductive Health Commodity Security; National Policy on Women; Draft Policy on HIV and AIDS and the Workplace; Armed Forces Policy on HIV and AIDS; Draft policy on the Elimination of Female Genital Mutilation, and; workplace policy for education sector on HIV/AIDS.60

At the state level, there are encouraging developments with regard to development of HIV/AIDS-related policies. The following are some of the policies that are operational in some states. The following list, though not exhaustive, are some of the policies which are operational in some states: Enugu State Policy on HIV/AIDS; Cross River State Policy on HIV/AIDS; Edo State Policy on HIV/AIDS; Edo State Safe Motherhood Policy; Edo State policy on Trafficking in Women and Children; Bayelsa state Policy on HIV/AIDS; Policies on Female Genital Mutilations in Rivers, Delta, Oyo, Ebonyi and Bayelsa states. In Edo States, for example, there are reports on the policy on trafficking yielding a lot of good outcomes. For Faith Based Organisations (FBOs), CHAN, Anglican Church and Nigerian Catholic have Policies on HIV and AIDS. The Supreme Council of Islamic Affairs and ECWA are also working towards the development of an HIV/AIDS policy. Similarly, workplace policy for work sector on HIV/AIDS is being developed.

8.1.2 Constraints

Gender not addressed: Despite the rich HIV/AIDS related policy environment, there are constraints in this area, which may stand in the way of an effective national HIV/AIDS response. Like in most Southern African countries, the epidemic in Nigeria is fueled by gender inequalities. As such, for any policy guidelines to address the challenges of HIV and AIDS, it should ensure that the gender and socio-economic issues at the center of the epidemic are addressed in the policy pronouncements. A review of most HIV/AIDS supportive policies (HEAP, National HIV/AIDS policy and others), show a major weakness of failing to mainstream gender. The policy guidelines are thus missing the core of the epidemic.61

Gaps in Policies: A review of existing policies also indicated gaps in some sector policy guidelines. There is absence of gender sensitive national policies or standard guidelines in the areas of insurance, HIV testing, drug testing, ARV distribution, home based care, orphan and vulnerable children, just to mention a few.


Lack of Awareness, Knowledge and usage of policies: Having excellent policies is one good step which is not complete if the people for which the policy is developed are not aware of the existence of such policies much less the knowledge and usage of the policies for their programme guidelines. Feedback from key stakeholders consulted for the Nigerian HIV/AIDS response review process confirmed that most HIV/AIDS implementers, including women and youths, were not even aware of the HIV/AIDS policies Nigeria has produced.\(^62\)

Difficulties in Accessing Policies and Protocols: Lack of awareness apart, the FBOs consulted observed that they have difficulties accessing national protocols and policies that they are aware of.\(^63\)

8.1.3 Emerging Issues

Policy Reviews: Given the weak gender and human rights focus of most existing HIV/AIDS-related polices, there is need for the policy reviews of a good number of the policies. The Nigerian Armed Forces Policy on HIV/AIDS for instance, contains provisions for pre-employment mandatory HIV testing and for those to take foreign services. Such pre-requisites are a violation of individuals’ human rights, which may need policy debates for review. The current national HIV policy and the NNRIMS are key policy documents, which may need urgent review for harmony between them and the new National Strategic Framework that is in the process of development.

Gender Capacity Development: In support of such policy review, there is also the need for the development of the capacity of key players in HIV and AIDS on gender and human rights aspects of the epidemic.

Contradictions between some policies and legal provisions: The Penal and Criminal codes criminalize prostitutions and make the existence of brothels illegal, which conflict with the need to implement condom programmes in brothels for the HIV prevention and control.

8.1.4 Recommendation

- More states and FBOs should be encouraged to develop policies on HIV/AIDS that are sensitive to gender and vulnerable groups.
- There is the need for widespread dissemination of policies among critical stakeholders.
- Any HIV/AIDS-related policy reviews should take on board not only the content review but should also mainstream gender and human rights aspects into such policy.
- There is need for periodic review of most HIV/AIDS-related policies to keep pace with dynamic changes in the field.


• There is need for capacity development among key HIV/AIDS implementers on
genre and Human rights dimensions of HIV/AIDS to operationalise gender and
human rights friendly policies
• There is the need for the harmonization of policies between NACA, SACAs and
LACAs.

8.2 Advocacy

Advocacy for greater focus on priority areas of the epidemic is a critical component of
the HIV/AIDS response. Ability to single out the key drivers of the epidemic is therefore
critical for the development of an effective advocacy strategy for an effective national
HIV/AIDS response. Print and electronic media have both played important roles as
advocacy methods. For an effective response to the epidemic, there is need to engage
many key stakeholders in advocating for priority HIV/AIDS issues in Nigeria.

8.2.1 Progress to Date

A number of advocacy strategies for different areas of interventions, are, to date, being
employed by different stakeholders in Nigeria. According to the feedback from the
consultation with the Technical Working Groups, at least 70% of the communities had
been reached by advocacy messages for HIV prevention. Participants of the Technical
Working Group for this theme shared the following as key achievements to date. The
Nigerian Supreme Council for Islamic Affairs in their own experience trained the Imams
and religious leaders on the issues of HIV/AIDS in which they demystified the disease
and corrected some religious and cultural barriers militating against the HIV/AIDS fight.
They produced IEC materials that were supported with verses from the Holy Qur’an and
Hadith. The successes recorded in this program in those communities have led to the
replications in other communities. The Alliance for Gender Equality targeted students
using their lecturers, quotation from the Holy Bible, and the use of proverbs and alliance
for gender equality. Centre for Citizenship Emancipation worked with traditional rulers
in northern part of Nigeria. For example, the Kaduna Centre for Citizen Emancipation
worked with the traditional leaders as key change agents in the community for prevention
efforts in HIV and AIDS. REHRAC (Reproductive Health and Rights Research and
Advocacy Centre) used IEC materials targeting the nomadic pastoralists. They also
assisted the nomads in Southern Borno States to form CBOs, who in turn would
disseminate advocacy materials and information on Reproductive Health and HIV/AIDS
issues. CHAN has advocacy packages, but specifically have not developed the ones that
eliminate socio-cultural barriers.

65 Technical Working Group Meeting for the Review and Development of a new Strategic Framework for
8.2.2 \textit{Constraints}

Advocacy campaigns are being conducted on an ad-hoc fashion without drawing from a national plan of priority areas. The traditional advocacy methods of IEC materials, use of bill-boards are inadequate to address the growing need for advocacy on HIV/AIDS issues for low literacy population in both rural and urban settings. Skills in advocacy are a discipline on its own. There is need to build the capacity of key stakeholders to design and implement successful advocacy campaigns in priority HIV/AIDS issues. There is the need to match advocacy messages with the appropriate target audience for effective outcomes.

Schools (primary, secondary and tertiary) are also very important in SRH and HIV/AIDS advocacy. Guidance and Counselors and school social workers supposed to be in all the primary, secondary and tertiary institutions. Unfortunately, while there are Guidance and Counselors in almost all the secondary schools in Nigeria, these guidance counselors are not found in our primary schools and only a few of our tertiary institutions have them. What is more, they primarily deal with career guidance, and the school social workers that are supposed to deal with social and personal problems, are non-existent in almost all our three tire educational system.

8.2.3 \textit{Emerging Issues:}

There is need to prioritise the key issues which form the basis for a national advocacy drive. Given that gender issues are at the centre of the epidemic, these should form part of the priority areas. As the epidemic shifts slowing from being an HIV epidemic to an AIDS epidemic, there is need for community preparedness for access to treatment. The youth who are increasingly becoming more vulnerable group to HIV and AIDS issues should have a share in the priorities for advocacy. There is thus the need for a well-crafted nation-wide advocacy strategy, which forms the basis for advocacy activities from which various stakeholders can draw from. The use of sermon guide on HIV/AIDS to be delivered at the religious institutions appears promising but this should be developed by experts to avoid misrepresentations of fact about transmission and prevention of HIV and AIDS.

8.2.4 \textit{Recommendations}

\begin{itemize}
  \item Need for a development of national HIV/AIDS advocacy strategy providing priority areas and guidelines for effective advocacy for different target audience.
  \item Have a national plan for targeted advocacy visits to influential persons such as legislators, Sector Ministers, Governors of States, leadership of LACAs, traditional community leadership, Private sector leadership and more.
  \item More documentation of advocacy strategies needed.
  \item Develop a plan for capacity development of key multi-stakeholders on advocacy.
\end{itemize}

To ensure coverage of different strata of the Nigerian populace, there is the need to broaden the current advocacy methods to include more innovative ones that can reach difficult to reach groups.

8.3 Legal Issues

Laws can contribute towards or mar the fight against HIV and AIDS. An analysis of existing legal provisions is critical if laws are to be aligned to an effective fight against HIV and AIDS. There appears to be a paradox within Nigerian legal provisions, which, on the one hand, provides for the protection of girls and women and, on the other hand, the provisions and implementation of some of the laws contribute towards discrimination and abuse of these groups, which can also lead to an increase in vulnerability to HIV infection. This sub-component of the thematic group, analyses the legal environment as it relates to HIV and AIDS. Highlights of progress to date, constraints, emerging issues and recommendations are presented.

8.3.1 Progress to Date

Not withstanding gaps in legal provision linked to key HIV/AIDS policies, the Nigerian legal environment has substantial laws, which have the potential for use as a tool to fight the epidemic. Under the laws and statutes, Nigeria has the following legal instruments: The Nigerian Constitution (1999), the Penal Code of Nigeria (1958), The criminal Code of Nigeria (1948), Children and Young Persons Law (1999), Child Rights Act, Matrimonial Causes Act (1990), Marriage Act (1990), Civil Service Rules. Each of these laws and statutes contain provisions that can both help fight HIV and AIDS as well as fuel the epidemic. The legal instruments developed prior to the maturity of the epidemic may not adequately provide a legal environment favourable for the fight against HIV and AIDS.

A number of case laws in favour of PLWAs are available to inform court actions on similar cases. There are a number of legal provisions that can be harnessed and reflected in national and sectoral policies on Sexual and Reproductive Health and HIV/AIDS policies.

8.3.2 Constraints

Defilement: A review of the legal tools revealed a number of gaps within the legal provisions, which contribute towards putting women and girls at high risk of HIV infections. The provisions of the Criminal Code are discriminatory against the girl

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While defilement of a boy is a crime punishable with 7 years imprisonment, defilement of a girl is only a misdemeanor punishable with 2 years. This has the tendency to encourage offender to abuse young girls and thus put them at high risk of HIV infections given the age differentials. Sexual dealing with a child above the stipulated ages becomes criminal only if engaged in without the consent of the child. The age differentials between the girl child and her adult abuser are not considered. A girl child who is married cannot be defiled even if she is below the stipulated age, to the extent that the Penal Code implies that it will be rape if the child-bride has not reached puberty at the time of intercourse (S.6 of the Criminal Code, S.282 (2) of the Penal Code).

Forced early marriages: This is a form of child abuse, which puts the girl child at high risk of HIV infection. Apart from the statutory laws of marriage, both customary and religious laws allow early marriages and marrying of a girl without necessarily seeking of her consent because it is assumed that such girls do not know what is in their best interest due to their tender ages.

Girl child labour: Under its section 58 of the Nigerian Labour Act provides that “No juvenile shall be employed in any work, which is injurious to his health or which is dangerous or immoral”. An evaluation of current labour practices involving young girls points to the fact that a good proportion of young girls are being abused through hawking, domestic labour, and child trafficking. A good number of states have developed state laws against child trafficking and there is a federal law protecting girls from child labour, abuse and trafficking.

Criminalisation of People Engaged in Same Sex Practices (PESSP) and SW: The Penal and Criminal codes’ criminalization of PESSP (i.e., MSM and WSW), Commercial Sex Workers (SWs) and the existence of brothels make it difficult, almost impossible, to use these groups for clinical trials.

Legal backing for HIV/AIDS related policies: There is a general lack of legal backing for most HIV/AIDS policies, which could be a tool for recourse in the event of violation of such legal provisions. Legal provisions are most needed in the areas of workplace policies, insurance coverage and others associated with easier violation of one’s human rights. The 1999 constitution of Nigeria does not provide for positive social, economic and cultural rights which were in the 1989 constitution from which to build for an effective fight against HIV and AIDS.

8.3.3 **Emerging Issues**

Many legal instruments in Nigeria have a lot of discriminatory clauses or sections, which militate against an effective fight against HIV/AIDS. There is then need for a review of most of the legal instruments to make them supportive of the fight against HIV and AIDS. Women and girls are the most affected by such legal provisions. Prop-poor, pro-gender and pro-children legislations do not appear to be a major concern of politicians, which make legal reforms very difficult. For example, the Children Act has been adopted only by four states, which are Anambra, Ebonyi, Imo and Ogun states.

8.3.4 **Recommendations**

- There is need to engage politicians and key stakeholders in the HIV/AIDS field and others to mount an effective campaign for review of legal instruments which hamper effective fight of the epidemic.
- The remaining 34 states and FCT should adopt and enforce CRA.
- There is the need to enforce the existing laws amenable to the protection of the infected and affected by HIV/AIDS.
- There is need to expedite the legalisation of NACA as a separate legal entity for an effective HIV/AIDS response.
- Need to advocate for review of current NACA Bill in order to harmonize operations of NACA and other bodies such as SACAs, LACAs, etc.
- There is need for concerted and coordinated mass literacy programmes and civic education programmes around legal issues and HIV and AIDS

8.4 **Human Rights**

The protection of individuals’ human rights in the context of HIV and AIDS is critical for an effective response to HIV and AIDS for many reasons. Human rights and public health share the common objectives of promoting and protecting the rights and well-being of all individuals. The promotion of human rights is necessary to achieve the public health goals of reducing vulnerability to HIV infection and lessening the adverse impact of HIV/AIDS on those affected. In the face of stigma and discrimination many affected groups will not seek counseling, testing, treatment and support. The incidence and spread of HIV is disproportionately high among groups that already suffer from lack of human rights protection or are marginalized by their legal status. Vulnerable groups whose human rights are more likely to be violated in the face of HIV are women, children, people living in poverty, minorities, migrants and internationally displaced people. This sub-component of this thematic area highlights progress to date in the area of human rights and HIV and AIDS in Nigeria. It also identifies some constraints and offers some recommendations.
8.4.1 Progress to Date

There is generally little knowledge among key stakeholders in the HIV and AIDS field in Nigeria on the linkages between human rights violations and HIV and AIDS. Despite this, a good proportion of sectors, NGOs, private sector and, most recently, the public sector, have worked towards the development of HIV/AIDS workplace policies, which can be used as a tool for protecting the human rights of workers and safeguarding their protection from discrimination in the workplace on the grounds of their status. The Nigerian Government is currently working towards finalizing a draft HIV/AIDS workplace policy.

8.4.2 Constraints

Feedback from stakeholders consulted in the Technical Working Groups reported cases of human rights violations from different sectors of the Nigerian society.71 Mandatory testing in the Armed Forces was viewed as a violation of officers’ human rights. Some Faith Based Organisations require negative HIV tests as pre-requisite for marrying couples in church. This was viewed as a gross violation of human right, which should be discouraged. It should be noted that encouraging intending couples to know their HIV status before marriage was not a bad move. However, refusing HIV positive individuals their rights to marry was a violation of one’s rights to found and start a family, which is enshrined in the universal human rights declarations. There was concern to broaden entry point for HIV testing beyond antenatal clinics, as there was growing stigmatizing of women who tested positive through these centers. Being the first in their families to know their HIV status, such women face discriminations, abuses and violations of other forms of rights. Advocacy for male involvement in VCCT was viewed as a strategy that would reduce stigma and discrimination among women. Despite increasing number of institutions developing workplace policies, there are scenarios of violation of workers human rights: Given that there is no binding law with regard to workplace policies, it is not clear what happens to workers when their human rights are violated at work. There is need for the development of laws that would legalize workplace policies, both federal and institutional policies.

Currently, National Health Insurance Services discriminate against HIV positive individuals. There is need to advocate for NHIS to provide service products which can accommodate the health insurance need of PLWAs. The advent of ARVs should offer opportunities for such NHIS providers to accommodate PLWAs, given that PLWAs can live longer when on ARVs. Nigeria could learn from the experience of some Southern African Insurance companies, which have developed products and services for PLWAs.

8.4.3 Recommendations

- There is need for increased awareness among HIV/AIDS stakeholders in the linkages between Human rights and HIV and AIDS.
- There is need for advocacy at very high level to ensure that national health insurance service providers package insurance products for PLWAs.
- There is need for the development of a rich legal environment that would ensure protection of PLWAs when their rights are violated. Laws alone with no legal backing fail to provide such support and protection.
9.0 RESOURCE MOBILIZATION AND MANAGEMENT

Resources are critical inputs for ensuring the achievement of stated objectives and results of any plan or programme, as such greater emphasis is placed on mobilising resources for developmental efforts, including efforts aimed at combating the HIV and AIDS pandemic. In the past years, there has been an increased commitment of resources at international levels while it is still relatively low at the local and national levels.

9.1 Progress to Date

There have been national level policies and pronouncements to support the regional and international declarations to which Nigeria was a signatory. Specifically, sections of the National HIV/AIDS policy (2003)\(^\text{72}\) that addressed resource mobilization and management said *inter-alia*:

- Government at all levels shall adequately fund the activities of the statutory bodies and where necessary source for assistance from international partners to complement local resources;
- Every federal, state and local government shall define a budgetary line item for HIV/AIDS prevention and control;
- All institutions engaged in the implementation of HIV/AIDS activities are expected to commit a minimum of 5% of their project to facilitate the monitoring and evaluation of their activities; and
- Private sector, parastatals, and non-governmental institutions in collaboration with the national, state and local government agencies shall mobilize resources and fully participate in the prevention and control.

The HEAP\(^\text{73}\) provided the context for the partnership in resources mobilization and programme implementation. Despite these policy components and promising signs of a renewed high-level government commitment to HIV/AIDS, available information shows that a large part of the resources available are from international donors and development partners. While donors and international partners’ contributions to the national response in 2001-2004 period swelled to US$300 million, Federal Government of Nigeria contributed only US$56 million during the same period.\(^\text{74}\)

At the launch of the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), the Nigerian Government pledged US$10 million, from which it also obtained $70.9 million grant to facilitate the participation of CSOs in the national responses to HIV and AIDS as well as expand PMTCT and ARV Programmes. The amount actually drawn down has been less than 5% of the total approved due to bureaucratic delays and capacity utilization. USAID and its partners have contributed significant resources through a large number of diverse activities. Between Financial Year 1999 and 2001, USAID funding for


HIV/AIDS increased by 400 percent, and continue to rise significantly. Nigeria is also a beneficiary of the United States President’s Emergency Plan for AIDS Relief (PEPFAR) from which she is expected to receive $1 billion between 2004 and 2009.

The current U.S. Programming is implemented by partner organizations that work in prevention programs including behavior change interventions and condom social marketing, care and support for people infected and affected, particularly orphans and vulnerable children. US support has also been directed at strengthening government capacities and at implementing policy change. Other U.S. Government agencies involved in HIV/AIDS in Nigeria include the Centers for Disease Control and Prevention; National Institute for Health, the Departments of Defense and Labor; and the Democracy and Governance; and Education office within USAID.

The United Nations community comprising UNAIDS, UNICEF, WHO, UNIFEM, UNDP, UNFPA, UNESCO, UNODC and ILO have a combined commitment of over $20.3 million. Areas of intervention in the past three years include strategic planning; policy formulation; capacity building; care for people affected by AIDS, especially children; prevention of mother-to-child transmission; surveillance; gender mainstreaming and work place programs.

Nigeria is a beneficiary of the World Bank multi-country HIV/AIDS program for Africa with funding of US $90.3 million over five years (2002 – 2007). The $90.3 million credit through the International Development Association represents the single largest facility to support country-wide HIV/AIDS programme in Nigeria. The funding consists of three components that operate at the Federal and State levels. The capacity building component is earmarked to evaluate and approve proposals from sectional ministries, monitor and evaluate the implementation of HEAP, and provide overall project management, including monitoring and evaluation activities. The second component is earmarked to support and expand public sector response particularly HIV/AIDS activities carried out by line ministries, while the third component, the HIV/AIDS Fund (HAF) is to provide support (direct grant and technical assistance) to non-governmental, faith-based and community-based organizations, the private sector, and communities to prepare and implement proposed interventions. To date, 18 States and the Federal Capital Territory, 17 line ministries and 69 non-governmental / community based including faith-based organizations have received support for various HIV/AIDS activities and projects.

The United Kingdom Department for International Development (DFID) has been the primary donor to an extensive contraceptive social marketing project managed by Population Services International (PSI) and implemented by the Society for Health. The project developed innovation mass media and interpersonal communications strategies to promote behavior change, while substantially increasing distribution of condoms throughout Nigeria.

DFID has mainstreamed HIV/AIDS interventions across its Nigeria programme, while working with NACA and other international donors to enhance more systematic capacity building for States that will lead to more clearly defined and quantifiable achievements.
through the Strengthening National Response (SNR) project. A total of $42 million health system reform, and $73 million for combating HIV/AIDS have been allocated for partnership States.\(^7^5\)

Other foreign donors have committed financial assistance to Nigeria HIV/AIDS program. They include the Canadian International Development Agency, the Japanese International Cooperation Agency, and the Government of Italy have all committed support for HIV/AIDS interventions in excess of $50 million over an unspecified time period.\(^7^6\)

The Bill and Melinda Gates Foundation is the largest source of private foundation support, and the Ford, Packard and Mac Arthur Foundations are also actively engaged in HIV/AIDS activities.

At the State levels, the resource contributions vary from State to State. For example, Kaduna State, funded its SACAs to the tune of =N=42 million for the 2000 – 2002 period while the Lagos State AIDS Control Agency receives =N=10 million annually from State Government. Overall, resource mapping is difficult as the efforts are isolated, and not coordinated. There is also no information about the financial and resource contributions of local Government areas. Technically, speaking most of the credit effective States (under IDA Credit) could be said to have contributed =N=10 million which is the counterpart funding required. However due to the World Bank IDA credit, participating States have had their capacities strengthened and also have in place appropriate financial systems.

The private sector response and resource contributions have been sporadic and largely from the multi-national companies. Due to the recognition of the private sector’s role in resource mobilization and increased interest in developing comprehensive workplace programmes, the President initiated the establishment of the Nigeria Business Coalition Against AIDS (NIBUCCA) in December, 2003. Since its creation, some modest achievements have been recorded. These include: having a membership of thirty corporations and development partners; recruitment of programme staff; development of work plan for stimulating and mobilizing effective private sector investments in HIV/AIDS.

Notable support (including funding)/projects funded by the Private Sector include:
- The caravan border project by Coca – Cola Nigeria
- Provision of secretariat of NIBUCCA including furnishing by Julius Berger’s support for;
- Provision of free telephone line and HIV/AIDS text messages to the public by V-Mobile Corporation
- The establishment of a pilot “Youth Friendly Centre” at University of Port-Harcourt by Ecobank Ltd.

\(^7^5\) United Nations Development Programme (2002): Donors’ Profile
Equally, there are indigenous private foundations and philanthropists that have contributed resources, but there is no documented information. The faith-based organizations also mobilized resources (human, material, and financial) to provide IEC materials to their congregations, as well as providing care and support for OVCs and PLWHA particularly material needs and psychosocial support. Civil society organizations resource contribution has been focused on the economic empowerment of PLWHA and vulnerable youth through the provision of skills training and micro credit as part of their care and support strategies.

A community-level resource has also increased in the last three years. These have been largely in terms of providing psychosocial support (food, clothing, housing, etc) and are mostly in kind making it difficult to capture.

9.2 Constraints

Although there is commitment at the federal level to combat HIV/AIDS, this must be fully complemented by the state and local governments and private sector to yield significant results. At present, the commitment of most states and local government to HIV and AIDS is very low. Funds and resources are hardly allocated in their budgets for HIV/AIDS. The State and Local Government AIDS Action Committee set up to coordinate programmes still rely on up to 95% financial resources from the national level government. Due to lack of effective mechanism for allocation of donor funds, there is imbalance in resource distribution to high need areas geographically and programmatically. Bureaucratic bottlenecks and capacity utilization have also robbed Nigeria of external resources particularly from the GFATM.

Over-dependence on donor funding has restrained the responsiveness of indigenous resource mobilization; the private sector is not adequately involved and religious bodies and communities are not sufficiently motivated. The absence of national, state and local fund raising campaigns have also contributed to the resource gaps in the national HIV and AIDS response. There is also lack of capacity for costing and tracking public and private funds committed and expended for HIV / AIDS programmes.

There is insufficient information on coverage, results, impact of resources mobilization, distribution and management at all levels of government and the private sector international development partners. This is critical in order to set resource priorities and to effectively scale – up programme interventions.

9.3 Recommendation

With an existing budget model for estimating the resource needs for HIV / AIDS programmes, the capacities of national, state, local and private sectors can be enhanced in resource development and management. Working through the New Economic Partnership for Africa Development (NEPAD), the African Union is committed to mobilizing resource throughout the continent to leverage development donor funding. A
critical consideration is promoting local manufacturing of essential drugs in the management of HIV / AIDS.

**Recommendations**

Despite the country’s ability to attract significant resources, there is still a huge resource gap in view of the scale and enormity of the epidemic, thus the following recommendations should be given immediate attention:

- Development of a resource framework to ensure equitable distribution and targeting of resources;
- Provision of incentives to private sector to stimulate investments in HIV / AIDS programme through corporate social responsibility.
- Development and implementation of a nation-wide fund raising campaign aimed at the general public as well as the private sector with the support of development partners to contribute to annual targeted HIV / AIDS theme – based fund.
- Publishing of annual donor support records and audited statements of NACA for accountability and transparency.
- Provision of capacity building at all levels for HIV / AIDS resource mobilization and management.
- Conduct of a comprehensive study on donor support to map activities, strengths, and impact of investments HIV / AIDS programmes.
- Review Country Coordinating Mechanism (CCM) operations to enhance effective access and release of Global funds for HIV / AIDS etc.
- Develop institutional mechanism for transparency and accountability at public and private sectors for HIV / AIDS resource mobilization, allocation, and utilization.
- There should also be appropriate mechanisms to track information on HIV/AIDS spending at all levels.
10.0 COORDINATION AND INSTITUTIONAL ARRANGEMENTS

In 1997, through the Federal Ministry of Health, Nigeria adopted the National Policy on HIV/AIDS and STIs, which was designed to check the spread of HIV/AIDS. Acknowledging that HIV and AIDS have gone beyond being a health challenge, a multi-sectoral response was adopted and the Presidency established the National Action Committee on AIDS (NACA) to coordinate HIV/AIDS activities in the country. NACA\textsuperscript{77} is made up of representation from thirteen Federal Ministries. Membership is also drawn from the HIV/AIDS civil society umbrella network organizations in Nigeria (CiSNHAN and NEPHWAN) and the National Assembly. NACA’S status is however yet to be backed by an enabling Law.

The Presidential AIDS Committee (PAC)\textsuperscript{78} has been constituted by the President of Nigeria to respond to the AIDS epidemic with himself as chairperson and line ministries as members. The Ministries include Defense, Education, Finance, Health, Information and National Orientation, Internal Affairs, Labor and Productivity, Women’s Affairs and Youth Development and the National Planning Commission. The secretary to the Government of the Federation (SGF) is also a member.

At the state level, State AIDS Action Committees (SACAs) were established and have provision for a SACA secretariat run by a Secretary. At least 17 states with AIDS Action Committees established\textsuperscript{79} have representation of between 4 and 12 line ministries. At the Local Government level, Local Government AIDS Action Committees (LACAs) were estimated\textsuperscript{80} to have been established, in at least 87 percent of the 774 local governments in Nigeria.

Civil Society, primarily NGOs, CBOs, FBOs and other categories also responded to the multi-sectoral approach. Three coordination bodies exist for NGOs, CBOs, and FBOs. These are CiSNHAN, Network of People Living with HIV and AIDS in Nigeria (NEPHWAN) and Interfaith Coalition. CSO Networks exist in a majority of states. There are on average, 700 CSOs registered with CiSNHAN.

The HIV/AIDS Emergency Action Plan (HEAP)\textsuperscript{81} which was developed for the period 2001 to 2004, provided the road map for a national HIV/AIDS response from which its multi-sectoral stakeholders draw their HIV and AIDS interventions.


\textsuperscript{78} ibid, p.13

\textsuperscript{79} Actionaid Nigeria “SACAs: Issues and Challenges to Multi-Sectoral Responses to HIV/AIDS in Nigeria” 2003 p.6

\textsuperscript{80} An analysis of semi structured open ended questionnaire administered to SACA representatives during TWG meeting of the NRR Between December 14 - 17, 2004 – Process Report of NRR

\textsuperscript{81} HIV/AIDS Emergency Action Plan (HEAP) document 2002
A strong coordination mechanism to harmonise the efforts of all the stakeholders, service providers and beneficiaries is a critical challenge. This thematic area reviews progress to date, constraints, emerging issues and recommendations for future action towards the coordination and institutional arrangement of the Nigerian HIV and AIDS response.

10.1 Progress to Date

The development of the Nigerian HIV/AIDS Emergency Action Plan (HEAP) document is in itself an achievement for Coordination of the HIV/AIDS response. The HEAP identified 200 activities that had to be carried in the four-year period of HEAP. The HEAP recommended a multi-sectoral approach to combating HIV/AIDS and placed coordinating government entities at all tiers of government namely federal, state and local government (NACAs, SACAs, LACAs) at the centre of coordinating the HIV/AIDS response. Within the multi-sectoral approach, these coordinating bodies are linked vertically and horizontally to other stakeholders such as line ministries, people living with HIV and AIDS, faith based and community based organizations. The entire stakeholders have demonstrated commitment to fighting HIV and AIDS.

Between 2001 and 2004, NACA and all multi-sectoral players in the National response have succeeded in increasing general awareness of HIV/AIDS among the Nigerian populace to 88%. NACA as the overall coordinating body has been successful in bringing CSOs, line ministries and private sector into participating in the national HIV/AIDS response. NACA has clearly facilitated the placement of HIV/AIDS agenda on the map of the Nigerian polity.

Some CSOs through the capacity decentralization component of HEAP and overall coordination of NACA were able to access donor funds to undertake HIV/AIDS activities. The World Bank HIV/AIDS Fund (HAF 1) has enabled many CSOs to access funds for HIV/AIDS programmes. Thirty-eight CSOs accessed HAF 1 while 65 partners (54 Private Sector/NGOs and 11 umbrella organizations) requested for funding to the tune of 286,869,778 Naira through HAF 2 that is presently being implemented. The third tranche, HAF 3 will be advertised in due course. An evaluation of the programme implementation by the HAF 1 recipients indicated a 63% success rate in programme implementation.

A grant of 120,000 US$ has been made by MacArthur Foundation to CiSNHAN to be utilized over a period of three years for budget tracking in three states. Of this amount a total sum of 40,000 US$ had been disbursed by 2004. CiSNHAN also received funding from HAF 2 to the tune of 23,980,000 Naira. An installment of 7,194,000 Naira has so far been paid.

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82 ss. 2(1); 2(2);3(1) to 3(6): Constitution of the Federal Republic of Nigeria 1999
83 FRN “National HIV/AIDS and Reproductive Health Survey” (NARHS) FMOH 2003 p.36
85 Oral interview with CiSNHAN in February 2004
86 HAF 2 call for Proposals (October 2003) Final Selection (Umbrella Organizations)
HAF 1\(^87\) was used to develop capacity of CSOs in Community mobilization, prevention and behavioral change communication; care and support as well as capacity building programs at community level. Since April 2002, 103 CSOs\(^88\) have benefited from the HAF component of the World Bank Credit.

### 10.2 Constraints

Non-enactment of the appropriate enabling legislation for the establishment of NACA, SACAs and LACAs is a key challenge. Although SACAs and LACAs have been formed as coordinating bodies, the majority of them are not functional. There is a big challenge to make them functional. Each state should show political commitment by providing the stipulated counter-part funding, which in most cases has not been forthcoming from most states. Political interference in SACAs has also been reported as a challenge. A situation where Governors do not regularly make decisions on HIV funding and related issues creates bottlenecks, which tend to stifle SACA HIV/AIDS activities. A majority of LACAs have not also demonstrated serious commitment to HIV/AIDS programmes. While challenges on effective functioning of SACAs and LACAs persists and is common for the majority of cases, it should however be noted that there are some exceptional SACAs and LACAs which are being run effectively and have acted as best practices. The concern here is that the number of effectively managed SACAs and LACAs is still far below 50 percent.

The multi sectoral approach demonstrated at the federal level (NACA), is unfortunately not equally adequately applied at state and local government levels. While SACA and LACA documents indicate the importance of a multi-sectoral approach, the reality on the ground is that such bodies have failed to bring on board key sectors such as CSO, private sector and youth representation into their HIV/AIDS programming.

The proper consideration of gender issues in the coordination process is a key challenge and an area of concern. It is an incontrovertible fact that gender inequalities drive the HIV/AIDS epidemic in Nigeria. As such, coordination bodies should reflect the importance of addressing gender in the composition of structures, programme implementation and budgets. Gender representation at all level of coordination (NACA, SACAs, LACAs) is very low and where there is gender representation, sometime it is tokenistics. In most of the structures, there is no gender desk or gender focal person. There is also lack of clear budget set aside for building the gender capacity of key stakeholders. Coordination bodies have no systems of gender auditing of funding and programme activities. Nigeria through its three tier coordination structures, lack a gender management system\(^89\) that would be useful for taking stock of gender related activities and sharing of best practices in gender mainstreaming during HIV/AIDS programming. There is also a need to promote the maintenance of a data base of gender experts for

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88 ibid
89 CIDA “Gender Equality” CIDA Ottawa 2002

65
gender capacity development for each multi-sector player while ensuring proper monitoring of gender issues in HIV/AIDS programmes.

NACA, SACAs and LACAs have not been able to track\textsuperscript{90} specific activities of key players in the field especially at the community level. This has resulted in an inability to have a fair picture of the national response. As such the capacity of NACA to capture data on HIV/AIDS has been limited to a few activities of functional SACAs and LACAs, which in some cases did not extend beyond Abuja. There is need to develop an effective system of monitoring national level trends in the HIV/AIDS response and regularly share such data with all key stakeholders within the Partnership framework.

10.3 Emerging Issues

There is need to scale up coordination of activities among multi-sectoral players in the areas of Home Based Care, Care of Orphans and Vulnerable children (OVC) and ART. For a harmonized implementation of such programmes, there is need to develop gender sensitive, home based care guidelines which will form the basis of future programme development by all key stakeholders. As the demand for ART grows, there is also need for a development of clear gender sensitive guidelines on equitable access and distribution of ARV Drugs. To prepare communities for ART there is need to develop national programme guidelines on community preparedness for increased access to treatment programmes. Given the increasing concern on youth issues\textsuperscript{91}, there is need for nation-wide guidelines on youth HIV/AIDS programming that can be used by all stakeholders in developing their own programmes. There is also need secure full participation of the private sector. The private sector play will increasingly play a critical role in financing the HIV and AIDS response in the country considering their social responsibility to the population supporting their markets.

10.4 Recommendations

- There is urgent need to work towards the legal status of NACA and to also ensure that a review of the current Bill on NACA, allows for an effective coordination relationship between NACAs, SACAs and LACAs.
- There is need to revise the terms of reference for the coordinating bodies so as to allow for gender representation of these coordinating bodies as well as the appointment of gender focal persons who would move the gender agenda in HIV/AIDS in these bodies forward

\textsuperscript{90} NACA “Capacity Review of SACAs and LACAs in Nigeria” – A Study Report by NACA 2002 pp.26-27

• There is need to support the establishment of a gender management system at all the levels of coordination.
• NACA need to work on the establishment of an effective information system for capturing HIV/AIDS responses by multi-sectoral players in all states. It also needs to develop a system of data sharing to keep stakeholders updated on the progress and trends in the fight against the epidemic.
• There is need to provide technical support to SACAs and LACAs in order to strengthen their ability to coordinate all stakeholders within the response.
• States and Local Governments require sustained high-level advocacy to secure commitment of political office holders and Administrative institutions.
11.0 MONITORING & EVALUATION, SURVEILLANCE & RESEARCH

Nigeria’s national response to the growing problem of HIV/AIDS has to a large extent been guided by the National HIV/AIDS Emergency Action Plan (HEAP)\(^\text{92}\). One of the responses has been the development of a National HIV policy which serves as a guide to all HIV related issues. In terms of monitoring and evaluation, surveillance and research, both these documents address these areas to varying degrees. The HEAP outlines strategies for removing information barriers and for care and support of the infected and affected which encompasses objectives specific to monitoring and evaluation. The HIV/AIDS policy\(^\text{93}\) clearly addresses research and vaccine development and to some extent monitoring and evaluation. However, emphasis is not placed on actual programme monitoring and evaluation. A review of this thematic area will be presented in two parts: the monitoring and evaluation component and the research component. The review will give an overview of the subcomponent and then highlight achievements, constraints, emerging issues and recommendations for future action.

11.1 Monitoring and Evaluation

The launch of the Nigeria National Response Information Management System (NNRIMS)\(^\text{94}\) is one of the key achievements for Nigeria in terms of monitoring and evaluation. This system was designed in alignment with global monitoring and evaluation needs and has been agreed on by major stakeholders as the core system for the nation. The rational for monitoring and evaluation is to: identify priorities so as to set achievable, realistic goals, maximise use of limited resources, ensure quality of programmes, ensure that gender and other cross cutting issues are appropriately mainstreamed into programming, promote accountability, fuel advocacy and promote an integrated response.

11.1.1 Progress to Date

There is evidence that some of the monitoring and evaluation strategies outlined in the HEAP have been implemented. There has also been additional substantial progress in this thematic area that fall beyond the scope of the HEAP. The major achievements of this thematic area include:

- **Periodic updates of data through HIV and Syphilis sero-prevalence surveys (and other surveys):** There have been regular surveys carried out to update our knowledge of the HIV pandemic and associated determinants.

\(^{92}\) Nigerian HIV/AIDS Emergency Action Plan (HEAP)  
\(^{93}\) Nigerian National Policy on HIV/AIDS 2003  
These surveys are:

<table>
<thead>
<tr>
<th>Survey</th>
<th>Dates</th>
<th>Responsible Organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV and Syphilis sentinel sero-prevalence survey</td>
<td>2001, 2003</td>
<td>FMOH/NASCP</td>
</tr>
<tr>
<td>National HIV/AIDS Reproductive Health Survey</td>
<td>2003</td>
<td>FMOH/NASCP</td>
</tr>
<tr>
<td>Behavioural Sentinel Survey</td>
<td>2003</td>
<td>FMOH/NASCP</td>
</tr>
<tr>
<td>Youth Behaviour Sentinel Survey</td>
<td>2003</td>
<td>FMOH/NASCP</td>
</tr>
<tr>
<td>Demographic and Health Survey</td>
<td>2003</td>
<td>National Population Commission, MEASURE DHS+ORC Macro International</td>
</tr>
</tbody>
</table>

Situation analysis of OVCs: An overview of Orphans and Vulnerable Children in Nigeria was published in February 2004 by USAID and the Policy Project.95

Establishment of an HIV/AIDS resource center in NACA: NACA has a functional resource center that is accessible to all stakeholders with a collection of books, flyers, guidelines, research reports, an operational information management system and a functional website.

Development of the National Response Information Management System: Nigeria’s National M&E system is outlined in the NNRIMS which was launched in 2004. The NNRIMS was designed to capture all the programmatic areas of HIV/AIDS. It is in line with national goals and targets outlines in the HIV/AIDS policy and is in agreement with global targets such as the millennium development goals, UNGASS, UNAIDS and USAID indicators.96 It outlines 41 core indicators covering 14 programme areas for monitoring, their frequency of collection, sources of information and the level of the indicators and targets. NNRIMS has been accepted among stakeholders as the core national system. A NNRIMS database has been developed and service coverage forms designed to capture HIV services, programmes provided by both the public, and private sectors at the LGA level. These forms have been field-tested and guidelines for filling in data clearly documented. These forms also capture the cost of programmes and the sources of programme funding. The NNRIMS is currently in the end stages of its pilot phase in 4 states of the country and is to be scaled up to all states.

11.1.2 Constraints

The main constraints faced by this thematic area were inadequate technical capacity for monitoring and evaluation at all levels. There was also an absence of an M & E plan for

96 MEASURE EVALUATION. HIV/AIDS Indicator Database. (http://www.measuredhs.com/hivdata/ind_tbl.cfm)
evaluating the HEAP. In addition, logistic issues such as inadequate staffing and delegation, poor funding and inadequate coordination posed constraints to monitoring and evaluation.

11.1.3 Emerging Issues

- **Inadequate baseline data:** Baseline information for some of the core indicators for monitoring national response is not available and this needs to be urgently addressed. Some of the indicators requiring baselines data include: HIV prevalence among injecting drug users by gender, percent people receiving ARV by gender, pregnant women counselled and tested for HIV, Percent HIV positive women provided with ART in pregnancy, percent large companies with HIV/AIDS workplace policies and those with gender sensitive workplace policies, drug supply at STI care services, attitude of male and female health workers to PLWHAs.

- **Current M & E plan not comprehensive to cover 2005-9 thematic areas:** The current NNRIMs was developed before the NSF and consequently does not capture monitoring of all thematic areas for the new NSF such as policy, advocacy, legal issues and human rights, coordination, resources mobilisation and management and sectoral response to the epidemic. To fit in the context of the Nigerian scenario and the NSF, there is a need to incorporate appropriate indicators to evaluate progress in these areas and to capture the multisectoral approach.

- **Gender sensitivity of NNRIMS:** Not all population-based indicators are disaggregated by gender so they only give insight into the target population as a homogenous group. At national level, the differential impact of the indicators on gender is not captured. This is despite the fact that gender inequalities fuel the epidemic hence knowledge of epidemic form a gender perspective would inform future programming. There are no gender disaggregated surveillance measures available or planned for. There is scattered information on gender but it is not adequately analysed to isolate gender sensitive results to explain HIV/AIDS as related to socio-cultural variables.

11.1.4 Recommendation

- There is a need to review the NNRIMS in order to reflect indicators that capture all thematic areas for NSF at the national level. There is need for harmony between NNRIMS and NSF.
- Baseline figures for the NSF should be collated within the 1st year and complied in the form of a report to allow for information based planning.
- There is need for secondary analysis of surveys for gender HIV issues as well as a general population based sero sentinel survey.
There is need to establish desk officers for M&E at all levels of coordination—NACA, SACAs, LACAs, as well as persons responsible for collating relevant information at the facility/CBO/CSO/ and NGO levels. Such data should be forwarded to the state and then federal level for analysis and dissemination to all stakeholders.

There is need for intense capacity development for monitoring and evaluation (including gender sensitive monitoring and evaluation) at all levels of HIV/AIDS coordination.

There is need to ensure adequate funding for M&E activities by advocating for a minimum of 10% allocation of the HIV/AIDS budget to M&E for all the coordinating bodies.

11.2 Research

The HIV policy is committed to supporting epidemiological and behavioural surveillance in Nigeria. The importance of quality research and analysis for the success of the fights against HIV/AIDS is highlighted in the policy with emphasis on HIV-related academic and operational research that are ethically defined and action oriented. It clearly states the need for HIV research to be approved by an accredited Human Research and Ethics and Operational Guidelines of the National Ethics Review System in Nigeria. What follows are highlights of achievement, constraints, emerging issues and recommendations for this sub-component.

11.2.1 Progress to Date

The draft ethical guidelines\textsuperscript{97} were articulated in line with international guidelines, governing biomedical research involving human subjects. There is a HIV Vaccine Working Group which has been given the mandate to develop guidelines for reviewing HIV vaccine-related studies in conjunction with the National Ethics Review Board. Nigeria has a well documented protocol for the process of vaccine development.\textsuperscript{98} NAFDAC’s monitoring team on clinical trials has the responsibility of monitoring vaccine trials and ensuring adherence to approved protocols and proper conduct. An International Data and Safety Monitoring Board is to be developed to monitor trials in Nigeria. Research working groups also exist for Voluntary Counseling and Testing, antiretroviral drugs, Prevention of Mother to Child Transmission of HIV/AIDS and microbicides.

There has been progress in the area of local manufacture of ARVs. The pharmaceutical company Rambaxy has commenced manufacture in Nigeria. Cipla, Evans Medical and RC pharmaceuticals have plans underway to commence production shortly. The Nigerian Armed Forces also plans to commence ARV production in Lagos in conjunction with the United States Army. There are also plans for the local production of test kits and condoms.

\textsuperscript{97} National Ethic and Operational Guidelines of the National Ethics Review System in Nigeria, \textit{Draft format}

\textsuperscript{98} National HIV Vaccine Development Plan. Draft copy
11.2.2 Constraints

There are funding constraints in the area of HIV research, such as laboratory testing, parameters for treatment with ARVs, drug trials and drug resistance testing. Presently, there appear not to be a functional operational National Ethics Review Board constituted although research institutions have local institutional review boards. Though the roles of different institutions governing research have been documented, they also do not appear to be operational.

11.2.3 Emerging Issues

With increasing national efforts to provide comprehensive treatment for HIV/AIDS, there is the need to explore the long term sustainability of ARVs through its local manufacture and by annexing the potentials of new HIV clinical trials to increase ARV access by PLWHA. There is a need for a nationally defined minimum standard of care for future clinical trial participants involved in HIV research. There is also an emerging need to research ARV drug resistant strains.

11.2.4 Recommendations

- Research protocols need to be developed for all new HIV/AIDS technology beyond vaccine development:
- Drug regulatory systems need to be reformed to enhance access to developed products,
- There should be increased involvement of local researchers in research and development processes
- There is a need to ensure community preparedness in research design and implementation and to ensure community preparedness preceding community trials.
- NAFDAC, National Ethics Review Board, Vaccine Working Group and other monitoring groups need to feed into national response monitoring.
13.0 CONCLUSION AND WAY FORWARD
References

Chapter 4
1 2003 National HIV and AIDS Reproductive Health survey
2 National HIV/AIDS/Syphilis Sero-Prevalence Sentinel Survey
3 HIV/AIDS Emergency Action Plan
4 National HIV and AIDS Behavior Change Communication Strategy
5 National Reproductive Health Survey 2003
6 ActionAid Mapping of Civil Society Organisations January 17th 2005
7 Personal discussion with the National Coordinator of Interfaith Coalition
8 Family Health International (FHI) and the National AIDS and STDs Control Program (NASCP) Behavioural surveillance survey 1999
9 Population Services International/Society for Health (PSI/SFH) 2001
12 National 5 year BCC Strategic framework on HIV and AIDS 2004

Chapter 5
14 Activity reports outline 2001-2004 Salvation Army
15 Summary of activities 1990-2004 Network of Health Coordinators –Catholic North Dioceses
18 Activity reports outline 2002-2004: FHI,
19 ARV Guidelines FMOH 2004 and Plan to Scale-up Antiretroviral treatment for HIV or AIDS in Nigeria 2005-2009 FMOH, 2004
23 PMTCT Scale-up plan Nigeria, FMOH: 2004
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27 FMOH Health Sector Response Report 2004
28 National Tuberculosis and Leprosy Control Program (NTBLCP): Summary TB program desk report 2004 (as presented at the NRR-TWG)
29 On overview of orphans and vulnerable children in Nigeria, Policy commission USAID February 2004

Chapter 6
Chapter 7

This section relies on available activity reports of specified sectors and also derived from the analysis of brief key informant interviews with officers in those institutions. See the Tables I &II.


49 Journalists Against AIDS. Voices from the fields. Perspectives and priorities for action on HIV/AIDS in Nigeria (draft)

50 Armed Forces HIV/AIDS control policy guidelines. October 2003

51 Report from future groups


55 Verbal Discussions with Key prisons and other uniformed personnel during CCE stakeholders meeting. January, 2004
56 HIV/AIDS project for Abidjan-Lagos transport corridor. File://E:\Projects\20
20Project\20Details\corridor.htm . Accessed 27th November 2004

Chapter 8
59 HIV/AIDS Emergency Action Plan (HEAP), March 2002


Chapter 9


United Nations Development Programme (2002): Donors’ Profile


Chapter 10


ibid, p.13

Actionaid Nigeria “SACAs: Issues and Challenges to Multi-Sectoral Responses to HIV/AIDS in Nigeria” 2003 p.6

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ss. 2(1); 2(2) ;3(1) to 3(6): Constitution of the Federal Republic of Nigeria 1999

FRN “National HIV/AIDS and Reproductive Health Survey” (NARHS) FMOH 2003 p.36


Oral interview with CiSNHAN in February 2004

HAF 2 call for Proposals (October 2003) Final Selection (Umbrella Organizations)
Chapter 11

92 Nigerian HIV/AIDS Emergency Action Plan (HEAP)
97 National Ethic and Operational Guidelines of the National Ethics Review System in Nigeria, *Draft format*
98 National HIV Vaccine Development Plan. Draft copy
### TABLE 1: LINE MINISTRIES AND PARASTATALS’ HIV/AIDS ACTIVITY MATRIX

<table>
<thead>
<tr>
<th>Line Ministry</th>
<th>Prevention</th>
<th>Care, Support, Treatment</th>
<th>Policy</th>
<th>Programme Coordination</th>
<th>Resource</th>
<th>Emerging issues</th>
<th>M&amp;E</th>
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<td>-</td>
<td>+</td>
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<tr>
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<td>+</td>
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<td>+</td>
<td>-</td>
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<td>Youth Dev.</td>
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<td>+</td>
<td>-</td>
<td>-</td>
<td>+++++</td>
<td>-</td>
</tr>
<tr>
<td>Women affairs</td>
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<td>+</td>
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<td>Works</td>
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<tr>
<td>Culture And tourism</td>
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<tr>
<td>Information</td>
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<tr>
<td>Internal Affairs</td>
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<tr>
<td>Defense (AFPAC)</td>
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<tr>
<td>The Police</td>
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<tr>
<td>Power and Steel</td>
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<td>Justice</td>
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<td>National Planning Commission</td>
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<tr>
<td>Universal Basic Education</td>
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<tr>
<td>Aviation</td>
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<tr>
<td>LINE MINISTRIES/PARASTATALS</td>
<td>ACTIVITY</td>
<td>COMMITMENT</td>
<td>IMPACT MITIGATION</td>
<td>COMMENT</td>
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<tr>
<td>Ministry of Agriculture</td>
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<td>There is an integrated rural development sector strategy for Nigeria which mentioned the HIV/AIDS problem. It is to be disseminated.</td>
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<tr>
<td>Health</td>
<td>+</td>
<td>+</td>
<td>+/-</td>
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<tr>
<td>Education.</td>
<td>+/-</td>
<td>+</td>
<td>+</td>
<td>The ministry was recently moved from women’s affairs to join the intergovernmental affairs.</td>
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<tr>
<td>Youth Dev.</td>
<td>+/-</td>
<td>+/-</td>
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<tr>
<td>Women affairs</td>
<td>+/-</td>
<td>+/-</td>
<td>+</td>
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<tr>
<td>Transport</td>
<td>+/-</td>
<td>+/-</td>
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<tr>
<td>Labour and Productivity</td>
<td>+/-</td>
<td>+</td>
<td>+</td>
<td>It has successfully started a phone – in programme on HIV. This further boost the knowledge about the epidemic. It has drafted the workplace policy ready for the President’s assent.</td>
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<tr>
<td>Housing/urban development</td>
<td>+/-</td>
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<tr>
<td>Communication</td>
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<td>+/-</td>
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<tr>
<td>Works</td>
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<td>It is planning sensitization workshop for its staffers by 2005</td>
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<tr>
<td>Culture And tourism</td>
<td>+</td>
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<tr>
<td>Information</td>
<td>+</td>
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<td>+</td>
<td>The ministry needs a level of resources to match the expected programmes related to its constituency.</td>
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<tr>
<td>Internal Affairs</td>
<td>+</td>
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<tr>
<td>Defense (AFPAC)</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>It is significantly active in addressing the preventive and support for the infected soldiers.</td>
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<tr>
<td>The Police</td>
<td>+</td>
<td>+/-</td>
<td>-</td>
<td>The development of BCC materials for 7 states and care and support for infected personnel in the hq. office is not enough. A need for accelerated scaling up of programmes.</td>
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<tr>
<td>Power and Steel</td>
<td>+</td>
<td>+</td>
<td>+/-</td>
<td>The ministry has just developed work plan for 2005 addressing sensitization of its staffers.</td>
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<td></td>
<td>+</td>
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<td>No activity addressing the infection</td>
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<tr>
<td>Justice</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>No concrete activity</td>
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<tr>
<td>National Planning Commission</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>No concrete activity</td>
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<tr>
<td>Universal Basic Education</td>
<td>+</td>
<td>+/-</td>
<td>+</td>
<td>The national board is currently planning to address the issue of impact mitigation of HIV on staff and pupils especially the orphans</td>
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<tr>
<td>Aviation</td>
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</table>

**LEGENDS:**  + Strong;  +/- Fair;  - Weak.