

NIGERIA NATIONAL HIV/AIDS

RESPONSE REVIEW REPORT

2001 – 2004

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ACRONYMS

FOREWARD BY NACA CHAIRPERSON

EXECUTIVE SUMMARY

This report contains the findings of a comprehensive review of the National Response to the HIV and AIDS epidemic in Nigeria within the period 2001-2004

NACA in consultation with partners and stakeholders developed a 4-year HIV/AIDS Emergency Action Plan (HEAP) as the national strategic framework for the control of HIV/AIDS in Nigeria

The HEAP, a multisectoral plan covered the period under review (2001-2004), and had as its focus three major strategies;

- The removal of socio-cultural informational, and systemic barriers to catalyzing community-based responses;
- Preventive interventions targeted at high-risk population and the general public;
- Care and support for people infected and affected by HIV/AIDS

The stakeholders involved in the implementation of HEAP are PCA, National Action Committees on AIDS, (NACA), line ministries at the federal levels, States' Action Committees on AIDS, Local Government Action Committees on AIDS, the private sector, non-governmental organizations, associations (networks) of people living with HIV/AIDS, local communities and development partners.

Nigeria's population is a complex mixture of diverse ethnic groups, languages, cultures, religions and regional political groupings all of which pose major challenges for HIV-intervention programs.

The review of the National Response (assessed) captured; key achievements, constraints, emerging issues, lessons learnt, and recommendations relating to eight thematic areas in the HEAP. The thematic areas are;

Prevention and Behavioral Change

Care, Treatment and Support

Socio-Economic Impact

Regional issues

Policy, Advocacy. Legal Issues and Human Rights

Resource Mobilisation and Management

Coordination, Institutional Arrangements and Decentralisation

Monitoring, Evaluation, Research and Surveillance

Prevention and behaviour change communication constituted over 70% of the interventions during the period.

There is a visible shift from IEC on HIV/AIDS to BCC in the country. Increasingly, high quality BCC campaigns through messages, and variety of materials are being used to target at-risk, high-prevalence groups including youth, commercial sex worker, and the uniformed services to raise HIV/AIDS awareness, increase knowledge and foster behaviour change.

Activities included training of peer educators, focus group discussions, condom promotion and outreach programs by religious groups, community-based organizations, unions and limited work place programs. As a result of these efforts, cumulative data from IEC materials indicated that prevention messages reached more than 20 million people.

The integration of HIV/AIDS messages into sermons has been a veritable tool in awareness creation, with opportunities abounding at the Sunday and Friday services of the two religions respectively

Notable achievements and constraints included:

The adoption of the “Family Life Health Education Curriculum” and its integration into the national educational curriculum;

The NYSC peer education programme in most of the states, and the pet project established by NYSC members in fifty schools across the North-West geopolitical zones;

The community youth AIDS educational programs mostly use entertainment, as they find this more appealing to the youths. Musical concerts using popular artists are the commonest examples cited by the NGOs. The appeal of this approach obviously lies in its ability to reach a wider audience. However, there were no reports of its impact. Only the AIDS Alliance reported anecdotal evidence of positive change of attitude and greater willingness to go for HIV testing after the performance. A number of youth-serving and youth-focused NGOs, mainly in the South-Western axis also have programs aimed at either building life skills of the youth or developing income generating and technical skills.

Churches were also reported as sites for reaching the youths. The Redeemed Christian Church of God gave a report on a Lagos project where studies showed a high level of sexual activity taking place among the youths attending their church; this justified the need to introduce an AIDS education program to the youths within the context of religious injunctions. This led to an increase in the rate of secondary abstinences.

The private sector initiative by ECOBANK in collaboration with NACA to establish Youth Friendly Centres as information and resources centres in target tertiary institutions across the country

The more established youth-serving NGOs appear to be the only ones involved in the provision of a range of youth friendly reproductive health services. Action Health Incorporation (AHI) in Lagos and the Association of Reproductive and Family Health, Ibadan are in the vanguard in terms of provision of a whole range of youth-friendly services.

The creation of “Humanitarian Resource Clubs” facilitated by UNICEF, through which youth were trained as peer educators to sensitize rural youth on HIV

Training of peer educators and formation of anti-AIDS clubs in secondary schools appear to be the commonest approaches used. These peers, once trained, are deployed for educating other youths and for condom distribution.

Recognizing the potential of the FBO to impact on the AIDS epidemic and the need for synergy and coordination of activities, an InterFaith Coalition on HIV/AIDS was formed. The coalition operates through a network of ---- across the country.

During the period, about 19479 pregnant women attending ANC in the 11 sites had been screened, of which 819 were HIV positive. Of the HIV positive women, about a third received prophylactic antiretroviral drugs while only one in four of the children born to these women were given nevirapine.

Coverage of the ARV program is still very limited, less than 1% of the estimated 760,000 PLWHAs in need of ART are enrolled in the government program. At the treatment centres, the demand is very high, resulting in over-subscription and long waiting lists.

The government program to provide antiretroviral treatment which began in 2002, with the purchase of drugs and test kits for 10,000 people now covers 27 tertiary government health facilities with 11 model and 22 satellite centres for preventing mother-to-child-transmission.

Many treatment centres have exceeded treatment quotas, and about 17,000 people are currently receiving antiretroviral therapy

The Christian Health Association of Nigeria which has a network of 4,000 health facilities at different levels of care across the country was involved in providing ART. Some treatment was also provided by private pharmaceutical companies such as Ranbaxy, which supplied over 3,000 person-years of treatment outside the government program.

Through support for development partners more than 120 NGOs capacities were enhanced to promote prevention of HIV infection in their communities, and to provide care for orphans and people living with HIV/AIDS.

Despite the growing visible presence of PLWHAs, their involvement by stakeholders is still far from adequate. However major activities undertaken and achievements included: formation of new support groups; and strengthening of the existing one through institutional capacity building; provision of food supplements; representation at ARV centers; advocacy to government, traditional rulers, trade unions, awareness campaigns for communities, in place for worship, markets, schools, etc, and strong advocacy for participation of PLWHAs in national policies, programme development and implementations.

The Nigerian National Response, supported by partners has seen the development of a National Policy on Women and Development and the conduct of a national baseline

survey that has identified harmful traditional practices that fuel the spread of HIV in Nigeria. These are typically, but not exclusively localized as follows: Harmful Widowhood practices (in Eastern Nigeria); Early girl marriage and Vesico-vagin fistula (in Northern Nigeria); Female Genital Mutilation (in Southern Nigeria). Another national project has been the development, production and publication of a gender-training manual.

The impact of children orphaned by AIDS in the community is just beginning to manifest, especially in high prevalence areas. Traditionally, families and communities take care of their orphans but the rising poverty levels and the increasing number of orphans are stretching the coping capacity of many communities. As a result, orphans face serious threats to their well being; meeting their basic needs in terms of shelter, food, clothing, health and education are major challenges.

The lack of empirical data and the absence of a national policy and programs that address the problems of children orphaned by AIDS are major gaps in the national HIV/AIDS response. However, the Federal Ministry of Women Affairs is working with UNICEF to fill this gap. Meanwhile, a few NGOs and some partners have small-scale programs focusing on orphans; even then information is lacking on the number, distribution, focus and scope of these organizations.

The empowerment of women and girls, especially with education and economic skills remains the major strategy towards the reduction of their vulnerability to HIV/AIDS, both to the disease and its burden.

There are ways forward in the march to challenge gender inequalities in relation to HIV/AIDS: it is necessary to encourage a fuller participation of men in prevention, impact alleviation and care. It is also important to work with traditional and religious leaders to identify practices that influence gender relations, and to eliminate practices that increase vulnerability of women. The enactment and promotion of favourable laws and policies to mitigate discrimination and gender inequalities will also have a positive effect in prevention and care interventions.

The recently concluded National AIDS and Reproductive Health Survey showed that while the knowledge about HIV/AIDS is high, this has not been translated into behaviour modification to limit risks. Youth perceive their risk of getting HIV as very minimal; consequently, they are less inclined to adopt safe sex practices.

The Armed Forces AIDS Control Program trained over 1,800 armed forces personnel as peer educators and reached more than 50,000 at-risk service personnel with HIV/AIDS information and counseling.

AFPAC in collaboration with local NGOs are implementing HIV/AIDS prevention services among armed/allied forces.

The AFPAC programme is properly designed to address the needs of uniformed personnel. The existence of a draft FMIA and paramilitary sector HIV policy are notable steps in the positive direction. However, there is a need to intense advocacy to address the issue of mandatory testing without informed consent as a prerequisite for employment and deployment.

Other critical issues include; the need to enhance the creation of an enabling environment for HIV control and mitigation amongst inmates. The policy environment in the prisons is currently not conducive for extensive prevention, care, treatment and support for inmates.

The HEAP had no provision for vaccine, microbicides, or any other possible HIV prevention technology. However, a national HIV vaccine plan has been developed and adopted. There are presently no approval processes for trials of potential new HIV prevention technologies in the country, while the Nigerian Ethical Review Board is yet to be active.

It was recommended that the functional scope and capacity of NAFDAC be enhanced to serve as a regulatory agency for the research and development of new products including vaccine and microbicides.

There exists a National Policy on HIV/AIDS coupled with other relevant HIV/AIDS-related policies which include; the National Reproductive Health Policy and Strategy; National Adolescent Health Policy; Armed Forces Policy on HIV/AIDS; Draft Policy on the elimination of Female Genital Mutilation; Workplace Policy on HIV/AIDS.....

Majority of existing policies are gender insensitive, human rights unfriendly and poorly disseminated.

The challenge for HIV/AIDS-related policies remain poor knowledge among potential users, poor utilization of community experiences, slow pace of development and lack of legal backing. Advocacy remains a gray area for most key players requiring more capacity development. With regard to legal provision, there is paradox of protective laws vis a vis discriminatory laws that increase risky HIV/AIDS infections particularly among young girls and women. Mandatory testing among some sectors continue to be a violation of human rights. Women and young girls are the most affected with regard to violation of human rights. There is an urgent need for development of a gender sensitive home based care policy or guidelines to standardize operations. There is a growing need for developing capacities of stakeholders in advocacy skills and to prioritise emerging HIV/AIDS challenges of scaling up prevention intervention among high risk groups including young girls, women and youths. Advocacy community preparedness for access to treatment is also a growing priority advocacy area.

Despite promising signs of a renewed high-level government commitment to HIV/AIDS, political will (leadership) at national, state and local levels were assessed as weak.

A high priority is mainstreaming HIV/AIDS in all national, state, and local leadership agendas.

Also efforts to educate other sectoral leaders in particular private sector will help garner their support and that of their constituencies. In addition, promising new initiative to implement HIV/AIDS workplace policies and programs in businesses and labour unions will be expanded.

Many foreign donors have committed financial assistance to Nigeria's HIV/AIDS program. They include the United States Agency for International Development, United States Department of Defence, US Department of Labour, CDC, US Department of Education, British Department for International Development (DFID), the Canadian International Development Agency, Italian Cooperation, the Japanese International Development Agency, the World Bank, the European Union and the United Nations community. The Bill and Melinda Gates Foundation is the largest source of private foundation support, and the Ford, Packard and MacArthur Foundations are also actively engaged in HIV/AIDS activities.

NACA supported the formation of a network of NGOs involved in AIDS across the country, CISCHAN, with more than 700 NGOs working on the prevention and impact of mitigation of HIV/AIDS

Currently 17 line ministries are involved in public sector response and plan to include all ministries had started. The line ministries presently on board are: Education; Culture and Tourism; Information; Internal Affairs; Police Affairs; Defence; Women Affairs and Youth Development; Agriculture and Rural Development; Health; Aviation; Transport; Employment, Labour and Productivity; Power and Steel; Finance; Communications; Works and Housing and Urban Development

There currently exists SACA in 35 states and FCT, Abuja with only Yobe state yet to inaugurate. In terms of administrative structure, the majority of the SACA were still health sector dominated. The membership size of the SACA varies widely ranging from 12 to 230 with a median of 22 members.

Out of the 774 LGAs in the states visited, 529 (69.2%) had formed LACAs. However, only 134 LACA are active.

NACA relationship with SACA was assessed as poor and this is the same for SACA LACA.

Even though there is clear understanding of SACA's role as a coordinating body, most SACA were found to be engaged largely in implementing activities.

The major challenges of get SACAs to function are lack of technical assistance, lack of funds, and operational guidelines.

All SACA members were trained in a two-day workshop in 2002. In addition, individual members have had the opportunity of participating in workshops on many important aspects of HIV/AIDS control. Different development partners and NACA organized many of these workshops.

During the HEAP period, SACA members benefited from training workshop individually or collectively on a wide variety of subject organized by development partners.

The lack of monitoring and evaluation plan for the HEAP led to the development of the Nigeria National Response Information System (NNRIMS). This however was developed to monitor not only HEAP but also monitor strategies to address the emerging issues. The emerging issues also lead to an increase in behavioural surveys for the general population and targeted high-risk groups. In addition, a lot of research was undertaken to address gaps in knowledge of epidemic.

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 military 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 work place. Stigmatization ranges from subtle actions to the most extreme degradation, rejection and abandonment.

Unless the efforts to reduce stigma are stepped up in HIV campaigns, it will remain a major barrier to combating the HIV epidemic. Studies and data in this area are few and far between, but 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 4.2: HEAP Summary Strategic Framework

SN	Strategies (Areas of Work)	Objectives	Target Groups
A.			
Creation of an Enabling Environment			
1.	Removal of socio-cultural barriers	To mobilize key influential groups and the general public to respond to HIV and AIDS	Political opinion leaders General Public
2.	Removal of information barriers	To develop and maintain an information base to permit policy makers, program managers and the general public to design and implement proactive interventions for the prevention and mitigation of HIV and AIDS	Program Managers Policy Makers General Public
3.	Removal of systemic barriers	To develop National Program management capacity to successfully implement the HEAP	Line Ministries NACA, SACA, LACA Private Sector, NGOs
4.	Catalyzing community-based responses	To mobilize communities to respond to HIV and AIDS	Community-Based Populations
B.			
Specific HIV and AIDS Interventions			
5.	Preventive interventions targeted at high-risk populations: <ul style="list-style-type: none"> Youths: high-risk & non-high-risk youth population 	To reduce HIV transmission among youths	Young people aged 10 – 24 years
6.	Preventive interventions targeted at high-risk populations: <ul style="list-style-type: none"> Empowerment of women to negotiate safer sex 	To empower women and girls to negotiate sex	Women, Girls
7.	Preventive interventions targeted at high-risk populations: <ul style="list-style-type: none"> HIV and AIDS intervention with the armed forces and the police 	To reduce HIV transmission amongst personnel of the Armed Forces	Armed Forces, Police personnel
8.	Preventive interventions targeted at high-risk populations <ul style="list-style-type: none"> Prevention of infection through MTCT 	To prevent mother-to-child transmission of HIV	Women of reproductive age and children
9.	Preventive interventions targeted at high-risk populations: <ul style="list-style-type: none"> Commercial sex workers 	To integrate participatory mapping, peer counseling and promotion of condom use by CSWs	CSWs, Partners, Clients
10.	Preventive interventions targeted at high-risk populations: <ul style="list-style-type: none"> HIV and AIDS intervention in prisons and personnel at border, immigration border and control 	To reduce the rate of infection amongst prison population and staff and immigration	Prisoners, Prison Staff, Immigration Personnel
11.	Preventive interventions targeted at high-risk populations: <ul style="list-style-type: none"> Workplace policies and programs related to HIV and AIDS 	To prevent HIV infection and provide care and support for workers infected and affected through the initiation of workplace policies and programs	Workers in the public and private sector workplaces, including the informal sector workers
12.	Preventive interventions targeted at high-risk populations: <ul style="list-style-type: none"> HIV and AIDS interventions for Transportation-related workers 	To reduce the rate of transmission amongst LDDs, touts, seafarers	LDDs, Touts, Seafarers
13.	Preventive interventions targeted at high-risk populations: <ul style="list-style-type: none"> Preventive interventions for the general population 	To reduce HIV and AIDS and STD prevalence in the general population through promotion of syndromic management of STIs, safe blood supply, and voluntary and confidential counseling and testing (VCCT)	Health Care Providers, General Public, PLWHA

- | | | | |
|-----|---|--|--|
| 14. | Care and support for persons infected with HIV and AIDS | To provide care and support for persons infected with HIV and AIDS | PLWHA |
| 15. | Care and support for persons affected by HIV and AIDS | To provide care and support for persons affected by HIV and AIDS | AIDS orphans, widows, guardians, affected families, affected communities |

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

TWG	Technical group
1	Prevention, Behavioral Change
2	Care, Treatment and support
3	Socio-economic impact of the epidemic

4	Regional programmes and emerging issues
5	Policy, Advocacy, legal issues and human rights
6	Resource Mobilization and Management
7	Coordination, Institutional arrangements, Capacity decentralization and local responses & social support
8	Monitoring and Evaluation, research and surveillance

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

5.0 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 it's 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.

6.0 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, commercial 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, 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) 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 low personal risk.

4.1 Progress to Date

4.1.1 Youth

Young people especially women 20-24 years old are increasingly vulnerable. It is estimated that up to half of new infections occur among them. In the 1999 sero-positive 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%.

Within the context of the HEAP, 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 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 there are yet to be documented reports of the impact.

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.

Through a public private partnership between NACA, the University of Port-Harcourt and Ecobank Transitional 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, screening and treatment of STIs for youths in tertiary institutions.

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

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) as a framework for effective target programming demonstrates the commitment to increase the knowledge of the prevention of HIV/AIDS; 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.

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, but only 23% of male and 8% female respondent ever used or are using it.

4.1.3 Faith and Community-Based Organizations

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.

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.

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. 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.

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 Most at Risk Persons (MARPs)

Most At Risk Persons are defined as those with a higher chance of contracting or transmitting HIV either because of their HIV status or their sexual and other high- risk behaviors. The population consist of commercial sex workers, transport workers, and uniformed services. 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 commercial sex workers, and male truck drivers.

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 commercial sex workers in selected sites in the six geopolitical zones. The survey found out that whereas nearly 100% of commercial 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. 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 and 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 at-risk services personnel with HIV/AIDS information and counseling.

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.

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

4.1.6 Prevention of Mother to Child Transmission (PMTCT)/VCCT

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 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 behavioural 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

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.

4.1.7 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; 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 bring about the visibility of PLWHA. Through the support of UNDP, the capacity of coordinators of support groups were build on advocacy, prevention, VCT and community home-based care. Two credible micro-credit NGOs in six hot spots states, and six non-hot spot states have implemented micro-credit scheme for PLWHA, including training them as counsellors.

With these self help PLWHAs have been able to contribute to HIV/AIDS prevention and behaviour change program. Also during the HEAP period there has been an increase number of people who have openly declare their status and are coming together to form support groups. Involving trained PLWHA counsellors in strategic ways is tremendously helping to demystify HIV/AIDS and to build commitment of support groups in promoting HIV prevention and behaviour change.

4.1.8 Innovative Prevention and Behavior Change Communication Strategies

Thousands of people get infected with HIV daily in spite of the various approaches by government and the 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 (090-809-062,090-523-6979, 09-523-4263) for PLWHA in the Nigerian Civil service who are being threatened with or discriminated against in their place of work. The services have been used by over 50 persons.

The Federal Government, through some ministries, is working towards providing people oriented programs at the grassroot level. The Aso Broadcasting Corporation have conceived a program titled “AIDS is real” to be broadcasted on the radio.

4.2 Constraints

Non-Involvement of Traditional Rulers: In certain African society, 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 audiences. 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 barrier: 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. There is therefore a great need to 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.

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 the NGO culture is comparatively young in northern part of Nigeria, there is an inequitable distribution of the 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 Female Sex Workers (FSW): Negative perception of condom efficacy coupled with the attitude of men and lack of negotiation skills by FSWs, inaccessibility of condoms in rural areas and unavailability of female condoms. Difficulties in reaching FSWs due to fear of stigmatization and harassment by the police, insufficient VCCT centers and attitude of health care workers to FSWs, and lack of information on VCCT sites.

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 commonly involve 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 (Please merge with next lot)

- Reduce police harassment through involvement of all cadres of the police force
- Promote female sex workers friendly services for treatment of STIs by training health workers
- Provide capacity building towards effective negotiation skills for CSWs, utilizing CSWs as facilitators
- Increase advocacy among brothel owners through regular meetings and consultations
- Provide information booths and IEC materials on health and HIV/AIDS at motor parks and junction towns
- Engage long distance drivers in interpersonal communications to develop campaigns
- Utilize mobile communication units at hotspots, junction towns and in uniform services settings (police/army/prison barracks).
- **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, the commissions, and Broadcasting Organization of Nigeria. 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 consciously 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 MTCT -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 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:** 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.

7.0 CARE, SUPPORT AND TREATMENT

Government recognizes its responsibility to provide access to care, support and treatment to all HIV/AIDS infected and affected citizens. Given that no effective curative therapy currently exists for AIDS, effective management must include an emphasis on compassion and support for the persons infected and affected by HIV and AIDS. The HEAP objectives for care, support and treatment are; to provide care and support for persons infected and affected by HIV/AIDS; provide affordable and accessible treatment; and reduce HIV/AIDS morbidity and mortality.

5.1 Progress to Date

Through the implementation of the HEAP, there was an increased government commitment and development partners support for care, support and treatment initiatives in both public sector and community level.

The government is committed to the establishment of a network of voluntary and confidential counseling and testing services to provide access to affordable and high-quality testing and counseling.

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 protocols.

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.

The government program to provide anti-retroviral treatment began in 2002 with the purchase of drugs and test kits for 10,000 people.

Treatment was 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 (WHO, Summary Country Profile, 2004).

Out of the 17,000 receiving antiretroviral therapy, 11,435 received treatment through the government subsidized program. Treatment was also provided by private pharmaceutical companies such as Ranbaxy, which is supplying 3,000 persons – years of treatment outside the government program.

The Federal Ministry of Health provides national leadership in implementing anti-retroviral therapy programs including developing treatment policies and guidelines, allocating resources and providing technical support to states and implementers.

The Center for Specialist Studies provides anti-retroviral drugs free of charge on a monthly basis to people at two centers in Shagamu and Ile-Ife, including treatment for children.

The Christian Health Association of Nigeria, 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.

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 three sites.

WHO provides normative technical assistance in developing treatment policies, guidelines and strategies.

UNICEF's technical role provided support for procurement and assistance in obtaining the highest quality and anti-retroviral drugs at the best prices.

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.

The Nigerian Red Cross (NRCS) also 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; 2,640 youth peer educators were trained, with about 1 million youths reached; 720 home-based care facilitators trained, who rendered home-based care support to over 4,000 PLWHA; training of 72 counselors; pre and post testing counseling was offered to over 10,000 people; 6 anti-stigma and anti-discrimination campaigns were conducted across the country and HIV/AIDS disseminated to more than 14 million people.

Community-based care and psycho-social support activities aimed at helping PLWHA and OVC are being provided by CSO, with increasing participation of religious organizations. Many religious organizations are contributing in providing counseling, as well as material needs to their members affected and other people infected by HIV/AIDS.

As at December 2004, the population covered for "DOTS" implementation was estimated at 80 million people. There are 47 microscopic centers in 494 local government areas (LGAs) in the country.

Training of health workers and caregivers in the management of HIV/AIDS and counseling was conducted in 5 local government areas per state.

Nutritional supplement in the form of breast milk alternatives was initiated with the support of UNICEF.

A rapid assessment was conducted on the needs of orphans and vulnerable children (OVC) affected by HIV/AIDS. In February 2004, a national conference on OVC was conducted to facilitate the development of a national policy on OVC.

Certain micro-finance NGOs provided training in income generating activities and micro-credit support for PLWHA, people affected by AIDS and other vulnerable populations.

5.2 Constraints

Despite the laudable efforts and commitment to treatment, the national response did not give due attention to care and support of people infected or affected by HIV/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 also requires comprehensive capacity building and increased funding for it to be able to perform its functions effectively, especially in the areas of care and support, advocacy for drug access, anti-discrimination campaigns and general public enlightenment on HIV transmission and prevention.
- 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.
- Inadequate nutritional support strategies for PLWHA, and flawed logistics of the alternative to breast milk initiative led to disruption of supplies of breast milk supplements.
- Most ANC centers lack equipment, material and skilled personnel to meet the demand for HIV-related services.

- Inadequate coverage, accessibility and affordability of ARV drugs at existing centers; there is also inadequate storage facilities for the ARV drugs at 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 desegregation, monitoring and evaluation at all levels of care, treatment and support interventions.
- Low capacities of most stakeholders involved in care, treatment, support and treatment.

5.3 Emerging Issues

- On the ARV therapy policy, training of non-clinical personnel (including home, community care providers and counselors) must be addressed as a means of attaining and scaling 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.
- Stigma is still very prevalent among health care workers thus 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.
- Specific care and support initiatives appropriate for men who have sex with men (MSM); intravenous drug users (IDUs) and prison inmates need to be addressed by identifying gaps and fostering interventions.
- Psychosocial support and care policies/guideline in the workplace need to be reviewed to meet gender specific needs particularly of females and single person head of families in all sectors of labor and productivity.
- Strict implementation of workplace based support and care policies is necessary to eradicate stigma in the workplace.

5.4 Recommendations

Anti-Retroviral Therapy

- Scale-up and decentralize distribution.
- 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 VCCT 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.

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.

8.0 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 affects the economically productive adults in their prime (15-49 years). The epidemic is also impacting 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.

The cost of the epidemic is felt on the education section 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 NEED 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. **National Planning Commission, 2004.**

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 is over 300,000 in 2004 and this is expected to increase annually significantly with the attendant crises.

Women and girls are the mostly impacted by the epidemic. They suffer 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 a severe loss of future earning potential.
- Depleted resources as they are challenged towards caring for sick member hence no investment.

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 (Feb., 2004) vividly describes the crisis in Nigeria concerning the increasing trends of orphans and vulnerable groups. Orphans from all cases account for 9.6% of the population under 15 years while the trend is increasing due to the contributions of HIV/AIDS mortality of mothers or fathers or both. HIV positive orphans are likely to be abandoned by their extended family members. 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 related complications. The policy document of February 2004 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 member of the household.

Economic Impact

The major economic burden is on labour productivity and the cost of labour. According to the National Policy on HIV/AIDS 2003 (FGN), 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 (Nwaorgu 1999). The employer equally financed the treatment including ARV service.

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 to public and private enterprises due to the following:

- Increasing health care cost/burial fees
- Time/man hour loss as a result of absenteeism from attending burials and cost of training new personnel to replace dead workers due to complications of HIV/AIDS infection.
- Labour turnover resulting in less experienced labour force thus low productivity.

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. The implications include:

- Workers live separately from their families/spouse.
- They earn higher income than their host communities hence are likely to indulge in sex in exchange for money with the financially constrained female members of the community CSW.
- Redistribute infection to their spouse.
- Miners are highly trained personnel requiring long period and heavy financial input hence the loss is difficult to replace.

- HIV/AIDS in the sector at increasing level threatens productivity and in the case of Nigeria, national revenue. Though presently, the effect on the sector may be seemingly negligible, since the sector employs less than 2% of the workforce, the long term effect of the epidemic on the sector will be devastating. The high manpower intensive sectors of the economy are the most affected. In the case of Nigeria, the public service, transport, agriculture, health, education and the rural economy will be the key sectors for the impact.

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

Impact on Agriculture and Rural Development

The primary source of income for the Nigerian population is agriculture, which supplies about 45 per cent of the employed labour force in 1986, and was estimated to contribute 42.6% of GDP in 1995. Although cocoa is the main cash crop, it accounted for only 0.7% of total exports in 1995.

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. Today, 95% of people living with – and dying of – HIV/AIDS are in developing countries. The overwhelming majority is the rural poor and among them, women figure disproportionately.

A threat to sustainable agriculture and rural development: The epidemic is undoing decades of economic and social development and causing rural disintegration. For example, in sub-Saharan Africa, HIV/AIDS is depleting the region of its food producers and farmers, decimating the agricultural labour force for generations yet to come.

People living with HIV/AIDS in the terminal stages 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.

Impact on Health Sector

With an estimated number of 4 million Nigerians living with HIV/AIDS, the epidemic is erasing decades of progress made in extending life expectancy. Millions of adults are

dying young or in early middle ages. Average life expectancy in Nigeria has fallen from 53 years in 1990 and is now about 50 years in 2003 but would have risen to 57 years and gradually 62 years by 2015 in the absence of the epidemic. On the contrary, it is envisaged that life expectancy will decline further by 2010 with the expanding epidemic, thereby wiping away all the gains and improvements in standard of living and health care of the last two decades (UNDP 2004: Human Development Report for Nigeria).

Other impacts of the epidemic on health are; increased demand for health care services, reduced resources available for other health care issues, increased spending HIV/AIDS treatment. There is insufficient hospital beds due to occupation by people in the terminal stage of the infection. Risk of infection of health care providers in emergency cases and inaccessibility to trained and experienced health care providers has created a stressful environment in health care services.

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. The epidemic is now a major threat to transport operations in Africa. In Orubuloye, Caldwell and Caldwell (1994) 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" (ILO, 2004). Also in an extensive study of hot spots and risk settings across Nigeria, it was shown that the prevalence rates in junction towns is approximately 2% higher than median rates for the states in which they are located (Judith-Ann Walker, 2004). Transport workers are twice as likely to acquire HIV as workers in 'low-risk' occupations. Because of their high-risk sexual behaviour, long 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

Today, just 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 this is scarce, current infection trend shows that the supply and demand for education will be grossly affected by the epidemic. **Rework this section.** These include:

- Reduction in the supply of qualified teachers. In southern and eastern Africa, teachers have been depleted to about a – third in some countries.
- Reduced number of children/young people in school – increase in rate of dropout (girls pulled out from school for caring, orphans not able to afford fees and relevant materials).
- Low quality of education as parents burdened by cost of treatment and household expenses may experience difficulties purchasing necessary materials for children’s education.
- Poor time management in terms of teaching as teachers may spend more time accessing treatment or ill at home.
- Poor resource allocation to the education sector due to AIDS-related expenses by the government.

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.

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 ₦45,000 per annum per patient, are dispensed to PLWHA at a subsidized rate of ₦1,000 per month amounting to ₦12,000 per annum per patient. Treatment has been provided to over 12,000 PLWHA.

The PMTCT program is provided in 11 sites located in the tertiary hospitals. 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 FCT, to be replicated in other parts of the federation.

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.

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

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, 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.

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9.0 REGIONAL PROGRAMMES, EMERGING ISSUES AND NEW TECHNOLOGIES

This thematic areas focuses mainly on prevention efforts for high risk groups (uniformed personnel), 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. This part of the sub-component (regional issues) focuses mainly on transport related workers and communities. This thematic area review of national HIV/AIDS responses to date, analyses progress made to date, major constraints, emerging issues, lessons learnt and concludes by making recommendations for the thematic area.

7.1 Uniformed Personnel

Like any mobile aggressive force, the military personnel face formidable challenges of fighting the high risk of HIV infection among its forces and the communities it interacts with. Its involvement in peace-keeping operations and war crisis management often separates soldiers 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 presents its own challenges of potential risk of HIV infection. Most prisons 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 15% and 8% of male prisons in Kano and Lagos respectively were engaging in unprotected sex. Rape, coercion sex by consent are common among prison inmates.

The HEAP strategy (2001-2004) for Uniformed personnel focused on providing training for members of the armed forces and their wives, establishing Voluntary Counseling and Confidential Testing (VCCT) centers and promoting condom use amongst uniformed personnel. HEAP strategy for Prison 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 Commercial Sex Workers (CSWs) was to undertake integrated participatory mapping, peer counseling and promotion of condom use by CSWs.

7.1.1 Progress to Date

Interventions among Armed Forces and Police and immigration border personnel and workers are on-going. Armed Forces programmes on AIDS Control (AFPAC) and local NGOs through support from various local and international partners are implementing HIV/AIDS prevention services among armed and allied forces. With regard 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 HIB control among inmates. In 2002, the Futures Project produced a report on Knowledge, Attitudes and Practices (KAP) among armed forces. All the 12 divisional Headquarters have VCCT centers but personnel to run these centers remain a challenge because of movement of personnel. Sensitisation seminars for the prison staff and inmates were conducted in the 10 states of Imo, Portharcourt, Benue, Katisna, Sokoto, Lagos, Akwa, Ibom and Benin. At least 50 prison inmates were reached for 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. VCCT centers were established in all the prison clinics and 5 referral centers.

7.1.2 Constraints

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 Men having sex with men (MSM), lesbians, refugees, displaced persons, trafficked human, intravenous drug users and substance abusers jut to mention other categories of high risk behavior. While some training of armed personnel on HIV/AIDS was conducted, there is need to ensure gender balance of the trained personnel for wider reach of information and knowledge for both male and female officers. Gender discrimination is high in the barracks with women often with women often impacted on more.

The entire programme in the Police was donor driven, funded and supported by FHI and Pathfinder and its coverage was only in four states in Nigeria (Kano, Enugu, Lagos and Maiduguri). The sustainability of such an approach to programming is problematic. The sensitization programmes for Ministry of Internal Affairs, and staff of Prison and Immigration personell at Boarder control staff has reached only 10 states (Imo, Portharcourt, Benue, Katsina, Sokoto, Lagos, Akwa, Ibom and Benin). 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.

For effective programming, the operational structures in the uniform service personnel units is different that which operates in civilian community. It is more difficult to have an effective trickling down form the top. This is because the uniform service structure is an autocratic structure. This was not taken into consideration in the design of the HEAP. HIV/AIDS programmes programming has focused extensively on uniform services personnel to the exclusion of members of their community who include their spouses and family members.

7.1.3 Emerging Issues

In the majority of cases, programmes for armed forces 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 current programme has revealed that officers' wives are powerful tools for mobilization of officers and their communities for HIV/AIDS interventions. 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 allocate a budget line for HIV/AIDS programmes armed forces. Such programmes should be as comprehensive 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.
- There is need to develop and distribute gender sensitive 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.
- 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 New 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 from 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-focused research programmes, researchers, policy makers and communities can benefit from 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 three (3) past studies on microbicides in the country, and three (3) ongoing new HIV prevention technology research, 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.¹ 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. Nigeria already has committed institutions involved in the development of new HIV prevention technologies such as Gede Foundation, Asokoro Hospital, NNIPRD and other research institutes NIMR, LUTH, UCH and UPTH. The country has reference 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 has capacity for vial 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.

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.

7.2.2 Constrains

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

¹ Participants to the 1st National Advocates on New HIV Prevention Technologies in Nigeria. May 26th – 27th 2004, Abuja.

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 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 not involved in “new” research. 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 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.

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 AIS 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. 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 Nigerian Government is involved in the corridor project which 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 VCCT 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.

At the regional level, there is the UNAID Inter-Country Team for North Africa, 11 countries from Central Africa and 16 countries from 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 in coming up, only taking off late into the epidemic and the implementation still remains 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.

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 corridor project should be scaled up to involve more border towns within Nigeria including those in the North and Eastern parts of Nigeria

(Group 4 to be revised in line with minutes)

10.0 Policy, Advocacy, Legal and Human Rights Issues

This thematic area focuses on the 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 access progress to date, constraints, emerging issues and suggest recommendation which 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 objective, which had mention of policy makers, read: “*The development and maintenance of an information base, to permit **policy makers** ----- to design and implement proactive interventions for prevention, 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. Irregardless of coverage in the HEAP, what follows is an analysis of what has happened in the HIV/AIDS Policy, Advocacy, Legal Issue and Human Rights arena since 2001, when the HEAP was developed.

8.1 Policy

HIV/AIDS related polices, play a critical role in providing guidance to the various key stakeholders in their different activities all aimed at fighting the epidemic. Existence and knowledge of the policy by key stakeholders thus 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 reponses to HIV/AIDS in any given country. For Nigeria, three types of HIV/AIDS policies can be identifies. 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 follow 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 Reproductive Health/HIV and AIDS policy of 1997, which has been replaced by the current the 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 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.

At the state level, there are encouragement development with regard to development of HIV/AIDS-related policies. The following are some of the policies which are operational in some states (Please note that this list is not exhaustive as they may be other polices in some states not): Enugu State Policy on HI V/AIDS, Cross River State Policy on HI V/AIDS, Edo State Policy on HI V/AIDS, Edo State Safe Motherhood Policy, Edo State Trafficking in Women and Children, Bayelsa state Policy on HIV/AIDS, Policies on Female Genital Mutilations in Rivers, Delta, Oyo, Ebanyi and Bayelsa states. In Edo States, for example, there are reports on the policy of trafficking yielding a lot of good outcomes. For NGOs, CHAN, Anglican Church and Nigeria Catholic all had Policies on HIV and AIDS. The Supreme Council of Islamic Affairs, ECWA are also working towards the development of an HIV/AIDS policy.

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, any policy guidelines to address the challenges of HIV and AIDS 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.

Gaps in Policies: A review of existing policies also indicated gaps in some sector for 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.

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 knowledgeable about the existence and let alone can not use the policy for their programme guidelines. Feedback from key stakeholders consulted for the Nigerian HIV/AIDS response review process confirmed that most HIV/AIDS implementer including women and youths were not knowledgeable about the many HIV/AIDS policies Nigeria has produced.

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 for a good number of policies. The Nigerian Armed Forces Policy on HIV/AIDS for instance, contain 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 to that is in the process of development. **Gender Capacity Development:** In support of such policy review, there is also need for 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 criminalises prostitution and make the existence of brothels illegal, which conflicts with the need to implement condom programmes in brothels for the HIV prevention and control.

8.1.4 Recommendation

- Any HIV/AIDS-related policy reviews to take on board not only the content review but should also ensure mainstreaming of gender and human rights aspects of 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 gender and Human rights dimensions of HIV/AIDS to operationalise gender and human rights friendly policies
- Lack of harmonization of policies between NACA, SACAs and LACAs.

8.2 Advocacy

Advocacy for greater focus on priority areas of the epidemic is a critical components of the HIV/AIDS response. Ability to single out the key drives 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 an important role 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. While the priorities for HIV/AIDS response may vary from organization to organisation, ----
complete later----

8.2.1 Progress to Date

A number of advocacy strategies, for different areas of interventions, has to date be employed by different stakeholders in Nigeria. According to the feedback from the consultation of 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. It really worked in those communities and the leaders are already replicating the trainings at their own community levels. The Alliance for Gender Equality targeted student 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 Nigeria example is the Kaduna centre for citizen Emancipation. They worked with the traditional leader as key change agents in the community for prevention efforts in HIV and AIDS. REHRAC (**Dr Saad :name in full please**) 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 (**Dr SAAD name in full**) has an advocacy packages but specifically have not developed the ones that eliminate socio-cultural barriers.

8.2.2 Constraints

Advocacy campaign has being going 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. Need to match advocacy messages with the appropriate target audience for effective outcomes.

8.2.3 Emerging Issues :

There is need to prioritise the key issues which form the basis for a nation 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 increasing becoming an more vulnerable group to HIV and AIDS issues should have a share in the priorities for advocacy. There is thus 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 and this should be developed by experts to avoid misrepresentation of fact about transmission and prevention of HIV and AIDS

8.2.4 Recommendations

- Need for a development of national HIV/AIDS advocacy strategy providing priority area, guidelines for effective advocacy for different target audience.
- Have a national plan for targeted advocacy visits to influential persons, more documentation of advocacy strategies, these groups could include, Sector Ministers, Governors of States, leadership of LACAs, traditional community leadership, Private sector leadership and more
- Develop a plan for capacity development of key multi-stakeholders on advocacy

- To ensure coverage of different strata of the Nigerian populace broaden the current advocacy methods to include more innovative ones which can reach difficult to reach group

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 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

Notwithstanding gaps in legal provision linked to key HIV/AIDS policies, the Nigeria 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), 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 cover for creating 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 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 infection. The provision of the Criminal Code is discriminatory against the girl child. 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 infection 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 ages, 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: 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 Islamic 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, “*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 point 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.

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 other 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 and pro-gender legislation does not appear to be a major concern of politicians, which make legal reforms very difficult.

8.3.4 *Recommendations*

- There is need to engage politicians and key stakeholders the HIV/AIDS field and others to mount an effective campaign for review of legal instruments which hamper effective fight of the epidemic.
- 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, 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, 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, analyses highlights of progress to date in the area of human rights and HIV and AIDS in Nigeria.

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 violation 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 safe guiding 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 case of human rights violation from different sectors of the Nigerian society. Mandatory testing in the Armed Forces was viewed as violation of officers' human rights. Some Faith Bases Institutions 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 however be noted that encouraging intending couples to know their HIV status before marriage was not a bad move. However refusing HIV positive individuals their right to marry was a violation of one's right 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 ante-natal 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 most women faced discrimination, abuse and violation of other forms of rights. Advocacy for male involvement in VCCT was viewed as a strategy which would reduce stigma and discrimination among women. Despite increasing number of institutions developing workplace policies, there are scenarios of violation of workers who test positive. The following were cited as lop-holes in the protection of workers human rights: Given that there is no binding law with regard to workplace policies, there it is not clear what happens to a worker when their human

rights are violated at work. There was need for the development of laws which would legalise workplace policies both the federal policies 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 programmes insurance products for PLWAs
- There is need for the development of a rich legal environment which would ensure protection of PLWAs when their rights are violated. Laws alone with no legal backing fail to provide such support and protection.

11.0 RESOURCE MOBILISATION (DR. TAYO)

To be typed

12.0 COORDINATION AND INSTITUTIONAL ARRANGEMENTS

In 1997, through the Federal Ministry of Health, Nigeria adopted their National Policy on HIV/AIDS and STI, which was designed to limit the spread of HIV/AIDS. Acknowledging that HIV and AIDS went beyond being a health challenge, a multi-sectoral response was adopted and the Presidency established the National Action Committee on HIV and AIDS (NACA) to coordinate HIV/AIDS activities in the country. NACA is made up of representation from thirteen Federal Ministries. Membership is also drawn from the civil society umbrella organisation Network for Civil Society Organisations in Nigeria (CiSCHAN) and the National Assembly.

The Presidential AIDS Committee (PAC) 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 Defence, Education, Education, Finance, Health, Information, Internal Affairs, National Orientation, Labour and Productivity, Women's Affairs and Youth Development. The secretary to the Government of the Federation (SGF) is also a member.

At the state level, State AIDS Action Committees were established. SACAS have representation from seven ministries and have provision for a SACA secretariat run by a secretariat. At the Local Government level, Local Government AIDS Action Committees (LACAs) were also established in all the 774 local governments in Nigeria.

Civil society, primarily NGOs, CBOs, FBOs and other categories also responded to the multi-sectoral approach. Two coordination bodies exist for NGOs, CBOs, and FBOs. These are CiSCHAN and Network of People Living with HIV and AIDS In Nigeria (NEPHWAN) CSO Networks exist in a majority of states under CiSCHAN. There are on average 704 CSO are registered with this network.

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

A strong coordination mechanism to harmonise the efforts of all the stakeholders, service providers and beneficiaries is critical and a mammoth challenge. This thematic areas reviews highlight of progress to date, constraints, emerging issues and recommendation for future action for 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 4 year period of HEAP. The HEAP recommended a multi-sectoral approach to combating HIV/AIDS and placed coordinating governments agents at all tiers of government namely federal, state and

local government (NACAs, SACAs, LACAs) at the centre of coordination the HIV/AIDS response. From a 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 organisations. All the stakeholder have demonstrated commitment to fighting HIV and AIDS.

Between 2001 and 2004, NACA has succeeded in increasing general awareness of HIV/AIDS among the Nigerian populace to the about 79%. It has been able to bring successful in bringing CSOs, line ministries and private sector into participating in the national HIV/AIDS response. NACA has clearly places the HIV/AIDS agenda on the map of the Nigerian polity.

Some CSOs through the capacity decentralisation component of HEAP and overall coordination of NACA, were able to access donor funds to undertake HIV/AIDS activities. The world Bank Assisted programme through HIV/AIDS Fund (FAF 1) has enabled many CSOs to access funds for HIV/AIDS programmes. The first half of HAF 1 SERVICED OVER 38 CSOs and many more accessed funding through the second part of HAF 1. This programme is being scaled up and HAF 2 programme is at an advanced stage for opening up call for funding proposals. An evaluation of the HIV/AIDS programme implementation by the recipients of HAF 1 indicated a 90% success in programme implementation.

CiSCHAN has also received 120 000 US\$ over three years for budget tracking in three states from the MacArthur Fund. It also accessed funding form HAF 1 to the tune of 28 million US\$. This money was used to develop capacity of CSOs in programme design, implementation, budgeting, monitoring and evaluation. About 50 CSO were reached in zone adding up to 300 CSOs reached for capacity building form this fund.

10.2 Constraints

Even though SACA and LACAs have been formed as coordinating bodies, the majority of them are not functional. There is a big challenge to make them functional as each state should show political commitment by providing the stipulated counter-part funding, which in most cases have not been forthcoming form most states. Political interference in SACAs has also been reported as a challenge. Governors have to make decisions on most funding related issues and as such, the beauracatic bottlenecks has tended to stifle SACA HIV/AIDS activities. A majority of LACAs also have not demonstrated serious commitment to HIV/AIDS programmes. While challenges of effective functioning of SACAs and LACAs 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 only challenge, is that the number is still far below 50 percent of these bodies which is cause of concern.

The multi sectoral approach present at the federal level (NACA), is unfortunately not equally demonstrated 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 in their HIV/AIDS programming.

The issue of address of gender issues in the coordination process is an area of concern. It is an uncontested 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, SACA, LACAs) is very low and where there is gender representation, sometime it is a tokenistic. In most of the structures, there is no gender desk or a gender focal person. There is also lack of clear budget set aside for building 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 which would be useful for: taking stock pf gender related activities, sharing best practices in gender mainstreaming in HIV/AIDS programming, keeping a data base of gender experts for gender capacity development for different multi-sector players, conducting joint monitoring of gender and HIV/AIDS programmes and more.

NACA has not been able to harness specific activities of key players in the field especially the community level, in order to have a fair picture of the national response. NACA's capacity to capture data on HIV/AIDS has been limited to a few activities and functional SACAs and LACAs and in most cases has not gone beyond Abuja. There is need to develop an effective system of monitoring national level trends in the HIV/AIDS responses and share it with all key stakeholders.

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 (OVCs) and ARVs. For a harmonised implementation of such programmes, there is need to development of a gender sensitive, Home Based care guidelines which will form the basis of for programme development by all key stakeholders. As the demand for ARV grows, there is also need for a development of clear gender sensitive guidelines on equitable access and distribution of ARVs. To prepare communities for ARVs there is need to develop a national programme guidelines on community preparedness for increased access to treatment programmes. Given the growing importance of addressing youth issues, there is need for a nation-wide guidelines on youth HIV/AIDS programming which can be used by mulit0stakeholders in developing their own programmes. There is also need to bring the participation of private sector into full wing. Hey play an critical role in also financing the HIV and AIDS responses in the country as a form of social responsibility to the population which supports their commerce.

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 establishment of gender focal persons whose would take the gender agenda in HIV/AIDS in these bodies forward
- There is need to support the establishment of a gender management system at all the thee 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 need to develop a system of data sharing to keep stakeholders updated on the progress and trends in the fight against the epidemic.

13.0 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). 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 attempt to address these issues 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 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. In both the two sub-components the review will begin by explaining what the subcomponent entails 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), 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 rationale 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.

Monitoring entails the routine tracking of programme or interventions in terms of the inputs into the programmes, the processes and the direct outputs from the programmes. This information is used to elicit if the programmes are functioning as designed and to feedback to improve the running of programmes. Surveillance is a routine tracking of disease or risk behavior using the same data collection over time. It is used to describe current epidemic and to project future trends and programming needs.

A national monitoring and evaluation system should have a well coordinated monitoring and evaluation unit, clearly articulated goals and objectives with core indicators and targets, an efficient data collection and analysis plan, and a clear plan for the dissemination of data generated in terms of the end users of the data. The data generated is useful for advocacy action, improving interventions and for generating identified, needed resources.

11.1.1 Progress to Date

There is evidence that some of the monitoring and evaluation strategies outlined in the HEAP have been implemented. These include the following:

Periodic updates of data through HIV and Syphilis sero-prevalence: The most recent sentinel sero-prevalence survey was carried out in 2003. There have also been other regular surveys such as the National Reproductive Health Survey, Behavioural Sentinel Survey, Youth Behaviour Sentinel Survey and the Demographic Health Survey.

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

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

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 outlined in the HIV/AIDS policy and is in agreement with global targets such as millennium goals, UNGASS, UNAIDS indicators and USAID indicators. It outlines 41 core indicators covering the 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. NNRIMS has 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.

11.1.2 Constraints

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 from a gender perspective would inform future programming.

Programme Evaluation: NNRIMS does not address the issues of programme evaluation. A committee has been established under the monitoring and evaluation unit to address this area and draft protocols have been developed and under review.

Pilot stage: Although there is good structure for the NNRIMS, it is still in its early stages of implementation. The NNRIMS is currently being piloted in four states of Cross

Rivers, Kano, Benue and Anambra. These states were selected on the basis of the functionality of their respective SACAs, the level of state activities and the presence of donor funding for HIV/AIDS activities. Lagos and Nasarawa states are serving as control sites. The effectiveness of this system cannot yet be assessed. No annual reports have been published or disseminated although the process has been initiated.

Inadequate baseline data by gender: 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 PLWAs.

M&E not comprehensive to cover 2005-9 thematic areas: The current NNRIMS developed in 2004, 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 socio-economic impact of the epidemic. These areas do not fall within the global indicators for the 14 programmatic groups. To fit in the context of the Nigerian scenario and NSF, there is need for the development of appropriate indicators to evaluate activities in these areas.

Multi-sectoralism: The current M&E system does not capture multi-sectoral involvement at different levels of the response. A system of monitoring the different sector's contribution to the national response needs to be developed.

11.1.3 Emerging Issues

Nigeria is a country with many sub-epidemics, so it is best to adjust strategies to meet monitoring and evaluation needs of the different groups, youth, women, culture, socio-economic status and region. The national HIV policy which is meant to be a background to the development of the HEAP, was developed two years after the HEAP came into existence. As a result, priorities from the policy documents related to this thematic area were not captured in the HEAP document. The NNRIMS, while a very good document, is mainly strategic in focus and needs to be operationalised for implementation by all stakeholders. It was mainly used to monitor what was taking place. As such it does not capture certain key sectoral areas such as legal issues, advocacy, coordination and resource mobilisation. Baseline indicators are not available for most of the core indicators.

Gender and HIV/AIDS is an emerging issue and special gender based surveys must be planned for. 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 urgent need to review the NNRIMS in order to for it to reflect indicators that capture all thematic areas for NSF. There is need for harmony between NNRIMS and NSF.
- Baseline figures for the NSF should be collated within the 1st year and compiled in the form of a report to allow for information based planning.
- There is need for stabling desk officers for M&E at levels of coordination NACA, SACAs, LACAs, as well as persons responsible for collating N&E information at the facility/CBO/CSO/ and NGO levels. Such data should be forwarded to the federal level for analysis and dissemination to all stakeholders
- There is need for intense capacity development for gender sensitive monitoring and evaluation at all levels of HIV/AIDS coordination.
- There is need to advocate for setting aside a minimum of 15% 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 were articulated in line with international guidelines, governing biomedical research involving human subjects. There is recently 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. 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.

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 in Nigeria, although research institution 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

The NNRIMS does not outline research priorities and how to implement them. A section on ethical issues was not included, while procedures for carrying out core components of HIV focused research is not clear, and guideline on research on human subjects are yet to be disseminated and included in NNRIMS. In the light of the increased provision of treatment for persons infected with HIV/AIDS in Nigerian, there is a need for quality management system to monitor and evaluate and provide evidence based planning on quality of service issues in both research and provision of care services.

11.2.4 Recommendations

- Research protocols need to be developed for all new HIV/AIDS technology beyond vaccine development.
- NAFDAC, National Ethics Review Board, Vaccine Working Group and other monitoring groups, need to feed into national response monitoring.
- There is need for secondary analysis of surveys for gender HIV issues as well as advocacy for funding a general population based sero sentinel surveys within the next 24 months.

14.0 CONCLUSION AND WAY FORWARD