

*Managing HIV/AIDS  
at the Local Level in Africa*

*Project outputs and  
achievements*

**MAKURDI, NIGERIA**

**2006**

- & Makurdi Summary*
- & Makurdi City HIV/AIDS Profile*
- & Report on the Makurdi HIV/AIDS  
City Consultation*
- & Makurdi HIV/AIDS Action Plan*

# **MANAGING THE HIV AND AIDS PANDEMIC AT THE LOCAL LEVEL**

## **EXPERIENCE FROM THE MAKURDI, NIGERIA**

### **A. INTRODUCTION**

One of the most devastating scourges of our time is the problem of the Human Immunodeficiency Virus Syndrome (AIDS). Undoubtedly HIV and AIDS present a major challenge to human development in Nigeria. Besides poverty, no problem has given Nigeria a more daunting challenge than the present battle with HIV/AIDS. AIDS is indeed devastating Nigerian communities and poses a real threat to poverty reduction efforts and the achievement of the UN Millennium Development Goals. Undoubtedly, HIV/AIDS presents a serious challenge to human development in Nigeria because the exact cost and spread of the epidemic is still very difficult to calculate.

HIV prevalence amongst the sexually active age group of 15 – 49 years has been on the increase since the first survey in 1991 when the national average sero-prevalence rate was 1.8% to 3.4% in 1993, 4.5% in 1995 and 5.4% in 1999, 5.8% in 2001 and 5% in 2003 (Policy project 2003). Based on these prevalence rates, a total of 3.5 million of the estimated national population of 120 million were estimated to be living with HIV.

Currently, Nigerian has become the first largely populated country to cross the critical epidemiological threshold of 5%. It has since been projected that by the year 2009, in the absence of major changes in sexual behaviour and other control measures, the number of people living with HIV will reach 5 million. Considering the global spread of the HIV/AIDS, of the 40 million people identified to be living with the disease, 3.5 million is the estimated number of Nigerians living with HIV/AIDS. This accounts for 10% of the 40 million people infected worldwide (UNAIDS/WHO/UNICEF 2002). In a country like Nigeria, with limited public capacity and resources to combat the problem, the prevalence is so high that the HIV virus is infecting more than 30 people a day, and the disease is growing faster than the authorities' response to it. The prevalence reports in Nigeria reveal the fact that there is no community in Nigeria with a zero prevalence. (FMoH,) 1999.

### **B. THE HIV/AIDS PANDEMIC IN MAKURDI**

In the 1999 and 2001 national antenatal HIV sero-prevalence survey, Benue State recorded the highest state prevalence rates in both 1999 and 2001: 16.8% in 1999 and 13.5% in 2001. The higher prevalence rate in 1999 of 16.8% is thought to be either an overestimation due to mistakes in the methodology or due to the large variation around the mean in the relatively small samples. When comparing the confidence intervals of the Makurdi site for both years, they tend to overlap.

Makurdi has a projected 2005 population of 273, 724 people with 142,231 males and 129,483 females. The city has a projected Annual Population Growth Rate of 2.6% and is predominantly populated by the Tiv ethnic group. Other minority ethnic groups in the city include the Idoma, Jukun and the Igalla. The dominant religion in the city is Christianity and the residents are mostly farmers, civil servants and traders. The city has a well laid out and planned road network, and maintains high environmental standards (little refuse was seen by the streets) because of the strict enforcement of environmental legislation in the state. In general, the people are accommodating, hospitable and friendly to visitors.

The city of Makurdi has a high incidence of the HIV/AIDS pandemic. It occupies the North Central Geopolitical Zone of Nigeria and is the socio-political capital of the region. While it suffers from all the disadvantages that encourage the spread of the disease, the city is located in an environment that engages in cultural habits that spread the disease such as traditional circumcision, tattooing etc. Unfortunately, the location of the city places it in a geographical location where the literacy rate is low and the incidence of poverty very high.

Like other cities in Nigeria, people identified as having HIV/AIDS are usually ostracized by the rest of the community. Consequently, nobody will own up to being infected with the disease. Unsuspecting sexual partners are thus easy victims. Because of the social stigma involved, people are not ready to carry out HIV tests. Lastly for the country, not much is being done to assist victims as well as check the spread of the epidemic. Consequently, the lives of the youths are perpetually under the threat of HIV/AIDS. There is thus the need to bring all segments of the people together to discuss the problem and find solutions to control the scourge.

### **C. THE MAKURDI HIV/AIDS INITIATIVE**

Working together with the Development Policy Centre in Ibadan, Nigeria, the City of Makurdi aimed to undertake a study on the situation of HIV/AIDS in Makurdi and how people were affected. The results of the study were presented at a Makurdi City Consultation on HIV/AIDS, which was held in April 2005. The outcome of the city consultation was a Makurdi Action Plan to address HIV/AIDS in the city.

The study commenced with desk reviews and a pilot survey of the city of Makurdi. This enabled the research team to identify stakeholders for the City Consultation and brief them about the vision of The African Network of Urban Management Institutions (ANUMI) and the City Consultation on AIDS. It also afforded the research team the opportunity to plan the data gathering required for the city profile report. The research team found that although there were numerous AIDS intervention programmes in the city, the expected benefits to PLWHA were not commensurate with the activities in this regard. This finding necessitated the involvement of PLWHA throughout all stages of the City Consultation process.

Next, the research team began the data collection phase of the study, using primary data. The team administered questionnaires among PLWHA at the Federal Medical Centre and the Bishop Murray Catholic Mission in the city, the two distribution centres for antiretroviral drugs in the city. Another set of questionnaires was administered among stakeholders involved in policy making with regards to AIDS. In Makurdi, this includes officials of the Benue State Ministry of Health and Human Services, the Federal Medical Centre, Bishop Murray Catholic Mission Health Centre, The Nigerian Television Authority, Associations of People Living with AIDS, non – governmental organizations and local action groups involved in AIDS management etc. The data from the questionnaires was complemented with focus group discussions with PLWHA to capture their perspectives about the disease and its impact on their lives.

The next step was the city consultation, which was held from 6 - 8 April 2005. This event was well attended by a range of stakeholders. Various papers were presented and discussed, including a review of government policy on HIV/AIDS, challenges facing PLWHA, HIV/AIDS and the MDGs and the Makurdi HIV/AIDS City Profile. The recommendations and policy issues put forward included the following:

- The political will is in existence to act decisively to prevent the further spread of HIV/AIDS and mitigate its impact, but efforts on the ground are too limited to make positive meaningful impacts on the lives of PLWHA. Political will need be strengthened to take care of these limitations. Stakeholders need to be sensitized about the impact of HIV/AIDS on lives and

livelihoods, and advocacy needs to take place to mobilize resources and effort to address the spread of the epidemic.

- Policy actions are needed, not only on awareness programmes, but also more in the area of infection prevention, strengthening of care and support to PLWHA and caregivers. Efforts need be intensified on mitigating the impacts of HIV/AIDS.
- There is an urgent need to give much more attention to appropriate prevention measures in all cities and communities, with particular focus on high risk groups, that is, the youths and others affected by poverty and inequality which enhance susceptibility to infection.
- AIDS is still a highly stigmatized disease in Benue State, and as a result, HIV/AIDS is not addressed openly. This affects prevention, care and support interventions. Stigma also prevents the collection of accurate data on which to base policy and program decisions. Hence, policies to eradicate stigmatization must be put in place and intensify it across the federation.
- As regards care and support, the challenge here is how best to assist and strengthen local support networks so that they can become more effective without becoming overwhelmed. Support must build on local initiatives and existing safety nets, avoiding the development of external or parallel support systems which cannot be sustained. PLWHA needs be empowered, provided with employment and enough drugs to go round all the PLWHA identified in the country.
- Care and support efforts should focus directly on target groups and the most vulnerable groups such as: PLWHA, orphans, widows and elderly caregivers.
- PLWHA need better access to care, which improves their health, quality of life and survival. Caregivers and the bereaved need be economically engaged, financially empowered, given socio-psychological counseling and other types of support. Home-based care needs to be strengthened to prevent existing safety nets from collapsing and to improve quality of care. There is an urgent need to strengthen the involvement of civil society organizations in providing care and support.

Smaller groups within the city consultation were formed to discuss and prepare an Action Plan for the city of Makurdi. In order to actualize practical, innovative and sustainable participatory governance vis-à-vis the AIDS epidemic, the Makurdi City Board on HIV/AIDS (MCBHA) was formed on the second day (7th April, 2005) of the City Consultation. The Board focused on a Makurdi City HIV/AIDS Prevention and Impact Mitigation Initiative, with the goal of reducing the prevalence and impact of HIV/AIDS on the Makurdi City Population. The objectives and action items are as follows:

1. To increase the programme implementation rate in Makurdi City by 15% in the year 2006 through improved condition mechanism and effective mobilization and utilization of resources.
2. To increase the percentage of youths who practice abstinence from sex, by 10% for both males and females by the year 2006.
3. To increase access to comprehensive gender sensitivity prevention care treatment and support services for people living with HIV/AIDS by 2006.
4. To strengthen the capacity of the board members and stakeholders in Programme design and implementation, proposal writing, resources, mobilization, monitoring and evaluation, advocacy etc.

**CITY PROFILE  
OF  
HIV/AIDS IN THE CITY OF  
MAKURDI, NIGERIA**

**BY**

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# 1. INTRODUCTION

## A Background to the Study

One of the most devastating scourges of our time is the problem of the Human Immunodeficiency Virus Syndrome (AIDS). Undoubtedly HIV and AIDS present a major challenge to human development in Nigeria. Besides poverty, no problem has given Nigeria a more daunting challenge than the present battle with HIV/AIDS. AIDS is indeed devastating Nigerian communities and poses a real threat to poverty reduction efforts and the achievement of the UN Millennium Development Goals. Undoubtedly, HIV/AIDS presents a serious challenge to human development in Nigeria because the exact cost and spread of the epidemic is still very difficult to calculate.

Upon noticing the scourge in 1986, with just one person affected, the infection rate has grown exponentially since then. By June 1999, the Federal Ministry of Health (FMOH) in Nigeria had recorded 26,276 AIDS cases. Because of the fear of social stigmatization, many cases are not reported through the hospitals, which means, the reported cases were gross underestimations of the rate of occurrence of the epidemic. The National AIDS/STDs Control Programme (NASCP) of the FMOH estimates that the total cumulative number of AIDS cases would have reached 590,000 by the end of 1999.

HIV prevalence amongst the sexually active age group of 15 – 49 years has been on the increase since the first survey in 1991 when the national average sero-prevalence rate was 1.8% to 3.4% in 1993, 4.5% in 1995 and 5.4% in 1999, 5.8% in 2001 and 5% in 2003 (Policy project 2003). Based on these prevalence rates, a total of 3.5 million of the estimated national population of 120 million were estimated to be living with HIV.

Currently, Nigerian has become the first largely populated country to cross the critical epidemiological threshold of 5%. It has since been projected that by the year 2009, in the absence of major changes in sexual behaviour and other control measures, the number of people living with HIV will reach 5 million.

Considering the global spread of the HIV/AIDS, of the 40 million people identified to be living with the disease, 3.5 million is the estimated number of Nigerians living with HIV/AIDS. This accounts for 10% of the 40 million people infected worldwide (UNAIDS/WHO/UNICEF 2002). In a country like Nigeria, with limited public capacity and resources to combat the problem, the prevalence is so high that the HIV virus is infecting more than 30 people a day, and the disease is growing faster than the authorities' response to it. The prevalence reports in Nigeria reveal the fact that there is no community in Nigeria with a zero prevalence. (FmoH,) 1999

Across the states, the table below also reveals that no state is an exception. Although some parts of the country are more affected than others, all states record more than 1% prevalence. In 2003, prevalence rates ranged from 1.2% in Osun State to 12% State in Cross River State. Nationally, the prevalence rate is higher in urban than in the rural areas. Persons between the ages of 20-29 are the most affected although in the South-south and Southwest zones, the prevalence is highest among the 15-19 age group.

The situation on the ground in Nigeria is very sobering indeed, Even with the recent drop in the National prevalence rate from 5.8 per cent to 5 per cent. According to official statistics, 3.5 million Nigerians already live with HIV and AIDS, which is more than the entire population of some countries. About 300,000 Nigerians die annually of AIDS-related diseases and 1.5 million Nigerian children have been made orphans as a result of these deaths. The fact that Nigeria's prevalence rate is in single digits can be misleading and can give one a false sense of security. In real fact, Nigeria has the second largest number of infections in Africa, going by the actual figures, not the percentages.

In fact, the epidemic has acquired a "Generalised" status in Nigeria, meaning that HIV and AIDS is spreading across all geo-political zones of the country, spreading in both rural and urban areas equally and across all segments of the population, not just confined to high-risk groups such as commercial sex workers, homosexuals and drug users.

A more recent study by USAID in 2003 tagged "Policy Project" further reveals the terrible situation of the HIV/AIDS epidemic along geo-political zones, the states and the profile of the infections, and possible rate of spread in the nearest future. The table below reveals the details along the geopolitical zones, the South, South Zone and the North Central zones are in the lead with 7.0% and 5.8% prevalence rate accordingly from 7.0% and 5.2% in 1999. And at the state level, the spread reveals that Cross Rivers is on the lead with 12.0% followed by Benue State in the North Central Zone with 9.3% prevalence rate.



**Table 1.10 Geopolitical Distribution of HIV Prevalence in Nigeria**

	Population 2003	HIV Prevalence (%)	Number of people infected (2003)	Number of people infected (2008)	Number of youth (15-24yrs) infected (2003)	Number of youth (15-24yrs) infected (2008)	Number of HIV+ pregnant women (2003)	Number of HIV+ pregnant women (2008)	Number of people requiring Antiretroviral drugs (2003)
<b>North Central Zone</b>	13,894,924	7.0%	460,719	500,633	83,822	107,698	40,820	43,821	91,346
Benue	3,902,638	9.3%	238,328	212,772	29,640	45,517	21,246	18,318	53,825
FCT	526,977	8.4%	26,427	27,499	4,956	6,953	2,126	2,194	4,501
Kogi	3,044,411	5.7%	90,974	106,093	20,111	23,419	8,556	9,395	15,296
Kwara	2,194,976	2.7%	39,901	35,937	6,428	7,603	3,506	3,026	7,356
Nassarawa	1,712,241	6.5%	67,897	68,570	7,887	16,092	5,897	5,917	15,862
Niger	3,432,980	7.0%	129,660	149,327	31,699	35,336	11,415	12,896	20,676
Plateau	2,983,339	6.3%	105,860	113,207	12,741	18,295	9,320	10,393	27,659
<b>North East Zone</b>	16,870,701	5.8%	498,589	550,631	102,828	127,399	44,439	47,668	84,788
Adamawa	2,979,806	7.6%	117,322	137,387	27,810	31,448	10,675	12,005	17,419
Bauchi	4,056,992	4.8%	127,064	127,314	22,474	27,123	11,502	10,785	18,226
Borno	3,595,100	3.2%	66,142	69,230	11,858	16,929	5,425	6,013	17,303
Gombe	2,110,953	6.8%	79,597	91,323	14,180	21,828	7,153	7,880	12,792
Taraba	2,143,617	6.0%	69,039	78,538	16,949	19,000	6,157	6,955	13,770
Yobe	1,984,233	3.8%	39,425	46,839	9,557	11,071	3,527	4,030	5,273
<b>North West Zone</b>	32,481,910	2.7%	726,975	762,883	135,757	184,383	63,447	65,646	140,811
Jigawa	4,076,353	2.0%	42,587	49,834	9,852	12,585	3,646	4,226	7,657
Kaduna	5,579,401	6.0%	237,248	211,354	26,142	49,110	20,368	17,917	56,406
Kano	8,237,029	4.1%	179,842	205,620	41,912	50,095	15,558	17,696	33,086
Katsina	5,320,243	2.8%	84,861	95,984	15,639	23,231	7,596	8,413	14,398
Kebbi	2,932,237	2.5%	51,768	46,092	9,723	10,724	4,540	3,971	10,227
Sokoto	3,397,878	4.5%	80,761	96,072	20,538	24,160	7,332	8,393	10,782
Zamfara	2,938,769	3.3%	49,908	57,927	11,951	14,478	4,407	5,030	8,255
<b>South East Zone</b>	15,272,983	4.2%	393,315	369,983	48,913	83,237	34,940	31,438	91,969
Abia	2,712,984	3.7%	64,954	77,871	13,275	17,330	6,071	6,679	10,672
Anambra	3,964,073	3.8%	107,853	92,485	15,130	20,136	9,066	7,315	23,007
Ebonyi	2,060,679	4.5%	56,422	50,769	6,939	11,885	5,160	4,508	14,420
Enugu	3,012,091	4.9%	76,860	81,998	4,629	19,095	6,719	7,258	21,494
Imo	3,523,156	3.1%	87,226	66,860	8,940	14,791	7,924	5,678	22,376
<b>South South Zone</b>	18,985,583	5.8%	726,324	802,554	97,792	174,843	66,167	67,871	120,239
Akwa Ibom	3,415,174	7.2%	168,862	157,240	1,742	31,415	15,401	13,434	33,042
Bayelsa	1,590,201	4.0%	44,784	46,783	5,985	10,422	3,963	3,832	7,705
Cross Rivers	2,709,823	12.0%	171,420	204,526	39,103	46,461	16,280	17,763	20,618
Delta	3,672,077	5.0%	97,727	113,135	17,901	25,017	8,913	9,751	19,358
Edo	3,078,963	4.3%	77,397	83,794	10,939	18,076	6,970	7,111	16,594
Rivers	4,519,345	6.6%	166,134	197,076	22,122	43,452	14,640	15,980	22,922
<b>South West Zone</b>	24,744,106	2.3%	546,522	510,112	86,130	91,546	43,995	38,655	104,460
Ekiti	2,177,048	2.0%	27,722	26,633	3,932	5,802	2,286	2,048	5,128
Lagos	8,116,535	4.7%	216,826	236,820	36,597	53,894	16,252	18,099	53,441
Ogun	3,308,128	1.5%	50,913	33,082	7,384	1,716	4,077	2,303	7,558

	Ondo	3,188,875	2.3%	91,770	58,309	13,189	2,045	7,747	4,242	12,794
	Osun	3,059,128	1.2%	55,094	30,598	7,409	1,000	5,097	2,435	9,683
	Oyo	4,894,392	3.9%	104,197	124,670	17,619	27,089	8,536	9,528	15,856
		126,250,207	5%	3,352,444	3,496,796	555,242	769,106	293,808	295,099	633,613

**Source; USAID Policy Project 2003.**

In everyday language, all Nigerians are now at risk, no matter where they live, no matter their stations in life, no matter their sexual orientations. It is evident that things could get worse very soon and if care is not taken, Nigeria may be one of the worst hit countries in the world.

## **B. Factors Responsible For the Spread of HIV/AIDS**

The cause of the disease all over the world relates to individuals' social behaviour such as sexual exposure and intravenous drug use (FmoH 2002). In Nigeria however, the leading driving force for the spread of the HIV infection includes low level of education and high level of ignorance, cultural practices such as polygamy and wife hospitality, crippling poverty and lack of access to appropriate reproductive health services and information particularly for young people. The practice and use of traditional surgery such as uvulectomy and blood-letting procedures with unsterilized instruments, sexual relations with traditional healers as part of treatment of infertile women, and non-observance of infection control procedures by traditional birth attendants who are heavily patronized in Nigeria, may all be key factors responsible for the spread of HIV/AIDS in Nigeria.

Other factors blamed for the spread of the epidemic are cultural practices that encourage multiple sexual partners such as concubines, Levirate, wife exchange, polygamy and wife hospitality. This in addition to other cultural practices that expose people to unsterilised sharp objects such as body scarification and circumcision; subordinate role of women and its attendant vulnerability which prevents women from negotiating safe sex; ignorance; stigma and discrimination. Poverty, illiteracy and the nonchalant attitude of some individuals to the disease are significant factors as well.

In spite of various efforts at both domestic and international levels, the Nigerian situation seems not to translate into any cheering news about the HIV/AIDS epidemic. It is becoming more of a development problem than simply being a health problem. The problem should be considered a major challenge to sustainable human development in Nigeria, which must be a concern for all. It is against this backdrop that the present research effort was undertaken with the hope of introducing a more pragmatic approach tagged 'A City Consultation' that could translate into a more sustainable effort to step down the spread and the impact of HIV/AIDS epidemic.

The study focuses on one of the leading states in Nigeria in terms of prevalence, Benue State. The effort is focussed on Makurdi Local government.

## **C. Justification for the Study**

Concerns for the poor, especially people living with HIV/AIDS (PLWHA) in terms of socio-psychological disturbances, discrimination, financial difficulties and other attendant problems as a result of HIV/AIDS infection, prompted this study. This study focuses on Benue state, located in north central Nigeria. The State has a total population of 2,780,398 (1991 census), which has been projected to 3,100,311 (1996), with average population density of 99 persons per sq. km. This makes Benue the 14<sup>th</sup> most populous state in Nigeria. However, the distribution of the population according to Local Government Afeas (LGAs) shows a marked duality. There are areas of low population density such as Guma, Gwer, Ohimini, Katsina-Ala, Apa. Logo and Agatu, each with less than seventy persons per sq km. While Vandeik

Okpokwu, Ogbadibo, Obi and Gboko have densities ranging from 140 persons to 200 persons per square kilometre.

The state's population shows a slight imbalance in favour of the females, constituting 50.2 per cent. Benue State is one of the most under-developed parts of Nigeria. This region was depleted of its human population during the trans-Saharan and trans-Atlantic slave trade. It is largely rural, with scattered settlements mainly in tiny compounds or homesteads, whose population ranges from 6-30 people, most of whom are farmers. In the Idoma-speaking part of the state, the settlements are larger (i.e. 50-200 people). (NAPEP – Overview of Benue State).

#### **D. Why Benue State and Makurdi In Particular?**

In the 1999 and 2001 national antenatal HIV sero-prevalence survey, Benue State recorded the highest state prevalence rates in both 1999 and 2001: 16.8% in 1999 and 13.5% in 2001. The higher prevalence rate in 1999 of 16.8% is thought to be either an overestimation due to mistakes in the methodology or due to the large variation around the mean in the relatively small samples. When comparing the confidence intervals of the Makurdi site for both years, they tend to overlap.

#### **E. Makurdi City (The Study Area)**

Makurdi has a projected 2005 population of 273, 724 people with 142,231 males and 129,483 females. The city has a projected Annual Population Growth Rate of 2.6% and is predominantly populated by the Tiv ethnic group. Other minority ethnic groups in the city include the Idoma, Jukun and the Igalla. The dominant religion in the city is Christianity and the residents are mostly farmers, civil servants and traders. The city has a well laid out and planned road network, and maintains high environmental standards (little refuse was seen by the streets) because of the strict enforcement of environmental legislation in the state. In general, the people are accommodating, hospitable and friendly to visitors.

The city of Makurdi has a high incidence of the HIV/AIDS pandemic. It occupies the North Central Geopolitical Zone of Nigeria and is the socio-political capital of the region. While it suffers from all the disadvantages that encourage the spread of the disease, the city is located in an environment that engages in cultural habits that spread the disease such as traditional circumcision, tattooing etc. Unfortunately, the location of the city places it in a geographical location where the literacy rate is low and the incidence of poverty very high.

Like other cities in Nigeria, people identified as having HIV/AIDS are usually ostracized by the rest of the community. Consequently, nobody will own up to being infected with the disease. Unsuspecting sexual partners are thus easy victims. Because of the social stigma involved, people are not ready to carry out HIV tests. Lastly for the country, not much is being done to assist victims as well as check the spread of the epidemic. Consequently, the lives of the youths are perpetually under the threat of HIV/AIDS. There is thus the need to bring all segments of the people together to discuss the problem and find solutions to control the scourge.

#### **F. Objectives of the Study**

The aim of this study is to depict a comprehensive picture of the situation of People Living with HIV and AIDS (PLWHA) in the city. The objectives are as follows:

1. Conduct desk reviews of HIV/AIDS studies in other cities.
2. Conduct a reconnaissance survey of Makurdi to familiarize the research team with the study area and plan the data gathering process for the study.
3. Conduct a series of mini-consultations among stakeholders to encourage them to attend and discuss the problem of HIV/AIDS in an omnibus city consultation.
4. Develop practical and sustainable strategies towards localizing the UN Millennium Declaration on HIV/AIDS in Makurdi

## **G. Methodology**

The study commenced with desk reviews and a pilot survey of the city of Makurdi. This enabled the research team to identify stakeholders for the City Consultation and brief them about the vision of The African Network of Urban Management Institutions (ANUMI) and the City Consultation on AIDS. It also afforded the research team the opportunity to plan the data gathering required for the city profile report. The research team found that although there were numerous AIDS intervention programmes in the city, the expected benefits to PLWHA were not commensurate with the activities in this regard. This finding necessitated the involvement of PLWHA throughout all stages of the City Consultation process.

Next, the research team began the data collection phase of the study, using primary data. The team administered questionnaires among PLWHA at the Federal Medical Centre and the Bishop Murray Catholic Mission in the city, the two distribution centres for antiretroviral drugs in the city. Another set of questionnaires was administered among stakeholders involved in policy making with regards to AIDS. In Makurdi, this includes officials of the Benue State Ministry of Health and Human Services, the Federal Medical Centre, Bishop Murray Catholic Mission Health Centre, The Nigerian Television Authority, Associations of People Living with AIDS, non – governmental organizations and local action groups involved in AIDS management etc. The data from the questionnaires was complemented with focus group discussions with PLWHA to capture their perspectives about the disease and its impact on their lives.

Data from the questionnaires were analyzed on a computer software package called The Statistical Package for Social Scientists (SPSS). Descriptive analysis of the data, including case summaries of the questionnaire variables were carried out and the results were used to develop a comprehensive profile of AIDS in Makurdi.

## **2. LITERATURE REVIEW**

### **A. Empirical Findings of HIV/AIDS Studies**

The Acquired Immune Deficiency Syndrome (AIDS) results from damage to the individual immune system. According to Piot P, Kapita, BM, Ngugi E.N, Mann J.M, Colebienders R and Wabitsch R (1992), AIDS was first recognized in 1981 in the United States of America in young homosexual men.

Claxton & Harison (1991) reported that the disease is caused by a virus that weakens the immune system of the body. According to them, it was first identified in Paris in 1983 and called Lymphia deno pathi associated virus LAV. According to WHO 1994, researchers in the USA identified the virus in 1984 and called it Human T-cell hyumphotropic Virus type III (HLTV-III). The International Committee on Taxonomy of viruses recommended the use of the term Human Immunodeficiency Virus.

The AIDS virus has been linked to the moral and sexual decadence prevalent in the west such as homosexuality. According to the Association for Survival Progressive Intervention (1999,) United Nations Statistics indicate that 33.4 million adults and children are living with AIDS worldwide and 22.8 million or 68% are from Sub Saharan Africa.

As far as AIDS is concerned, African countries, especially Sub-Saharan Africa, which incidentally have the poorest nations, have suffered the most devastation. Natural disasters have enhanced the spread of AIDS by breaking apart community life and disrupting stable relationships.

AIDS has become a major public Health crisis in Nigeria. The spread of AIDS to and within Nigeria has been well established. By 2001 Nigeria was said to be occupying the 27<sup>th</sup> position in the hierarchy of the worst infected AIDS nations.

### **B. Factors Enhancing the Spread of HIV**

In spite of the intense fight against HIV/AID by the government and non government agencies, HIV infection continues to thrive and spread at an alarming rate.

WHO (1994) identified the following factors enhancing the spread of HIV:

1. Complacency
2. High risk Behaviour (WHO 1994)
3. War and Disaster
4. Migration - Urban Rural migration increases vulnerability to AIDS, as people leave their families to urban cities in search of work. This includes young men who leave their countries to seek work in other countries. In addition, adolescent girls that are used in western countries for prostitution, Shaibir and Larson (1995) identified this factor as a major route or spread of HIV.

According to a study on Dar es Salaam and the HIV epidemic, the AIDS epidemic did not begin in the capital city. Almost certainly it was brought to the city by migrants and travellers from Kagera, which was the first area to be affected. The first cases were noted in

Dar es Salaam by the mid-1980s. Ten years later, the levels of prevalence of HIV were higher than anywhere else.(NACP 1998 b:19)

AIDS has now become the commonest cause of death in the capital. With a population of over two million, the city of Dar es Salaam is growing fast. During the 1980s when the last census was held by the Government of Tanzania, Dar es Salaam had an annual average growth rate of 4.8 per cent compared with the overall national rate of 2.8 per cent.

Rapid urban growth has meant an influx of rural people who rarely settle permanently in the capital. Women as well as men form part of the migratory flow. They live in crowded houses in neighbourhoods full of the noise of life and commercial activity. In Dar es Salaam there is a social setting characterized by high geographic mobility, with a population weighted towards the most sexually active age group, where individuals are making new lives away from the constraint and support of Ken and elders and where social conventions to contain relations between the sexes and generations and to mediate the babel of contrasting customs and patterns of behaviour are rooted in shallow soil.

At the extreme, life in the poorer neighbourhoods of Dar es Salaam goes on in high sexualized contexts where risk and survival hunt together. According to a field work report on Manzese, Dar es Salaam in 1997, the following was extracted:

*During the night, people at Hyena Ground (in Manzese) become so many, they went to the extent of doing and shouting a lot of things without being aware of what they are doing. Sexuality and sex are displayed openly, especially by the prostitutes who are there renting rooms and waiting for customers. There are times when the slum houses, special for short time renting, are too few for the number of customers and each customer has to book his time from the house owner. After returning from school, children from poorer families come here to sell cooked food brought from their homes to earn money for their families. Mostly young girls between the ages of 10 and 12, they arrive at around 6pm and work to 10pm. We saw many young and old men trying to seduce them by offering money which would cover the total sale of food and give them the chance to have sex with the girls. One man was overheard to say "I'm giving you this money to give mama so that we can make love before you have to get off home."*

Other factors that lent risk to AIDS were men having a greater purchasing power than women. Women had greater needs in this regard. According to an observation at a field work in Kigambom Dar es Salaam in 1995 it is said that women are selling the disease to men with money buy it. It is said that men are reluctant to use condoms in encounter with sex workers, even though it is cheaper. Women who agree to have sex without condom augment their income but put their lives at risk as do their customers.

Other factors responsible for the spread of AIDS in this context include male violence and sexual brutality, sexual abuse of young girls by older men. (a form of class exploitation) and Young men's inability to marry given due economic circumstances.

There are institutions which express collective values of proper behaviour. These include churches, mosques, local leaders, ethnic associations, parents struggling to keep families together and protect their children. Poverty leaves people hopeless enough to turn to the solace of drugs or make prostitution a survival strategy.

“AIDS in Kapulanga Mongu: Poverty neglect and gendered patterns of blame” by Kapulanga, a squalor settlement on the outskirts of Mongu in Zambia’s western province is a case study, according to Bujra and Baylies (2000). The location of this settlement has an influence on the high prevalence of HIV in the area. It is situated near the capital of the Zambia’s western province and Mongu near where it is located in an important commercial and administrative center.

In spite of the apparent context of relative isolation due to the bad road network and the consistent flooding of the river very near it, AIDS is deeply entrenched in this area. One of the factors attributed to this is the migration of young men from the settlement and environment to find work in the South African diamond fields as early as 1880. Ref Hall 1965.

Early introduction of education within the settlement was another factor. This meant exporting educated individuals mainly men (later women) as civil servants and later professionals into the neighbouring towns. The outward movement of these people did not witness movement into the settlement.

By 1962, there was a large influx of families from a residential area and the number of people expanded. Later refugees fleeing political dislocations in Angola moved in with its attendant AIDS related implications. A higher proportion of Zambia’s population is urbanized – 44% against Tanzania’s 26%. The latter, however has a higher rate of urbanization whose consequent human mobility could be aggravating the spread of the disease.

Transit stops in both countries, like Livingstone and Chipata in Zambia or Mwanza and Mbeya in Tanzania, spread AIDS rapidly, because of commercial sex activities of travellers. According to Zambia’s Ministry of Health, prevalence rates for AIDS were higher in urban areas than rural ones – 27.9% vs 14.8% respectively. Women under 25 were particularly vulnerable to the disease in both countries.

In a recent workshop focussing on Ibadan city, Shokunbi, W.A (2002) observed that the average number of sexual partners per long distant driver was 6, corresponding to an equal number of locations where they spent the night. For female hawkers aged between 10-40 years, 15% reported losing their virginity through rape, 60% had two or more sexual partners and 20% claimed they had gonorrhoea in the past.

According to Adeniyi J.O, Adeniyi EO, WA Shokunbi, C. Uwakwe, Titi Ipadeola, 74% of adult respondents in Ibadan have received injections by patent medicine dealers, 6% by dispensary, 7% by pharmacists and 13% by self administered injection.

According to Shokunbi’s other findings, African prostitutes in Anglophone countries do not reveal the true nature of their profession, claiming they are traders. French Francophone ones are more open about the sex industry, stating it on their passports. Studies by Konotey Ahulu revealed certain perceptions that people had about PLWA. In Ghana, an ill patient from Abidjan was perceived to be suffering from AIDS until proven otherwise. There were similar suspicions of East African patients from Rakai district in Kampala or Kagera region in Dar es Salaam.



Lawson's A.L (1999) study of 'Women and AIDS in Africa' was aimed at examining social organizational and socio-economic gender inequality issues affecting effective implementation anti HIV/AIDS policies. The corresponding findings are as follows:

1. Since women in Africa tend to bear more children than other regions of the world, the risk of mother to child transmission is higher. Because of their generally subordinate role, they have little say in sexual relationships with their partners, like insisting on male spouses to use a condom. This increases transmission from husbands to wives.
2. Certain cultural practices like circumcision, genital mutilation, ritual sacrifices and various skin perforations spread the transmission of AIDS among women.
3. Divorce in matrilinear societies may expose women to polygamous or multi-partner relationships, increasing their likelihood of catching the disease.
4. In general, societal gender roles permit men to have multiple sexual partners, while women are not allowed to do so. This increases HIV transmission to women.
5. Polygamous marital relationships speed up AIDS transmission because polygamous men are more likely to bring in the disease from the city. Migrants in general also play a role.
6. Men who marry younger women increase transmission since the men may have been contaminated from previous relationships.
7. Premarital sex is becoming more acceptable in most societies, exposing women to HIV transmission.
8. Other factors are sexual mobility of women, poverty which pushes many into prostitution (because of denial of land rights).
9. Education of adolescent girls is crucial because the average age of their first sexual experience in reducing.
10. Increasing awareness about condom use.
11. Provision of services to reduce HIV transmission e.g well screened blood to clinics, improved nutrition for pregnant women, prevention of anaemia, treatment of infections and blood losses due to complications during pregnancy, etc.
12. Female contraception independent of male ones . This tends to make it easier for women to talk about safe sex with their male partners and even countering the latter's objections in this regard.
13. Counselling and HIV screening should be provided to mothers before they become pregnant.

Sikwibele, A, Shonga C, Baylies C (2000) carried out comparative studies in Zambian and Tanzanian communities. Their research was carried out in 2 phases in 6 separate sites, within the two countries. The first phase monitored the spread of the disease at the national level, government's response to it and how it was being managed at each site. The second phase monitored community action around AIDS, with particular reference to its gender dimensions. In each country, a neighbourhood within or adjacent to the capital city was chosen as 1 of the 3 sites for local in -depth research.

The 3 research sites in Zambia were Kanyawa, a suburb of the capital Lusaka; Kapulanga, a squatter area adjacent to Mongu, the capital of Western Province; and the catchment area of a health clinic in Mause, the capital of Luapula Province. In Tanzania, several neighbourhoods in and around Dar es Salaam constituted the first of the sites. The second was a rural area in the mountain above Lushoto in the Tanga region and the third a set of villages near Rungwe.

According to them, AIDS is deeply entrenched and the town is 600km west of Lusaka and relatively isolated by poor roads and flooding from the Zambezi river. A quarter of the town's adults are infected with the disease. Local cultural understandings and historical patterns of integration within a wider political economy have shaped the people's perception of AIDS.

The town has a strong cultural heritage, but high rates of poverty and the belief that sex is crucial to physical and psychological well being of the people promoted polygamy and extra-marital sexual activity, which spreads the disease. Subjugation of women's rights and their legal problems meant they had little control or voice in their sexual relationships which tend to spread the disease. Most sampled respondents identified sexual promiscuity as the prime reason for the spread of AIDS, caused by poverty. Women received a disproportionately large share of the blame for spreading AIDS. Prostitution, unwillingness to control sexual desires, poverty etc, were other causative factors of AIDS.

A study by Najem G.R and Okuzu, E.I compared medical students' perception of HIV and AIDS in two cities with different cultural and educational backgrounds. A total of 292 1<sup>st</sup> and 2<sup>nd</sup> year medical students (45% samples were selected from New Jersey Medical School and Benin Medical School, Nigeria). The former were more knowledgeable and had more positive attitudes and behaviours regarding HIV infection and AIDS. Misconceptions regarding modes of transmission were significantly higher among the Benin Students. The Newark students had more frequent sexual intercourse and used condoms more frequently, but the Benin students had more sex partners. Perception of personal risk and concern of contracting AIDS was significantly higher among the Newark students than the Benin students. These results indicate it is important that medical educators in medical schools convey accurate information to improve medical students' perception about HIV infection and AIDS.

Abiona, B.T.A(2001) carried out a descriptive study examining female adolescents perception of sexual behaviours and the risks involved in two selected secondary schools - Co-educational and Girls Schools in Bayelsa State of Nigeria. A simple random sample of 100 female adolescents was used and data was collected through a 38 item self administered questionnaire. Data was analysed by descriptive and inferential statistics.

The hypothesis revealed an insignificant relationship between peer influence and sexual behaviour of female adolescent. The findings also revealed a statistically significant difference of the awareness level of the risks involved in the sexual behaviour of the 2 schools. Female adolescent sexual behaviour and associated risks can spread Sexually Transmitted Diseases (STDs). Therefore, early sex education for girls was prescribed (including precautionary measures). Replications of the study using a larger population for generalization purposes was recommended.

The Methodology of the study used simple random sampling of Akpalakpa Grammar School with a total population of 146 students in SSI and SSII (two of the senior secondary school classes) and St Judes Girls Grammar School, Amarata-Yenagoa with a total population of 350 students in SSI and SS II. The sample size for the 2 schools was 100 subjects, corresponding to 20% of the target population. Questionnaire instruments captured the data.

Among her findings are as follows:

- 1) Forty seven percent (47%) of respondents had boy friends and 53% did not.

- 2) Sixty-four (64%) of respondents had boyfriends for the sake of it, 1% because their friends had boyfriends, 8% because they were of age, 2% because they needed to prepare for marital life and 19% for other reasons.
- 3) Seven percent (7%) of the respondents were pregnant and 93% had never been pregnant before.

The study made a number of policy recommendations, which are listed as follows:

- 1) Health professionals, should, as much as possible educate the public as well as policy makers to give adequate attention to female adolescents.
- 2) Government and NGO's should periodically organize seminars and workshops for adolescents.

Finally the study suggested areas for future research:

- 1) Further studies on the effect of peer influence, poverty and ignorance on the sexual behaviour of female adolescents
- 2) Comparative studies of male and females' adolescent sexual behaviour.

Ibiobeleari's D.S (2004) study of nursing schools in Ibadan was aimed at determining the knowledge and attitudes of student nurses towards the care of HIV/AIDS clients in 2 schools of nursing in Ibadan – The School of Nursing, UCH and The School of Nursing, Eleyele. The objectives of the study were to assess the level of knowledge student nurses and determine the relationship between their knowledge and attitudes.

The study design was based on a descriptive survey based on the objective. The school of Nursing, Eleyele was established in 1949 at the old prefabricated army barracks in Eleyele. Entry qualifications at that time were government class 4, Junior and Senior Cambridge. The new admission criteria are 5 credits in SSC or GCE/WASC including English, Mathematics, Biology, Chemistry and Physics. The school shared its clinical experience with Adeoyo Hospital in 1972. The school has been running a 3 years basic programme. It is overseen by the Ministry of Health and supervised by the Directorate of Nursing Services.

The School of Nursing, UCH was founded in July, 1952 at a temporary site at Eleyele. It moved to its present location at Oritamefa in 1957. Its aim is to train professional nurses to fulfil the fundamental needs of Nigeria in the nursing field and contribute to the world population of nurses of international standards. Applicants had to be at least 17½ years old, with 5 credits in WASC/SSCE and pass the common entrance test and a personal interview given by the school of Nursing, UCH.

The target population was the student nurses of both schools with a sample size of 30% in the School of Nursing Eleyele and 30% in the School of Nursing UCH. In Eleyele 1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> year Students were sampled with 30, 35, 35 from the respective classes (100 total). In UCH, 60 were sampled out of 180 with 20 selected from 1<sup>st</sup> and 3<sup>rd</sup> year.

Questionnaires were administered to students to capture demographic data and information about their source of knowledge and pathophysiology, knowledge on mode of transmission and universal standards, respondents' attitude. Data Analysis was done through the use of descriptive statistics in the form of graphs, frequencies and percentages, t-test and Pearson's correlation. Hypotheses were tested using Pearson's correlation and t-test on SPSS software.

Among her findings were as follows:

- 1) Eighty percent (80%) of respondents had received their information about AIDS from school, 63.8% from TV Lectures, 37.5% from radio, 10.6% from rallies, 37.5% from seminars/workshops, 22.5% from conferences and 25.6% from friends and relatives.
- 2) Forty three point one percent (43.1%) of respondents had not received a lecture on AIDS, 16.3% received AIDS lectures in their first year, 29.4% in their 2<sup>nd</sup> year and 11.3% in their 3<sup>rd</sup> year and 58.1% had managed HIV positive/ AIDS clients. About one-third of the respondents had not received a formal lecture on HIV/AIDS.
- 3) Most of the respondents did not know the composition of the cell that fights the disease. Most were knowledgeable about the mode of transmission of the disease e.g unprotected heterosexual intercourse, blood transfusion, sharing of sharp instruments.
- 4) Most respondents had little knowledge about universal standards of AIDS prevention among health care workers e.g hand washing use of gloves, masks and gown, using needles place in punctured resistant containers and protection of the eyes.
- 5) Based on hypotheses tests, there is a positive and significant relationship between the attitude and the quality of care given by the respondents in question. There is a low positive correlation between knowledge and sources of information. There is no statistically significant difference between the attitude of the students in both UCH and School of Nursing Eleyele.
- 6) Eighty four point four percent (84.4%) of student nurses agreed that care of HIV/AIDS patients was obligatory, 86.3% agreed that HIV/AIDS patients should be given the same care as any other patient. Thirty percent (30%) agreed that AIDS patients should be isolated, 39.4% agreed that nurses should have the right to choose to work with AIDS patients, 86.3% agreed that all patients should be screened for HIV, 69.4% believed it was unethical for hospitals to refuse admission to AIDS patients or discharge them because of the disease, 51.2% were reluctant to care for AIDS patients and 83.3% agreed not to discriminate against them. Fifteen point seven (15.7%) agreed that HIV/AIDS patients should be nursed by their relatives alone.
- 7) Education programmes involving training sessions on HIV/AIDS should be organized for student nurses at regular intervals from the onset of training to run throughout the programme.
- 8) Nursing education programmes should integrate key issues regarding knowledge about HIV/AIDS and attitudes to improve clinical practices in this regard.
- 9) Clinical instructors should ensure strict compliance among nurses regarding WHO's universal standards to prevent HIV transmission in the clinical setting, in order to ensure safe practices.
- 10) The Nursing and Midwifery council of Nigeria should change the curriculum for training and integrating HIV/AIDS issues as early as the 1<sup>st</sup> year.
- 11) Role models such as staff nurses and nursing officers should be involved in in-service education, seminars/workshops and reading of current relevant journals on HIV/AIDS.
- 12) Nurses should be trained in the counselling of AIDS patients. The more they know about the disease the more they are likely to be involved in its treatment.
- 13) Requirements needed for universal WHO standards should be provided regularly. Government should increase funding of health care facilities and ensure that funds are used appropriately.

Suggestions on Future Studies were as follows:

More studies are needed on the knowledge of student nurses about the pathophysiology of HIV/AIDS and universal standards.

### **C. HIV/AIDS and Governance**

The following findings on governance were made, based on community interventions in Kanyama, an urban neighbourhood in Zambia's capital Lusaka. It is a residential district of greater Lusaka. There are different interventions methods in place in this regard:

**1. The use of Church based Traditional educators.**

These are a group of women in Kanyama who called themselves traditional educators but in fact are drawn from various church denominations. They emerged in the early 1970's. They offered guidance to adolescent girls, prospective brides and married women on sexual matters.

They are being guided by AIDS activists at the National level and NGOs who have directed attention to them, guiding and training them so that they can use their role to impact knowledge on others about HIV. They incorporate customs which are consistent with their religious beliefs in gaining access to talking to women.

**2. Peer education programme supported by UNICEF AND NORAD.**

This project, according to a research survey, was the best known among AIDS activists. The program targeted vulnerable women including sex workers. The educators worked in small groups and moved around the area performing minidramas, facilitating general discussion and distributing condoms.

**3. The Home Based Care Programme.**

This was operated under the auspices of the Catholic Church. This new program is an offshoot of an earlier program started in 1994 around a group of eight women who received training in counselling and care of those with HIV. Members of the group visited homes in Kanyama and provided counselling on care and assistance.

**4. The International NGO CARE**

In the mid 1990s CARE's activities were primarily concerned with poverty alleviation through means intended to build local capacity.

These organizations faced a number of challenges, which are listed as follows:

1. Lack of adequate support
2. Insufficient information about AIDS
3. Lack of Finding
4. Inefficient Networking
5. Administrative Bureaucracy
6. Goal displacement caused by departure from posts via promotion and more prestigious appointments.
7. Lack of trust and mutual mistrust
8. Political Interference
9. Corruption

Intervention work in Tanzania was targeted at diverting young people from sexual activity. It focused on Information, Education and Communication Programme (IEC). This is based on

the assumption that it was ignorance which fuelled risky sexual behaviour and spread of AIDS. Its policy thrusts are as follows:

1. Inclusion of Reproductive Health Issues in the curricula of primary and secondary schools.
2. Organising seminars.

The National Intelligence Council (2002) evaluated the effectiveness of the governance of some nation states regarding the control of the HIV/AIDS epidemic. According to them, the commitment of 'Senior Political Leadership' is a key variable in the few successful AIDS intervention programmes around the world. They concluded that the leaders of Nigeria, Ethiopia, Russia, India and China will be challenged to balance AIDS with other pressing domestic and foreign policy issues. They states that some leaders are paying more to the disease but have not given it the priority attention it deserves.

Active leadership is critical in checking widespread public ignorance of the disease. The challenge is especially great in these countries because of fragile communications links, numerous government jurisdictions and difference ethnic and language groups.

Nigeria's leadership has been the most active of the five countries in trying to raise AIDS awareness e.g by hosting a regional AIDS conference in 2000 and giving public warnings about the risk of extinction on the continent. This was in spite of the fact that Obasanjo's administration had other pressing issues, like upcoming elections and rising ethnic and religious tension. The deterioration of government institutions over the last 10 years undermines these initiatives. According to them, Nigeria has developed domestic monitoring and diagnostic capabilities, especially in Lagos, and a major study on the economic effects of HIV/AIDS in underway. The Nigeria military, concerned about the loss of key personnel from AIDS, now mandates training about the disease for soldiers.

The Ethiopian Government does not appear to be focussed on AIDS, despite occasional statements on the issue. The government has focussed in recent years on the conflict with Eritrea. Healthcare workers privately have criticized efforts in recent years as half hearted, and UN officials have publicly warned Ethiopian leaders to take more measures to stem the epidemic.

The Russian Government has not mounted a sustained effort up to now to publicize the growing threat of HIV/AIDS. Russia faces so many other serious problems that HIV/AIDS is unlikely to receive a high level attention for an extended period until the economic and security costs of neglect became more tangible.

The Indian Government has taken numerous steps to highlight the risk that AIDS poses to the country, but tensions with Pakistan and growing religious strife clearly are considered more pressing issues. Furthermore, India faces competing priorities to address such other health challenges as Tuberculosis (TB). Nonetheless, the Indian Government did react to the emergence of HIV/AIDS in 1986 by creating the National AIDS Control Organization (NACO).

The Chinese Government has become significantly more open over the last year in acknowledging the rising HIV/AIDS problem after ignoring it for years. The central government has organized some public relations events to increase awareness about the

disease and Beijing has sought bilateral assistance from the United States and others to improve its anti-AIDS campaign.

Nonetheless, domestic funding to combat the disease remains low, and Chinese leaders will have difficulty keeping HIV/AIDS high on the agenda as they struggle to deal with such challenges as maintaining economic growth, diffusing rural discontent, managing the communist party leadership transition, opening Chinese markets more widely to trade, and modernizing the military. Moreover, decision making has become so decentralized in China on healthcare and education that senior leaders in Beijing cannot always count on provincial and local leaders to follow through, in this regard.

### **3. PERSPECTIVE OF PEOPLE LIVING WITH HIV/AIDS (PLWHA) IN MAKURDI**

#### **A. Introduction**

In order to formulate policy strategies to benefit PLWHA in Makurdi and localize the UN MDG on HIV/AIDS in the city, the research team carried out a series of focus group discussions among PLWHA in the city of Makurdi. The discussants were AIDS patients at the two distribution outlets for Care and Support Services in the city, namely the Federal Medical Centre and the Bishop Murray Catholic Mission. These discussions were meant to obtain first-hand information from the people affected by the disease and to complement the quantitative analysis of the questionnaires filled by AIDS patients in the city. The focus group discussions were held after a series of mini-consultations of all AIDS stakeholders in the city during the reconnaissance survey and city profile stages of the City Consultation process.

#### **B. Awareness Level Of PLWHA**

In general, the respondents were aware about the disease, but had a few misconceptions about symptoms associated with the disease and modes of transmission. This partially explains why and how they contracted the disease. Most of them mentioned their knowledge of friends, relatives and colleagues who have the disease.

Most respondents relied on information derived from social relations with friends, relatives and colleagues to obtain sketchy information about the disease. Unfortunately, this source of information tends to be inefficient regarding enlightenment of the people about symptoms of AIDS, modes of transmission, availability of care and support services etc. This caused considerable stress and anxiety to some patients during the initial stages of their contracting the disease.

To buttress this point, one of the respondents shared her experience about the disease. According to her, she had heard about HIV but had never seen it with her naked eyes, until she contracted the disease. Then, she knew about the reality of the disease. As she fell sick, she went to the hospital, but the health workers did not tell her that she had contracted the disease. But she began to perceive that she had HIV. Instead, the health workers told her brother and he refused to disclose the information to her. According to her, she can identify people with the disease from their external symptoms.

The respondents had a number of suggestions concerning the control of the spread of the disease. Some believed abstinence from sex was a sure way of controlling the spread and the grace of God. They believed parents should play a more important role regarding the education of their children about the disease.

One of the respondents shared her experience. When she knew she had the disease, she did not hide it from her children. All of her children are aware that she and her husband have HIV. She sits with them to tell them about her health status before and after she contracted the disease and the dangers and risks associated with the disease. She educates them to abstain from sex until they are married. According to her, such initiatives should start from



the home to avoid overdependence on the local government. According to her, God has heard her prayers and her children are doing well.

The respondents believed HIV prevalence is higher among the youths and couples that want to marry should do so, even if one of them has HIV. If the couple is open in communication and takes the requisite precautions during sex, the spread of the disease could be controlled more effectively.

Other respondents believed that most people die from the disease because of ignorance. They believe others with the virus live in denial and most of them die because of poverty linked with the issue of having no relatives to support them. One of the main modes of transmission is through sex.

Furthermore, HIV, according to the respondents, is ravaging women mostly because of are more vulnerable to unsafe sexual practices and poverty drives them into prostitution. One of the respondents, an activist with the Benue Network of People Living with AIDS, shed more light about the prevalence and spread of the disease. According to him, his association is aware about the problem in Makurdi, especially the way the infection rate has been hitting young people in Benue State. Statistics have shown that the problem has severely affected many young people in this state and this has caused a lot of concern to the activists in his association. In this regard, his association is working on this particular issue and involving the youth to change behaviour that tends to spread the disease, such as casual sex.

### **C. Impact of HIV/AIDS On Poverty**

According to the respondents, HIV/AIDS has worsened their level of poverty. The patients purchase drugs at very high rates and drugs are often unavailable. Some of the patients buy the drugs at N7,000.00. The Civil Servants among the respondents stated that the cost of the drug takes more than half of their annual salary. According to the farmers, HIV/AIDS prevents them from farming effectively, as some of their children drop out of school because of their inability to generate enough revenue to pay their school fees. To make matters worse, the patients lack the money to provide other domestic needs like the healthcare of their children. Often they are compelled to sacrifice meals to conserve the few funds they have to purchase antiretroviral drugs.

One of the patients explained further about the financial problems of PLWHA. According to him, the government which should be subsidizing the cost of their drugs is not forthcoming in this regard. Most of the drugs, according to him, are very expensive. In his case, he has 6 children and the cost of purchasing the drugs for himself and his wife is N14,000.00 a month. With a monthly salary is N17,000.00 this leaves very little for other pressing needs, like his daughter's balance of N3,000 to gain admission into the university. Consequently, her admission is on hold because of his inability to pay this money. Most of his January salary paid this balance, leaving him with N1,000. That makes it impossible to continue the use of the drugs. In conclusion, he appealed to the government to alleviate their suffering in this regard.

In addition, the cost of foodstuffs and essential domestic needs in the market is very high now, so most of them lack the funds to buy food and things for their children, as well as the drugs, that are very costly and the PLWHA lack the money to buy them.

One respondent analysed the vicious cycle of the disease, poverty and social stigmatization. According to him, many HIV/AIDS infected people sell all their belongings to purchase drugs and end up with virtually no material possessions. With time, their bank accounts become empty, causing them to run to their families for financial assistance. Unfortunately not all families are caring enough to assist them. To make matters worse families even increase their stigmatization of their relatives living with the disease. Consequently, the affected patients begin to feel lonely, leading to depression, causing them to detach themselves from the world. Because of their lack of access to drugs, they begin to think that all hope of survival is lost and harbour thoughts of death, which is often the case with such people.

Some PLWHA lose their jobs because they are no longer strong enough to continue working so they are chased out of their jobs by their employers. Some of them who wish to be employed especially in the police force in the army are refused appointments because of their status, worsening their economic situation. Other employers require PLWHA to go for a test. Oftentimes the employers reject the applicant if found to be HIV positive.

#### **D. Social Problems Facing PLWHA**

The social problems facing PLWHA are indeed numerous and could be described in some cases as tragic. They range from personal depression, isolation, low self-esteem, stigmatization from friends, colleagues and relatives, discrimination at the workplace etc.

According to one of the respondents, he fell sick when he was told he was HIV positive. He became worried because he thought death followed anyone who contracts the disease. He became very worried over this and turned several times to God in prayer. He was admitted to the hospital and did not eat for a long period of time, neither did he drink water. His mouth dried up and became depressed, although the doctors at the hospital visited him. In addition he felt isolated as a result of contracting the disease. According to him, he was happy to be at the focus group discussion because it gave him an opportunity to socialize with his friends. Social gatherings like these were rare for him because people in the community keep away from people like him, once they know he is HIV positive.

Another respondent said HIV/AIDS is now becoming one of the leading cause of death in their society now, as most of their relatives are dying. It is affecting their brothers, sisters and friends so it is affecting family cohesion and social stability in general. He supported the fact that the disease is worsening their poverty. He wanted the government to come their aid. Although they are making some effort in this regard, they should do more. Their salaries are not paid as and when due, and some haven't even paid salaries for December, 2004 and January 2005. Their children have dropped out of school. In his case, he has 8 children and takes care of all of them, all in secondary school. They were all at home at that point in time. As a farmer, he supported the point that with HIV, farmers lack the physical energy to farm and no money to hire hands to assist in this regard. According to him, worrying about the disease causes early death because of associated complications of blood pressure and that contributes more to their problem. He repeated the suffering of their children, so he appealed to the government should come to their aid. Another respondent narrated the experience of workers and farmers they know are positive. Such people tend to hide, and feel ashamed to go to the hospital or find other forms of assistance. So they die, one after the other because they are ashamed of their status vis-à-vis their relationships with their parents, friends and relations.

To further buttress the fact that HIV/AIDS is causing severe strain on some families, a respondent pointed the prevalence of severe family conflicts, suspicion etc. For example, cases of a woman being HIV positive and the husband negative. Some of the husbands, in this regard, find it difficult to accept this fact, leading to the breaking of the home. Also, if the woman is negative and the husband is positive, the wife often becomes hostile to her husband, causing the breakdown of the affected home. In addition, the disease is known to divide many families, as family members who do not have the disease ostracize, neglect and even discriminate against those who do.

Another female respondent, a farmer, reiterated the previous points. The disease is affecting them in so many ways. They lack the money to take care of themselves and the badly needed drugs are very expensive. They lack the strength to work even in their farms. Their children are sent home from school because of their inability to pay their school fees.

Other respondents shared their social problems. Going to public places like church or the office causes people to avoid them and abstain from sitting next to them, upon knowing they have the disease. Several others infected by the disease are hiding and it is contributing to their slow death.

This is particularly painful for the AIDS patients because most of them had a social life, like going to the bank to withdraw money or going to the clubs for beer, church meetings etc. Others narrated their experience at commercial centres where their friends used to sit next to them, chat to them and pour out their love to them, but it is not longer so.

According to them most of the people who are HIV positive feel like failures so they abstain from most forms of social life. Friends who used to visit them no longer do so, upon knowing they have the disease. If they visit the respondents at all, they stay outside and talk to them because of fear of contracting the disease. To make matters worse, friends of PLWHA tend to be suspicious of them of being sexually immoral, knowing this is a leading mode of transmission of the disease, adding to their stigmatization.

According to the respondents, discrimination against them by their relatives and friends is quite common. For example, a widow among the respondents narrated her ordeal with her relatives. When her husband died and her relatives discovered he died of HIV they suspected that she had the disease. Consequently, they attempted to take her children away from her and leave her alone, because of their fears of being infected. She resisted this attempt, together with her father. As a result, none of her in-laws visit her. She reiterated the views of the previous respondent who mentioned how the disease has affected their social life. When the relatives visit her, they refuse to enter her house, again because of their fears of being infected. In fact neighbours, colleagues and friends tend to stay away from people like her, knowing they are HIV positive.

Consequently AIDS patients begin to develop low self-esteem and worry about why people tend to avoid them, among other negative thoughts. In addition, such people tend to think about death more often. Such people also worry about meeting domestic needs like children's education. The children too tend to suffer embarrassment and harassment at school because of the HIV status of their parents.

This respondent was lucky because her children are alive to take care of her. But she feels the tremendous isolation caused by friends who no longer visit her. With her meagre resources she tries to get by and make ends meet with her children.

Another respondent expressed surprise that people who are elites in the society and are learned and educated and health workers like nurses stigmatise and discriminate against PLWHA. According to her, the stigma is killing more people than the virus.

Psychologically, most HIV positive patients tend to think they have sinned and think they are no longer going to stay in this world for too long. This contributes further to their state of depression. To expound on this, other respondents believed that many PLWHA break down mentally, believing they no longer have hope in life. Some do not regard themselves as human beings any more, developing an inferiority complex around other people who do not have the disease.

Furthermore, the stigma causes PLWHA to live in fear, believing they can no longer exist and that they are nothing in the society. Thinking about their predicament adds to their stress and they wear out physically and mentally with time. Examples of thoughts of inadequacy and low self-esteem include inability to care for their children's education, inability to engage in gainful employment etc. These psychological problems hasten their death rate as they believe they cannot function effectively in society like other people.

## **E. Socio-Cultural Practices and HIV/AIDS**

The respondents believed that there were certain socio-cultural practices that tend to spread the disease and there are a number of such practices among the Tiv ethnic group in Benue State. The practice of polygamy, marrying several wives and indiscriminate sex tends to spread the disease. Because Tiv men believe that marrying several wives makes them rich, it is common for them to marry up to 10 wives and if this man is infected, that means all the wives are likely to be infected as well.

The respondents mentioned a 'Quayee Festival' where both boys and girls sleep in the same place for 2 or 3 days, causing them to engage in casual sex. The Quayee festival is a puppet theatre show, where a puppet made out of wood raffia and straw entertains an audience.

The respondents believed circumcision is another common mode of transmission of the disease. Although they are being educated that circumcision should be practiced only on the males, females practice it as well. Oftentimes, the instruments used are not sterilized before using it for another person and this spreads the virus. Also the use of unsterilized sharp object spreads the disease.

To explain this point further, the respondent shared their varied experiences, regarding these cultural practices. An example is the patronage of quack doctors in the surrounding rural areas of cities like Makurdi. Oftentimes, these doctors do not treat their needles, nor do they boil their syringes. Native doctors are in the habit of using one old roasted razor to cut several people for circumcision causing the disease to spread rapidly in the village environment.

Respondents recounted the case of one native doctor in their area who uses the same dish in treating thousands of people who patronize his services. In addition, he uses the same feather

to treat several people. As these objects make contact with open wounds, rashes etc, the HIV virus spreads quickly.

The respondents made further clarifications about circumcision because it applies more to males than females. In this regard, doctors use a knife called 'Antein' in Tiv. Oftentimes, they do not boil it anytime a male child is given birth. They use the knives to circumcise several babies, contributing further to the spread of HIV/AIDS. Furthermore, the razors used for tribal marks are oftentimes not sterilized and this also contributes to the spread of the disease.

The respondents were unanimous concerning the perceived practice of 'Wife Hospitality' among the Tiv. That is to say the practice among Tivmen of allowing visitors to sleep with their wives as part of their way of entertaining such guests. The respondents stated that Tivmen tend to be very jealous over their wives. They were known to inflict serious bodily harm or even kill people who attempted to befriend their wives. However, the respondents pointed out that wife hospitality occurs to some degree in the rural areas of the state and was more common there in the past. Interactions between male visitors and females regarding the sharing of food tended to encourage the practice then. They stated that, the practice will be more difficult today because women are more learned and know that they cannot be pushed around.

However, some of the respondents mentioned 'Wife inheritance'. In other words, when the husband dies and leaves the wife, the relatives will take over the wife, not knowing the cause of the death of that person. The relatives who inherit the wife end up being infected. Another one is superstition people believe that you can get HIV through superstition. That is to say, this is helping the spread of the virus. Instead of knowing the basic fact of HIV/AIDS they believe their strength shields them from the disease. Others believe people can be bewitched by HIV/AIDS. They believe that HIV/AIDS comes in various forms and is a fast killer. Therefore it can kill anyone at any point in time. Another issue in this regard is that some people believe that other people attempt to poison them and such people continue their attempts to manage the disease the traditional way, and by so doing they spread it more.

Another point mentioned by the respondents is the use of sharp objects by youths who want to acquire supernatural powers. Consequently, they cut their bodies, believing the powers they receive by doing this will protect them from attacks from cutlasses and bullets. Such youths believe a man should be prepared for such attacks at all times. This practice transmits the disease as well.

Another respondent mentioned the subordinate role of women in their culture that is indirectly contributing to the spread of the disease. According to her, when a woman does not have a say in the house she cannot negotiate safe sex with her partner and economically women are the most affected. Most women don't go to school and they are submitted to their husbands. Even though their husbands are infected, they are compelled to stay with them. Consequently if the infected husband wants his wife on his bed, she must submit to his demands. She believed that women should be empowered economically so that they can have a say in issues like safe sex in their homes. In addition, economic empowerment of women is likely to reduce the rate of prostitution among them, which is an important factor spreading the disease.

## **F. Local Governance and HIV/AIDS**

The respondents mentioned the efforts of government to create community awareness about the disease and provide care and support services for PLWHA. According to them, the Government has been making announcements on the radio and placing posters in the city, creating awareness. AIDS is sometimes discussed in churches and local television and radio programmes have awareness campaigns about the disease. This has increased the awareness level about the disease in the community and its realities among the people. One of the respondents supported abstinence from sex as a sure to avoid contracting the disease.

The respondents believed gatherings like the focus group discussions and other opportunities through churches, school, video clips and television will increase their awareness level about the disease. According to them, the Federal government is making some effort to manage the disease, as well as the Benue State government. They were unsure about the effectiveness of the local government in this regard. In fact, they believed the local government is somewhat quiet about the issue. In addition, they were not giving PLWHA tangible assistance and recognized the effort of the Federal and State government to cushion the hardships caused by the disease.

The respondents believed the HIV/AIDS epidemic poses a serious challenge to the government, although they were making some tangible efforts in trying to control the spread of the disease. For example, they spent money in buying drugs but the drugs cannot go round to benefit all the infected people.

They believed the local government should come out with a much stronger effort, because they are closer to the grassroots. They wanted the local government to extend their assistance to people in the surrounding rural areas to increase the overall benefits to PLWHA. The respondent suggested financial assistance first and then availability of drugs as priority issues for the government.

One of the activists on AIDS shed more light about government's effort to check the spread of the disease. At the Federal level, the National Action Committee on AIDS (NACA) is doing its best to coordinate the activities of the State Action Committees on AIDS (SACA). The State level is putting in place SACA and they getting through SPT in the coordination of SACA. SPT is getting money and this money is brought to the state from the few NGO's that are accessing this money to go out there and have HIV/AIDS activities done.

At the Federal Level the president have made available to the Ministry of Health few drugs but they are so few that they can not go round because of the high rate of infection. The drugs are so few in Benue State, 800 people are currently accessing the drugs and so many other people are infected in Benue State - almost half of the population and we are about 5 million. At the Federal Level, they are trying to bring in drugs but at the State level, the activists do not see anything tangible regarding the importation of drugs. The situation is even worse in the local government. They tend to have an adamant attitude in this regard.

This, according to the activist is unfortunate because the local government is nearer to the people. This makes it critical for them to be involved in importing drugs so that people who are infected can access these drugs. He confirmed the fact that access to drugs for most PLWHA is difficult and the few drugs available cost a lot. This contributes to the poor health status of the PLWHA because they have spent their money on other needs. Consequently,

they cannot access this money because they are poor, they cannot get the drugs, the drugs are scarce, money is scarce, everything is scarce so people are just dying like chicken everyday.

The activists appreciated the effort of federal government through NACA. Recently, they have put in place a structure to actually curtail the spread of HIV among the youth, so a body has been established at the national and all the state and all state coordinating agencies in this regard are charged with the responsibility of having a functional body at the local government level. The local government is also expected to go back to the community then down to the family health and children, and so by doing benefit people at the grassroots.

In addition to the federal level, NACA is also sponsoring some NGOs that are fighting against the spread of this virus. They are not only sponsoring state SACA, they are also sponsoring NGO's in Benue State. At the national level, there is a network of people living with HIV/AIDS that have come together and help to fight in the spread of HIV/AIDS. Even at the state level there are local networks operating.

For example, in Benue State there is a 'Benue Network for People Living with HIV/AIDS' (BENPLUS). Their mission is to educate people in Benue free of charge, concerning HIV/AIDS issues, so the strategies to check the spread of the virus are in place. There are other support groups that are part of the Benue network and their aim is to create awareness. The activists added that the money the federal government and the state is pumping here for the awareness and training people to create this awareness is much more than the impact it is having on the community. This money, according to him, should be used directly for care and support programmes. If this is done, the fight will be successful. He believed strongly that the only way one can succeed is by involving people with HIV/AIDS and by so doing, the spread of the disease will reduce. If there is no strong support most of the PLWHA will hide and this will increase the spread. This money should be used to train people living with HIV/AIDS and create awareness you will see that more people will come out.

Another effort to stop the spread of HIV/AIDS, according to the activists, is through the NGOs. He referred to and thanked the coordinator of a health care initiative (also present at the discussion), because she sometimes used her money in rural areas to create awareness, particularly on the use of condoms for sex. This view was hitherto opposed by most Christians, but most of them advise their children to use condoms because it helps a lot in stopping the spread of HIV/AIDS.

Other support group members added the fact that more support groups manned by people living with HIV/AIDS should be founded and if properly funded will achieve a lot regarding disease control. According to her, her group has not been funded by the State but the World Bank gave her a small grant last year and from that grant, she empowered her PMS, giving them food that they can live and treat the opportunistic infection. If given money, she believes she can consolidate her efforts with awareness programmes on T.V and radio. According to international agencies, NGOs, etc should support such initiatives with assistance and money that one can work with. This is important because being a PLM, she needs money to look after myself and her family. If real statistics are taken in Benue State one will find out that more than 2 people are infected per family. In her family, for example there are 3 people infected. These include her mother, herself and the last born in the family. She finds it difficult to help other people because of limited funds. She passes through a lot of stress, as some friends refuse to help her. Fortunately her family members were good to her because she was good to them too. In other words, such love and care should be

incorporated into these support groups. The strategy to do the work is in place but funds are lacking. Such initiatives will encourage PLWHA who are hiding to come out and support the cause to halt and reverse the spread of the disease.

Another respondent from a 'Peace Healthcare Organisation Makurdi Benue' State has a support group of people leaving with HIV/AIDS. Under this venture and they are ready to work so need support. As President of Network of people living with HIV/AIDS in Benue State the network has up to 30 branches across the state with some of the local governments in the state having more than 1 branch. Although the total number of branches is high, some local governments in the state do not have these offices, so he appealed to philanthropists, donors, and the government to give their network money to create this awareness ourselves.

The era that people living with HIV/AIDS cannot do anything has passed. He believed his network can go to the grassroots and create awareness and is in the process of doing just that. This explains why a lot of PLWHA are coming out. When they started the network it was only a small office on the ground. He also appealed for financial assistance to start a practical centre in Benue State. His personal 6 months training in this regard is not being utilized because of lack of funds. He desired a resort centre that can give information, a friendly centre to encourage more PLWHA to come out. According to him, care and support is the desire of these people, if these people come out and they are tested HIV positive and they lack the requisite care, they will hide themselves and spread the disease. Such care and support should include reading books, radio and television programmes to benefit surrounding rural areas that lack such services. This will also reduce the prevalence of AIDS orphans and the level of dependence of the people on government in this regard.

## **G. Care and Support Services For PLWHA**

The respondents believed that the availability of antiretroviral drugs is the most important support mechanism for PLWHA. They wanted the price of drugs reduced further to ensure affordability for anyone who needs it.

At this point in time, drugs are available but are very expensive. Availability of the drugs and regular use by PLWHA would greatly reduce the effects of the symptoms of the disease. I will like to ask everybody present what do you think can specifically be done to help prevent the spread of HIV/AIDS what specific effort can be done to help stop the spread.

The respondents appreciated the efforts of the local support groups because of their love, care and resources they could obtain from them to improve their quality of life. This includes awareness and education programmes about the disease, resources to have a balanced diet and an improvement in their self-esteem and sense of self worth. These support groups, if encouraged will greatly reduce the spread of the disease. In addition, they wanted family members and friends to encourage PLWHA.

Regarding the government, they wanted them to assist the associations of PLWHA manufacture the drugs locally and not buying them at exorbitant rates. Parents could encourage the training of their children in manufacturing drugs. They also wanted Voluntary Counselling and Testing to be cheaper to encourage people to test for the disease.



## 4. CARE AND SUPPORT SERVICES FOR PEOPLE LIVING WITH HIV/AIDS

### A. Availability Of Drugs

HIV/AIDS drugs appear to be generally available to people living with AIDS (PLWHA), as all the respondents were able to obtain their drugs. However, the majority of stakeholders are of the opinion that HIV/AIDS drugs are not widely available. This is perhaps the case as HIV/AIDS drugs at subsidized costs are accessible at only two locations, namely, the Federal Medical Centre Makurdi (FMC) and the Catholic Mission Hospital Makurdi.

According to stakeholders on whether distribution of HIV/aids drugs is effective, a good number of the respondents were uncomfortable with the distribution of drugs. As shown on table 4.10, 85% of them expressed ineffective distribution, with just 10% assessing the distribution as being effective. The remaining respondents did not know. Similar trends were experienced as regards the adequacy and equity of drugs distribution. Virtually all the respondents (9%) said the drugs are not adequate and not equitably distributed.

### B. Affordability of HIV/AIDS Drugs

HIV/AIDS drugs do not appear to be generally affordable, although the cost of drugs is being subsidized by the State Government. According to PLWHA on the type of support needed, a significant number of both unemployed and employed PLWHA are in need of cheaper drugs. As shown on table 4.20, 80.3% of unemployed PLWHA are in need of cheaper drugs, while 90.8% of employed PLWHA are also in need of cheaper drugs. This suggests that although the cost of HIV/AIDS drugs is being subsidized by the State Government, PLWHA regard the drugs as being unaffordable.

### C. Level of Dependence of PLWHA on Relatives

In assessing the PLWHA' level of dependence on their relatives etc, PLWHA have been categorized as unemployed and employed in order to identify some patterns. We begin with the employed PLWHA and their sources of help. The number of employed PLWHA is 98.

**Table a: Employed PLWHA and Sources of Help**

Sources of Help	Frequency	Percent
Financial Donations	31	31.6
Credits	7	7.1
Others	9	9.1

Source: Field survey(2005)

Table 4.30 shows that among sources of help, Financial Donations is highest (31.6%) followed by others (9.1%) and credits (7.1%).

**Table b: Unemployed PLWHA and Sources of Help**

Sources of Help	Frequency	Percent
Financial Donations	30	53.5
Credits	5	8.9

Others	4	7.1
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Source: Field survey (2005)

Table b shows that among Sources of Help, Financial Donations is highest (53.5%) followed by credits (8.9%) and others (7.1%).

Tables a and b show that the number of unemployed PLWHA receiving financial donation is more than that of employed PLWHA, 53% against 31.6%. This result is normal, as one would expect unemployed people to receive more financial donations than employed ones. We also see that the number of unemployed who obtain credits is slightly more than that of employed PLWHA - 8.9% against 7.1%.

A different trend was observed with regards to others sources of help, as employed PLWHA receive more help than unemployed PLWHA, which naturally ought to be the other way round, except in extraordinary circumstances.

We now consider specific sources of help for the PLWHA

#### **D. Helpers of Respondents**

**Table c Employed PLWHA and Helpers of Respondents**

<b>Helper of Respondent</b>	<b>Frequency</b>	<b>Percent</b>
Friends	16	16.3
Relatives	45	45.9
CBOs and Missions	9	9.1
Clubs and Society	4	4.0
Others	1	1.0

Source: Field survey (2005)

Table c shows that 45.9% among the help of respondents comes from Relatives, the highest, followed by Friends (16.3%), CBOs and Missions (9.1%), clubs and society (4%) and others (1%). These figures are fairly normal (expected) as one's relatives are particularly disposed to offering help than friends. Also, CBOs and Missions ranked higher than Club and Societies, especially as CBOs and Mission are devoted to assisting PLWHA more than clubs and societies.

**Table d Relatives who Consider the Unemployed PLWHA and their Helpers**

#### **Unemployed PLWHA and their Helpers**

<b>Helper of Respondent</b>	<b>Frequency</b>	<b>Percent</b>
Friends	10	17.8
Relatives	39	69.6
CBOs and Missions	9	16
Clubs and Society	-	-
Others	2	3.5

Source: Fieldsurvey(2005)

Table d shows that among the helpers of respondents, relatives rank highest (69.6%), followed by friends (17.8%), CBOs and Missions (16%) and others (3.5%). PLWHA receive

no help from clubs and society. This perhaps may be due to the financial implications of joining such clubs and society or discrimination against PLWHA.

In comparing both categories of PLWHA, it is clear that 69.6% of unemployed PLWHA receive help from relatives as against 45.9% of employed PLWHA. This is quite normal, as unemployed people tend to receive more sympathy from well meaning people. On the other hand, unemployed people tend to seek for help more than employed people. Again, 12.8% of employed PLWHA receive help from their friends as against 16.3% of unemployed PLWHA. This implies that unemployed people tend to receive help from their friends more than employed people.

Sixteen percent (16%) of unemployed PLWHA receive help from CBOs and Mission as against 9.1% of employed PLWHA. This is normal as institutions particularly disposed to helping PLWHA would give more consideration to the unemployed than the employed. On the other hand, unemployed people tend to seek for help from institutions particularly disposed to helping the less privileged. Again, more unemployed PLWHA receive help from others more than employed people.

### **E. PLWHA and Support Groups**

Again, we determine below how dependent PLWHA are on support groups.

**Table e Employed PLWHA Support Groups**

	<b>Frequency</b>	<b>Percent</b>
Share experiences with other PLWHA	24	24.4
Moral Support/Counselling	27	27.5
Receive basic needs e.g food	4	4
Govt Aid, Get drugs	4	4

Source: Field survey (2005)

From the above table, 4% of employed PLWHA receive basic needs, e.g food from PLWHA support groups. Again, 4% belong to PLWHA support groups to receive Government Aid and Medicines. This result corresponds with the number of PLWHA receiving help from relatives; in that, most of the PLWHA would have received their basic needs, such as food, and clothing from their relatives and friends. Again, the number of employed PLWHA receiving Government Aid and Medicines from support group exceeds the unemployed PLWHA.

**Table f Unemployed PLWHA Support Groups**

	<b>Frequency</b>	<b>Percent</b>
Share experiences with other PLWHA	13	23.2
Moral Support/Counselling	16	28.5
Receive basic needs e.g food	2	3.5
Govt Aid, Get drugs	2	3.5

Source: Field survey(2005)

From the above table, 3.5% of unemployed PLWHA receive basic needs such as food from PLWHA support groups. This is to be expected, given than most of PLWHA would have received their basic needs such as food from relatives and friends. Again, 35% of unemployed PLWHA receive government Aid and get drugs from PLWHA support groups.

This too is expected, as most of the Government Aid and drugs would have been allocated to the hospitals and medical centres.

In comparison, there is only a slight difference of 0.5% between unemployed PLWHA and employed PLWHA in the level of basic needs and Government Aid/drugs they receive at the PLWHA Support groups.

The low number of PLWHA attending supports groups may largely be due to ignorance, as overall, the level of dependency on PLWHA support group of both unemployed PLWHA and employed PLWHA is low. Thirty nine point eight (39.8%) of respondents are either ignorant or unaware of PLWHA support groups and 3% of respondents say their homes are too distant, while 1% give other reasons.

## 5. SOCIAL PROBLEMS FACING PLWHA

### A. Stigmatization

Stigmatization is quite a problem for PLWHA as 42.4% say that they have experienced stigmatization at one time or the other on account of their HIV/AIDS status. PLWHA experience stigmatization from members of society who feel that their life or interests may be threatened by the disease, such as employers of labour, friends, colleagues and even family members. This implies that PLWHA are denied access to people they are ordinarily entitled to and are essential for their existence. Thus, stigmatization is a significant problem for PLWHA.

Stigmatization among PLWHA appears to be evenly spread. According to the PLWHA, 42.4% say that they have experienced stigmatization, while 46.1% of respondents say that they have not experienced stigmatization. It is encouraging to note that the PLWHA who have not experienced stigmatization is the highest among the categories.

In what follows, we examine the types of stigmatization experienced by PLWHA in order of illiteracy.

### B. Types of Stigmatization Respondents Experience

Discrimination at place of work comes next, as 26% of PLWHA say that they have experienced discrimination at their place of work. According to PLWHA 14.5% say that they have experienced stigmatization from colleagues, while 9.5% say that they have experienced stigmatization from their employers. This figure suggests that it might have been the fear of contracting the disease on the part of colleagues and employers. Also, it might have been an attempt by employers to use discrimination to frustrate them out of their jobs, because of concern that their productivity may decline and that they may eventually lose them to death. Denial of social support is highest with 30% of respondents who said they have experienced this form of stigmatization. For unemployed PLWHA, this denial of social support such as loans, credit etc may have occurred at their clubs and societies to which they belong. Table 5.11 below shows this information.

**Table g Sources of Help for Unemployed**

	<b>Frequency</b>	<b>Percent</b>
Financial donations	30	53.5
Credit	5	8.9
Others	4	7.1

**Unemployed and Helper of Respondents**

	<b>Frequency</b>	<b>Percent</b>
Friends	10	17.8
Relatives	39	69.6
CBOs and Missions	9	16
Clubs and Society	-	-
Others	2	3.5

Source: Field survey (2005)

From table above, (sources of help); financial donations is the largest source of help for PLWHA. Credits and other sources of help are insignificant. Furthermore, according to the table, unemployed PLWHA do not receive any help from clubs and society. This is perhaps the denial of social support in the form loans and credit, which they ordinarily ought to be entitled to, but given their uncertain health status are being denied.

**Table h Source of Stigmatization of PLWHA**

	<b>Frequency</b>	<b>Percent</b>
Family members	19	18.4
Friends	25	24.2
Neighbours	34	33
Employers	10	9.7
Colleagues	15	14.5

Source: Field survey (2005)

From table h, the highest number of stigmatization cases is from neighbours. This is quite understandable, as people who live close to PLWHA tend to fear contracting the disease more than others.

The second largest number of cases of stigmatization is from friends. This is quite odd, as friends ordinarily ought to be sympathetic. However, the tendency for friends tend to hitherto come in close contact with their PLWHA friends in way that makes them vulnerable to contracting the disease, may explain the relatively large figure.

The third largest of number is from families. This is rather unfortunate that stigmatization would come from members of their families. However, close family members are quite vulnerable to contracting the disease given the fact that they tend to interact with PLWHA in particularly closer ways than others.

The stigmatization from colleagues comes next, with 14% of PLWHA stating that they have experienced stigmatization from colleagues. This also is quite natural as those who are often close to PLWHA, in this case colleagues tend to stigmatize PLWHA as to keep them away.

Stigmatization from employers is lowest (9.7%). This number suggests that employers are indifferent as to whether employees are PLWHA. This is likely to be the case with employment in which employers are not responsible for the health of their employees or in a situation where the supply of labour is relatively available.

### **C. Social / Psychological Discrimination**

#### **Discrimination from Health Workers and Hospitals**

HIV/AIDS patients experience discrimination from health workers and hospitals. According to stakeholders on whether health workers and hospitals discriminate against HIV/AIDS patients, a fair number of respondents are uncomfortable with the manner in which HIV/AIDS patients are being treated. As shown on table h, 40% of respondents express displeasure with discrimination against HIV/AIDS patients. An almost similar number (42.5%) however, are of the opinion that HIV/AIDS patients experience no discrimination. The balance (10%) says that they don't know.

### **Discrimination at the Workplace**

On whether PLWHA experience discrimination at their place of work, an insignificant 26% of them responded 'Yes'.

### **Discrimination against unemployed PLWHA**

On whether PLWHA experience discrimination in their search for employment an insignificant 3.6% of them claim they are unemployed on account of their HIV/AIDS status.

### **Discrimination by Clubs and Societies**

From tables above, unemployed PLWHA do not receive any financial support such as loans, credits etc from clubs and societies. This is perhaps due to their unemployment status.

## **D. Social Life of PLWHA**

PLWHA appear to be quite social based on the information from the table below.

**Table i Social Life of PLWHA**

	<b>Frequency</b>	<b>Percent</b>
Club	35	21.2
Parties	16	8.5
Village Meetings	61	37.0
Other Activities	3	1.8

Source: Field survey (2005)

According to PLWHA on the social outings they attend, a village meeting is highest with 37% of respondents who say they still attend village meetings. This is followed by 21.2% of respondents who belong to clubs, and then by 8.5% of respondents who attend parties and lastly by 1.8% of them who engage in other such activities. The results suggest that respondents are still social, but this might be as far as seeking support is concerned, considering that very few of them attend parties. It further suggests that social associations such as clubs and villages meetings do not discriminate against PLWHA. The PLWHA do not experience discrimination from clubs and village meetings. However, the PLWHA, particularly the unemployed seem to experience discrimination with regards to the credit and loan facilities of their clubs and societies.

## **E. Care and Support Programmes For PLWHA**

Care and Support Programmes for PLWHA are undertaken by the Government, through its agencies such as private institutions such as missions and non-governmental organization (NGOs). The outlets for these care and support programmes include hospitals, medical centres, support groups and etc.

### **Assessment of the State of Care and Support Programmes for PLWHA**

In this section, we assess the care and support programmes in the PLWA support groups. We also assess the PLWHA needs and the opinion of stakeholders on care and support programmes so as to enable us have a broad picture of the care and support programmes for PLWHA.

## **Assessment of the state of care and support programmes for PLWHA by Stakeholders**

According to stakeholders on whether HIV/AIDS prevention programme for women and children and students have been quite encouraging at all levels of governance, respondents are almost evenly split. In this regard, 42.5% express satisfaction with the programmes, while 45% express dissatisfaction with the programme. The balance (12.5%) do not know.

However as regards the adequacy of care and support programmes in Government hospitals, a good member of respondents are uncomfortable with the provision of care and support programmes. In this regard, 72.5% of stakeholders express dissatisfaction with the provision of care and support programmes have been adequate. The remaining 10% did not know.

## **Care and Support Programmes in PLWHA Group**

PLWHA receive moral support and counselling as well as setting an opportunity to share their experiences with other PLWHA and receive basic needs such as food, clothing and Government Aid, as well as medicines.

Among both unemployed and employed PLWHA they received more moral support and counselling as well as the opportunity to share their experiences with other PLWHA than receiving basic needs such as food, clothing and Government Aid. As shown in tables below, 23% of unemployed PLWHA set the opportunity to share their experience with other PLWHA. Also, 28.5% of unemployed PLWHA receive moral support and counselling. For basic needs, 3.5% of unemployed PLWHA receive basic needs, e.g. food, government aid and drugs.

For the unemployed PLWHA, the tables below show that a fair number of PLWHA (24%) get the opportunity to share their experiences with one another and also receive moral support and counselling (27.5%), while an insignificant number receive basic needs, e.g. (4%) and government aid and medicines (4%). Moreover the number of PLWHA receiving help from support groups is low, because 39.8% of respondents are either ignorant or unaware of PLWHA support groups.

## **PLWHA Needs**

In this section, the needs of respondents are assessed in order to have an idea of how well the care and support programmes are performing and perhaps how much they need to improve. In what follows, the needs of both unemployed and employed PLWHA are discussed in order of hierarchy.

**Table j Employed PLWHA and Needs**

	<b>Frequency</b>	<b>Percent</b>
Cheaper Drugs	89	90.8
Better Clinical Services	14	14.2
Basic needs	28	28.5
Employment	13	13.2
Available Drugs	13	13.2
Financial Assistance	22	22.4
Awareness/education to reduce	1	1



stigmatization of PLWHA		
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Source: Field survey (2005)

According to PLWHA on the type of support needed, a good number of respondents are in need of cheaper drugs (90.8%). This figure is high and suggests that existing care and support programmes have made little impact regarding drug availability for PLWHA. However, with regards to clinical services, 14.2% of PLWHA are in need of better clinical services. This figure is quite low and suggests that clinical services are quite adequate.

A similar trend is observed with regards to available drugs with 13.2% of PLWHA in need of available drugs. This figure suggests that HIV/AIDS drugs might be available.

In terms of 'Basic needs', a fair number of PLWHA (25.5%) are in need basic needs such as food and clothing. This is an insignificant number. An almost similar trend is observed with regard to financial assistance, as 22.4% of unemployed PLWHA are in need of financial assistance.

Awareness education to reduce stigmatisation of PLWHA – an insignificant number of PLWHA (1%) are in need of awareness/education to reduce stigmatization of PLWHA. This figure is insignificant and suggests that existing programmes on awareness/education of HIV/AIDS to reduce stigmatisation are adequate.

**Table k Unemployed PLWHA and Needs**

	<b>Frequency</b>	<b>Percent</b>
Cheaper Drugs	45	80.3
Better Clinical Services	4	7.1
Basic needs	17	30.3
Employment	18	32.1
Available Drugs	13	23.2
Financial Assistance	19	33.9
Awareness/education to reduce stigmatization of PLWHA	2	3.5

Source: Field survey (2005)

Table k shows that 80.3% of PLWHA are in need of cheaper drugs. This figure is significant. It suggests that care and support programmes have made little impact regarding the availability of drugs for PLWHA.

An insignificant number of respondents are in need of better clinical services (7.1%). This figure is insignificant. It suggests that care and support programmes have made much impact with regard to clinical services.

Next in the ranking of needs of unemployed PLWHA is basic needs. From tables j and k, 30.3% of PLWHA are in need of basic needs such as food and clothing. This figure is significant given that 69.6% of unemployed PLWHA receive help from relatives. This suggests that 30.3% could not receive any help from their relatives. Furthermore, it suggests that care and support programmes have not made much impact in the provision of basic needs. Next in the hierarchy of needs is unemployment, as 32.1% of PLWHA are in need of employment.

**Table 1 Unemployed PLWHA and Support Groups**

	<b>Frequency</b>	<b>Percent</b>
Share experiences with other PLWHA	13	23.2
Moral Support/Counselling	16	28.5
Receive basic needs, e.g. food	2	3.5
Govt Aid, Get drugs	2	3.5

Source: Field survey (2005)

From table 1, an insignificant number of PLWHA receive basic needs, Government Aid and get drugs from PLWHA support groups. The table shows that 3.5% of unemployed PLWHA receive basic needs such as food from PLWHA support groups. This figure is not surprising however, given that most PLWHA would have their basic needs from relatives and friends. Similarly, 3.5% are unemployed. PLWHA receive Government Aid and get drugs from PLWHA support groups. Also, this figure is to be expected as most of the government Aid and drugs would have been allocated to the hospitals and medical centres.

In comparing both unemployed and employed categories of PLWHA, it is clear that there is only a slight difference of 0.5% between unemployed PLWHA and employed PLWHA, the level of basic needs and government Aid/drugs that they receive from support groups.

Overall, the level of dependence of PLWHA on support groups is low. However, this low number of PLWHA attending support groups may largely be due to ignorance of PLWHA support groups on the part of PLWHA. According to PLWHA on why they don't attend support groups, 39.8% of respondents are either ignorant or unaware of PLWHA support groups. Also an insignificant 3% of them say that their homes are too distant from these groups. The remaining respondents give no reason (1%).

Next we compare the opinion of stakeholders with PLWHA in order to get an accurate picture of the state of care and support programmes. The tables above shows that 95% of stakeholders are of the opinion that there is inadequacy of drugs. However, both employed and unemployed PLWHA say that they are in need of cheaper drugs, 90.8% and 80.3% respectively.

With regards to clinical services, there is a contradiction in that 72.5% of stakeholders are of the opinion that care and support programmes at Government hospitals have been inadequate, whereas better clinical services do not constitute much of a need for both unemployed PLWHA and employed PLWHA, 7.1% and 14.2% respectively. On the issue of available drugs, 35% of stakeholders are of the opinion that drugs distribution is not effective. However 13.2% of employed PLWHA are in need of available drugs and 23.2% of unemployed PLWHA in need of available drugs. We can conclude that drugs are fairly available for PLWHA. In this section, we compare the opinion of unemployed PLWHA with employed PLWHA.

From the tables above, 30% of unemployed PLWHA are in need of essential materials, such as food and clothing. This figure is insignificant. Furthermore, 6% of unemployed PLWHA receive basic needs from PLWHA support group while 4% of employed PLWHA receive PLWHA for support. In conclusion, care and support programmes are perhaps focused more on unemployed PLWHA.

### **Funding of HIV/AIDS and Support Programmes (Care and Support Programmes)**

The funding of HIV/AIDS programmes appears to have been heavily funded by foreign agencies. According to stakeholders on whether foreign agencies dominate the funding of HIV/AIDS prevention, control and cure in Makurdi, a significant number of respondents expressed the view that foreign agencies dominate the funding of care and support programmes. Among the findings, 67% of them subscribe to this view, while 20% of them believe otherwise. The balances (12.5%) say that do not know. Obviously, this reveals that Governments at all levels have not quite lived up to their responsibility. According to stakeholders, Government action on AIDS is mere window dressing to attract international donations.

Next, we consider the performance of the various government action committees on AIDs, in order to get further insight on Government care and support programmes. On whether the state Government is contributing enough towards the care of HIV/AIDS patients, a number of respondents (42.5%) expressed displeasure with Governments' contributions, while 37.5% believe that government is contributing to the care of HIV/AIDS patients. The remaining 20% say do not know. Also, according to stakeholders on whether local governments have been forthcoming in the funding of HIV/AIDS prevention, 45% of respondents do not believe that local governments have been forthcoming in funding, while 32.5% think otherwise. The remaining (22.5%) do not know.

This is quite unfortunate for the fight against HIV/AIDS in Benue State. At the National level, the National Action Committee on AIDS seems to have been functioning well in the prevention, cure and control of HIV/AIDS in Makurdi. A good number of respondents (50%) are of this view, 35% of them express dissatisfaction with NACAs performance. The remaining 17.5% do not know. Also, NACA seems to have been having an impact on the reduction of HIV/AIDS in Makurdi, as 60% of respondents express satisfaction with NACAs efforts at reducing HIV/AIDS, while 17.5% think otherwise. The remaining 22.5% are split about NACA'S activity.

At the state level, the State Action Committee on AIDS (SACA) seems to have been performing well. On whether SACA has been functioning well in the prevention/cure and control of HIV/AIDS in Makurdi, 60% of respondents express satisfaction with SACAS activities, while 10% are of the opinion that SACA is not functioning well. The remaining (20%) are divided on the issue.

Also SACA seems to be having an impact on the reduction of HIV/AIDS in Makurdi, as a sizeable number of respondents (62.5%) are of the opinion that SACA is having an impact in the reduction of HIV/AIDS, while 20% think differently. The remaining 17.5% do not know.

At the local level, however, the local action committee on HIV/AIDS seems not to have performed well. On whether the Local Action Committee on AIDS (LACA) is functioning well in the prevention/care and control of HIV/AIDS in Makurdi as shown on, 47.5% of respondents express dissatisfaction with LACAs performance, while 22.5% think LACA is functioning well. The remaining 30% do not know. Also, LACA seems not to be having an impact on the reduction of HIV/AIDS in Makurdi. A sizeable number of respondents (60%) are of the opinion that LACA is not having an impact, 27.5% think LACA is having an impact. The remaining 12.5% do not know.

In conclusion, the efforts of the Local Action Committee on aids at combating HIV/AIDS is not effective. This perhaps due to the lack of funding on the part of the local government. Furthermore, the results suggest that there is some foreign funding of care and support programmes at the National and State Government levels. Funds appear to have been concentrated at the State and National level of Action because of the heavy responsibilities of providing as well as subsidizing drugs.

## 6. HIV/AIDS AND LOCAL GOVERNANCE IN MAKURDI

The local government has been involved in the fight against HIV/AIDS through such agencies as LACA. However, LACA does not seem to be effective in tackling the HIV/AIDS scourge. According to stakeholders on whether LACA has been functioning well in the prevention/cure and control of HIV/AIDS in Makurdi, 22.5% are of the opinion that LACA has been functioning well, while 47.5% are of the opinion that LACA has not been functioning well. The remaining did not express an opinion. Also, on whether LACA is having an impact on the reduction of HIV/AIDS in Makurdi 30% are of the opinion that LACA is having an impact, 40% are of the opinion that LACA is not having an impact. The remaining 30% did not express an opinion.

However, it appears that lack of funding may have been responsible for the poor performance of LACA. According to stakeholders on whether the Local Government has been forthcoming in the funding of HIV/AIDS prevention, 45% of them are of the opinion that the local government has not been forthcoming, 32.5% are of the opinion that the local government has been forthcoming. The remaining do not express an opinion (22.5%). Furthermore, there appears to have been heavy funding from foreign agencies but it does not seem to have reached LACA. A good number are of the opinion that foreign agencies dominate funding (67.5%) while 20% are of the opinion that foreign agencies do not dominate funding. The remaining 12.5% did not express an opinion.

However, funding seems to have been reached other agencies such as NACA and SACA as they appear to have performed well in the fight against HIV/AIDS. According to stakeholders on whether the National Action Committee on AIDS (NACA) has been functioning well in the prevention of HIV/AIDS, 29% of them express satisfaction with the activities of NACA in the prevention of HIV/AIDS, while 7% express dissatisfaction with NACA's activities. The remaining 4% do not express an opinion. Also, on whether NACA is having an impact in the reduction of HIV/AIDS in Makurdi, 60% of them are of the opinion that NACA is having an impact while 17.5% are of the opinion that NACA is not having an impact. The remaining 22.5% do not express an opinion.

According to stakeholders on whether the State Action Committee on AIDS (SACA) has been functioning well in the prevention/cure and control of HIV/AIDS in Makurdi, 60% of them are of the opinion that SACA has been functioning well, while 20% are of the opinion that SACA has not been functioning well. The remaining 20% do not express an opinion. Also, on whether SACA is having an impact on the reduction of HIV/AIDS in Makurdi, 62.5% of them are of the opinion that SACA is not having an impact. The remaining 17.5% of them do not express an opinion. Although we do not have information on the funding disbursement of the foreign agencies, we can conclude that the funding reached the NACA and SACA.

## 7. SUMMARY AND POLICY RECOMMENDATIONS

The city of Makurdi can be classified as an ‘AIDS endemic zone’ of Nigeria and requires urgent policy initiatives to reduce the impact and spread of the disease in Benue State. To achieve the Millennium Declaration on HIV/AIDS, which seeks to halt and reverse the spread of the disease, such policy initiatives entail the use of practical, result-oriented strategies agreed upon by all stakeholders in this regard. This includes the PLWHA and their local support groups, networks and associations, non-governmental organizations, government institutions, the media representatives etc.

In this regard, the following policy recommendations are made:

- 1) The political will is in existence to act decisively, to prevent the further spread of HIV/AIDS and to mitigate its impact. But efforts on the ground are too limited to make positive and meaningful impacts on the lives of PLWHA. Political will needs to be strengthened to address these limitations. Stakeholders need to be sensitized about the impact of HIV/AIDS on human lives and livelihoods, and advocacy needs to take place, to mobilize resources and efforts to address the spread of the epidemic.
- 2) As a follow-up to the previous point, the Makurdi Local Government requires the most urgent attention, in terms of capacity building to implement HIV/AIDS programmes to benefit the PLWHA. Such capacity building initiatives should include mini-consultations to sensitize them about achieving the MDG on AIDS, the city consultation forum proper and their involvement and follow-up proactive engagement on issues relating to fund- raising, networking with other stakeholders etc.
- 3) Policy actions are needed, not only on awareness programmes, but also more in the area of infection prevention and the strengthening of care and support to PLWHA and caregivers. Efforts must be intensified on mitigating the impact of HIV/AIDS.
- 4) There is an urgent need to give much more attention to appropriate prevention measures in all cities and communities, with particular focus on high risk groups, that is, the youths and others affected by poverty and inequality, which enhance susceptibility to infection.
- 5) AIDS is still a highly stigmatized disease in Benue State. As a result HIV/AIDS is not addressed as openly as it should. This affects the prevention, care and support interventions. The stigma also prevents the collection of accurate data, on which policies and programmes are based. Hence, policies to eradicate stigmatization must be put in place and intensified across the federation.
- 6) With regards to care and support, the challenge here is how best to assist and strengthen local support networks, to ensure their effectiveness without the corresponding personnel being overwhelmed. Support must build on local initiatives and existing safety nets, avoiding the development of external or parallel support systems, which cannot be sustained. The PLWHA need to be empowered, provided with employment and enough drugs to go round all the PLWHA identified in the community.
- 7) Care and support efforts should focus directly on target groups and the most vulnerable groups such as PLWHA, orphans, widows and elderly caregivers. PLWHA

need better access to care, which improves their health, quality of life and survival. Caregivers and the bereaved need to be economically engaged, financially empowered, given socio-psychological counselling and other types of support. Home-based care needs to be strengthened to prevent existing safety nets from collapsing and to improve the quality of care. There is an urgent need to strengthen the involvement of the civil society organizations in providing care and support.

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**Report of the Proceedings of**

**THE MAKURDI CITY  
CONSULTATION**

**On HIV/AIDS and LOCAL  
GOVERNANCE**

**6 – 8 April 2005**

**By**

**Ojetunde Aboyade**

**Development Policy Centre  
Ibadan, Nigeria**

## **INTRODUCTION**

The DPC team arrived in Makurdi on the evening of Sunday 3 April 2005. For the next two days members of the team were engaged in mobilizing stakeholders and reminding state officials and local organizations involved. Before then, all of them had already received invitations to the City Consultation. Handbills were also distributed among the general population of Makurdi.

Among the officials and organizations visited during this period were Dr. Ijir, the Special Adviser on HIV/AIDS to Governor George Akume, Dr. Jogo, Head of Clinical Services at the Federal Medical Centre, Barrister Chagu, Chairman of Makurdi Local Government, Honourable Iduma, Commissioner for Health and Human Services, the Special Adviser to the Local Government Chairman on Political Affairs and Mrs. Margaret Ugo, Secretary to the Local Government.

The team also visited Mr. Yongo and the Benue Network of People Living With HIV/AIDS, Federal Medical Centre, Bishop Murray Catholic Mission, Mrs. Ugor and the Benue State Action Committee on AIDS (BENSACA) Dr. Adedzwa and other officials of the Cooperative Extension Centre (CEC) of the Federal University of Agriculture, Mr. Godwin Tata and the Nigerian Television Authority, as well as Mrs. Akor of the Partnership for Transforming Health Systems (PATHS)

As a result of these pre-consultation efforts, the City Consultation was very well attended by a range of stakeholders, especially by State and Local Government officials, who stayed for as long as the programmes lasted on each day of the City Consultation.

### **Opening Ceremony**

The City Consultation was held at J.S. Tarka Conference Hall within the Plaza Hotel complex in Makurdi, beginning at 10 a.m on Wednesday 6 April 2005. Eighty five participants registered for the City Consultation (see enclosed lists). Among the high ranking state officials and other important stakeholders were Honourable Mike Iduma , Benue State Commissioner for Health, Mrs. Margaret Ugo, who represented the Chairman of Makurdi Local Government, Dr. (Mrs) Dokunmu, Medical Director, Federal Medical Centre at Makurdi, Dr. Andrea Jogo, Head of Clinical Services, Federal Medical Centre, Mrs. Ugor, Project Leader Benue State Action Committee on AIDS (BenSACA) Mrs. Grace Wende, Secretary of BenSACA, Rev. Tor Uja, another member of BenSACA, Mrs. Elizabeth Akor, Programme Director Partnership for Transforming Health Systems (PATHS) and Mr. Stephen Yongo, President of Benue Network of People Living With HIV/AIDS (BenPPLUS).

The DPC Team was lead by Professor Bimpe Aboyade, Chairman Development Policy Centre, who gave the keynote address. A number of goodwill messages were given orally. The Honourable Commissioner of Health gave a goodwill message on behalf of the State Governor Dr. George Akume who was unavoidably absent at the event due to some urgent state matters. He remarked that his government was pleasantly surprised that a non-governmental organization like the Development Policy Centre was organizing an event of such magnitude, adding that it was an unusual trend based on his experience with non-governmental organizations in the country. He added that the City Consultation was a welcome development in Benue State. According to him, Benue State cared a lot for People

Living With HIV/AIDS (PLWHA) and was providing the requisite health services for the prevention of AIDS. About four years ago, the infection rate in the state was very high – 16.4%, the highest in the country. It was reduced to 13%, then to 9%. The last sentinel survey of the country in 2003 revealed a reduced infection rate. He mentioned Governor Akume's recent donation of N12 million to a recent State government's AIDS intervention programme. He wished all the participants a successful conference.

Mrs. Grace Wende of BenSACA thanked the organizers for coming to Benue State. According to her, BenSACA's doors were open to groups interested in impact mitigation and alleviation of the disease's symptom among PLWHA. In addition, BenSACA was developing strategies to reduce the suffering of PLWHA.

Mrs. Margaret Ugo of the Makurdi Local Government welcomed all stakeholders to the City Consultation. She was pleased that Makurdi was chosen in this regard. She informed the gathering that Makurdi Local Government had a Local Action Committee on AIDS (LACA), adopting an inward looking methodology to cover Makurdi metropolis. LACA was particularly interested in the socio-cultural factors spreading the disease.

Mrs. Lizzy Akor of PATHS welcomed participants to the event and gave some information about her organization to the participants. She commended DPC for the City Consultation. Her goodwill message was the only one written out and is included in this report (please see Annex).

### **Plenary Session**

After lunch break, lead papers were given by four speakers, and participants had the opportunity to comment and ask questions on the various programmes aimed at combating the AIDS epidemic. The papers are reproduced in this report.

### **Syndicated Group Discussion (Day 2)**

Before the close of the first day, participants registered for the five discussion groups slated for the following day. Their deliberations are also reproduced in this report (please see annex).

Before the end of the day the recommendations emerging from various groups were considered by all participants together, and the action plan was agreed upon. Members of the implementation committee were thereafter chosen by participants.

### **Mini Fund Raising Event (Day 3)**

One day after the two-day event of the City Consultation proper, the newly inaugurated implementation Committee for the Action Plan, named Makurdi City Board on HIV/AIDS, met for a mini-fund raising meeting. This was attended also by the Benue State Commissioner of Health, Mike Iduma, a representative of Makurdi Local Government Chairman and other special guests mobilized by the Local Government and members of the new board.

The main objective of this meeting was to plan for the actual fund raising event that would come up in future. Honourable Mike Iduma used the opportunity to inform participants of

Governor Akume's special interest in the event of the City Consultation and of his wish to have his government involved in future activities of the implementation committee. The news was well received by everyone and the members of the new Board felt very encouraged. Besides, some of the special guests made pledges of financial contributions towards the implementation of the action plan.

Honourable Iduma assured the DPC team that a proper fund raising event would be organized with assistance from his Ministry, to ensure that the new board has sufficient funds to implement the action plan. The commissioner also expressed profound gratitude to the Development Policy Centre for its initiative and concern for Makurdi and its People Living With HIV/AIDS.

On the whole, the Makurdi City Consultation made a significant impact among State and Local Government officials, various support groups and the generality of Makurdi people. It also turned out to be a huge success.

# TOWARDS A PRO-POOR PARTICIPATORY GOVERNANCE IN THE MANAGEMENT OF HIV/AIDS

## **Keynote Address at the Makurdi City Consultation**

**6 – 8 April, 2005**

**By**

**Professor Bimpe Aboyade  
Chairman, Development Policy Centre, Ibadan**

His excellency Dr. George Akume, the Governor of Benue State ably represented by the Honourable Commissioner of Health Dr. Mike Iduma, and other Commissioners, Representative of the Chairman of Makurdi Local Government; State and Local Government Action Committees on HIV/AIDS; Representatives of the Association of People Living With HIV/AIDS; Members of the Media; Distinguished ladies and gentlemen:

Let me first say how very delighted I am to be here in Makurdi today at the start of the City Consultation process to combat the scourge of HIV/AIDS and begin to devise the means to reverse its spread. This is my first visit to Makurdi and since I arrive here I have been made to feel welcome and at home.

On behalf of the Development Policy Centre, I welcome you all to the event of the City Consultation starting today, which process will lay emphasis on pro-poor participation in governance especially in the management of the HIV/AIDS epidemic at the local level.

### **What is a City Consultation?**

A city consultation is a participatory event on a citywide level. It brings together stakeholders to create a better understanding of issues, to agree on priorities and to seek local solutions built around a broad consensus. The city consultation process supports the creation of a platform for dialogues between local government officials and local stakeholders with civil society.

However the city consultation is normally held, as we are doing from today, after a preparatory phase of situational analysis and base line studies. In this wise, the Development Policy Centre Research Team has been undertaking a reconnaissance and pilot survey of the city of Makurdi since the beginning of the year. This has involved series of mini consultations and discussions with a number of organizations and individuals who have programmes and interventions aimed at combating the spread of the disease. The DPC Team has also had extensive interactions and consultations with People Living With HIV/AIDS.

Among the institutions visited by the DPC team were the Federal Medical Centre, the Benue State HIV/AIDS Development Project, the Benue State Ministry of Health, Bishop Murray Catholic Mission, The Partnership for Transforming Health Systems, the Federal University of Agriculture and the Nigerian Television Authorities. I wish to take this opportunity to thank these and other organizations the DPC team interacted with, for their readiness to share their experiences with the DPC and their receptiveness to some of the ideas from our team. The DPC team was highly impressed by their efforts and the dedication shown by their operatives, to the course of combating the disease. Equally commendable are the openness and frankness exhibited by the people living with HIV/AIDS and their readiness to take their fortune in their own hands.

The City Consultation is expected to lead into an action planning and partnership development, and not just end as a talk shop. The City Consultation will start a process that will enable all stakeholders to map out how they can all work together to improve on the prevailing situation. It involves taking stock of what is already available in the locality and mobilizing these and new opportunities in a concerted effort to achieve the set objective, which in this case is to halt by 2015, and begin to reverse the incidence of the disease.

### **The Millennium Development Goals**

This indeed is one of the United Nations Millennium Development Goals, which also include the eradication of extreme poverty and hunger, achieving universal primary education, promoting gender equality and empowering women, reducing child mortality, improving maternal health, ensuring environmental sustainability and developing a partnership for development. All these, we all agree, are interrelated in the development process, and are achievable if they are addressed with all the seriousness they deserve.

The African Network of Urban Management Institutions (ANUMI) of which the Development Policy Centre is a member, is working to localize the Millennium Development Goals in Sub-Saharan Africa. ANUMI responds primarily to the needs of African local governments and urban communities, as it engages with global development frameworks. With regards to HIV/AIDS especially, the network continues to develop tools and methodologies, such as the City Consultation, to support local government in the development of strategic city action plans against HIV/AIDS.

It is widely known that Sub-Saharan Africa has been the worst affected region on the globe by HIV/AIDS epidemic. And within Nigeria, Benue State is among the worst hit. The survey undertaken by DPC in Makurdi confirms the fact established in other countries ravaged by the disease that the overwhelming majority of those afflicted are young and able-bodied people who should be producing food for the community, providing labor for industries, manning public institutions such as the Civil Service, Banks, Schools and Hospitals, and more importantly bringing up new generations of African leaders. [see H.E. Janet Musereni, Fighting HIV/AIDS through Attitudinal Changes. In proceedings on an All-Africa Conference, IFPRI, April 2004]

### **Creating Partnerships**

Arising from the declaration of the Millennium Development Goals, it is reported that all countries are modifying their policies and programmes to bring about the changes needed to meet those targets. And participatory policy action has been pushed to the forefront. We must now move from what has been termed “development-friendly rhetoric” to binding

documents specifying commitments, to concrete policy designs backed up by appropriate budgetary allocations, and to implementation activities that have impact on the ground. [As reported in IFPRI's Essay by Joachim von Braun, M.S. Swaminathan, and Mark W. Rosegrant. Annual Report 2003-2004].

At the same time it must be noted that lack of coordination of all initiatives and programmes will result in a waste of all these efforts. That is why a prime objective of this City Consultation is to create the opportunity and mechanism for all stakeholders in the fight against HIV/AIDS to harmonise their efforts. A sense of ownership by the people of the city of Makurdi is also important to ensure continuity and sustainability. Besides, in achieving the Millennium Development Goals, local communities, particularly those with large proportion of those living in poverty and/or HIV/AIDS need to be integrated fully into any action plan by allowing them to voice out what they need and what they can do for themselves with the assistance of the community at large. This will also ensure a shift in our development paradigm, so we begin to think of partnerships rather than “beneficiaries” and the patronage that implies.

### **Localising the MDGs in the City of Makurdi**

That is why in the programme of activities for this Makurdi City Consultation event, it is envisaged that a concrete action plan will emerge from the discussions that will give all stakeholders a voice and a role to play in a concerted manner in the management of HIV/AIDS. You will notice from the programme that tomorrow, the second day of the City Consultation, stakeholders will meet in small groups to deliberate on issues revealed in the city profile report and contributions made by various speakers today. In these syndicate group discussions, stakeholders will brainstorm intensively on these issues and agree on a set of recommendations of practical strategies to achieve the United Nations Millennium Declaration on HIV/AIDS. Representatives of each of the discussion groups will present their findings and recommendations to all the participants as whole. The recommendations will be subject to open debate before being ratified. This will constitute the Action Plan for the city of Makurdi. Participants and stakeholders will then proceed to appoint from among themselves members of a committee to implement the action plan on a continuous basis.

You will also notice from the programme that the third day is devoted to fund raising in order to assist the take-off of the committee of stakeholders that will coordinate and operationalise the activities agreed upon in the Action Plan. The funds so realized from community leaders will provide resources for the newly appointed body to start in earnest the implementation of the action plan, and thus improve participatory governance by harmonizing the views and perspectives of participating stakeholders. This fund raising event will serve as a major signal to all and sundry throughout the State, Country and among International Donor Agencies that the Makurdi people are doing something to help themselves, and therefore deserve to be further helped.

The experience of the Development Policy Centre in using the City Consultation to aid development projects in Nigeria has been one of great success. An example which has won international acclaim is the City Consultation on Poverty Reduction in Ijebu-Ode and its aftermath. It has become a reference point for other cities in Nigeria wishing to tackle the issue of poverty in their communities. There, a robust board of committed stakeholders charged with the responsibility of implementing their community's action plan, and working without remuneration, has achieved enormous success since its inception in 1999. As a result

of their acceptance by the generality of the people of Ijebu-Ode and the benefits that have accrued to the people through this process, the local government in the area has also benefited in the improvement it has achieved in local governance.

It is the hope of the Development policy Centre and its ANUMI partnership that this event of the Makurdi City Consultation will start a process that will also surpass our expectation of the community's achievement in combating the HIV/AIDS menace. In this, the Development Policy Centre can be relied upon to help the Makurdi community through its implementation committee with advice and guidance, as the Centre itself continues to draw from the pool of experience of our partners in the African Network of Urban Management Institutions, which are undertaking similar schemes in many other cities of the developing world, especially in Sub-Saharan Africa. In other words, the Development Policy Centre will continue to help build the capacity of the newly appointed body in achieving its target.

Above all, this City Consultation is to emphasize the role of everyone in the community in the struggle against HIV/AIDS. With regard to prevention, and in the absence of any known cure for now, there have to be attitudinal and behavioural changes on the part of the generality of the people. There has to be a change from superstition to scientific fact concerning how HIV is transmitted or contacted. There has to be a change in some of our cultural practices, like that of the male-next-of-kin inheriting widows, and a culture that expects only the women folk to be faithful to their partners, while it encourages or at best turns a blind eye on the men who have multiple partners. More importantly there has to be a change regarding the negative attitude of people to those among them who are infected.

In conclusion, I wish to thank His Excellency Dr. George Akume for his support and commitment to this course of action. Once again I thank and congratulate all organizations and individuals who have put in so much effort into combating this dreaded disease. Although a special vote of thanks will be moved later on, I wish to thank especially our host, the Chairman of Makurdi Local Government and his council members and all those who have come here today to participate in this event. I urge you to continue to participate fully throughout the three days of this special event, and not just for today alone. It is my fervent prayer that this City Consultation will usher in a new era of an overall sustainable development for all the inhabitants of the city of Makurdi in particular, and Benue State as a whole.

I thank you for your attention.

Bimpe Aboyade  
6 April 2005



## **Plenary Session**

The following papers were given at the plenary session on the first day of the City Consultation. These led to intensive discussions, questions and answers, among participants:

1. Review of Government Policy on HIV/AIDS in Benue State: Honourable Mike Iduma
2. Challenges facing People Living With HIV/AIDS (PLWHA): Mr. Stephen Yongo
3. City Profile of Makurdi: Dr. Abiodun Ojoawo
4. HIV/AIDS - Achieving the Millennium Development Goal (MDG): Dr. Andrea Jogo

### **Plenary Session – Paper 1**

**A BRIEF REVIEW OF GOVERNMENT POLICY ON HIV/AIDS IN BENUE STATE.  
PRESENTED AT THE PLENARY SESSION OF THE MAKURDI CITY  
CONSULTATION PROGRAMME ORGANIZED BY THE DEVELOPMENT  
POLICY CENTRE, IBADAN AT PLAZA HOTEL, MAKURDI 6<sup>TH</sup> APRIL 2005.**

BY  
Honourable Iduma  
Commissioner for Health  
Benue State Ministry of Health and Human Services

## **PROTOCOL**

### **INTRODUCTION**

It is fair to state up front that Benue's HIV/AIDS epidemic is characterized by one of the most rapidly increasing rates of new HIV/AIDS cases in Nigeria. Adult HIV prevalence increased from 1.6% in 1991 to 13.5% in 2001. In the context of Benue's projected population of about 4.0 million people, this is a worrisome situation.

HIV Prevalence Rate in Benue (By Year)

- |        |       |
|--------|-------|
| • 1991 | 1.6%  |
| • 1993 | 4.7%  |
| • 1999 | 16.8% |
| • 2001 | 13.5% |
| • 2003 | 9.3%  |

The factors contributing to the spread of HIV in Benue State include the following:

- Sexual networking practices such as polygamy
- A high prevalence of sexually transmitted infections
- Low condom use
- Poverty
- Low Literacy Levels
- Poor health status of the people
- Low (subordinate) status of women

- Stigmatization and
- Denial of HIV infection risk among vulnerable groups

The impact of HIV prevalence on Benue State are:

- Increased poverty
- Decreased life expectancy
- Increased number of HIV/AIDS orphans
- Increasing number widows and widowers
- Disruption of the family social structure
- Overstraining of health institutions and systems
- Reduced School enrolment
- Increased crime rate etc

### **STATE'S RESPONSE / POLICY**

When this administration came to power in 1999, there was a need to take a clear position on dealing with HIV/AIDS in the state. Government was challenged by the threat HIV/AIDS posed to the State and realised it had to develop:

- (a) A strong leadership
- (b) A clear strategy
- (c) Effective implementation

### **STRONG LEADERSHIP**

- 1) Gubernatorial trip to Uganda to learn lessons about the disease.
- 2) Appointment of a 'Special Adviser on HIV/AIDS' in the State
- 3) Setting up of a coordinating unit – BENSACA
- 4) Adoption of National Guidelines on HIV/AIDS
- 5) Production of a workplan
- 6) Clear Strategy (Prevention linked to care and support via VCT – Voluntary Counselling and Testing)
- 7) Key activities are directed at prevention by creating awareness. This is linked to improved care for those who are HIV positive by way of Voluntary Counselling and Testing

### **EFFECTIVE IMPLEMENTATION**

An HIV/AIDS Development project funded by a World Bank loan of about \$5 million is very well handled by a project development unit. An effective collaboration and coordination network with donor agencies, missions and CBOs is being developed to handle a comprehensive HIV/AIDS strategic plan, developed with the Federal Government

### **POLICY FOCUS**

Government effort is now aimed at eliminating denial, stigma and discrimination by improving care for those who are HIV positive. Encouraging early diagnosis and getting more people to come out with the fact that they are HIV positive and that they can live with HIV. It is clear at this state that treatment is the single short-term intervention that will make a difference to the way the HIV/AIDS epidemic unfolds in Benue State.

On the whole providing treatment is a direct challenge to the ignorance, denial and stigma that have fuelled the AIDS epidemic since inception. Government is considering the procurement of effective drugs for the State, working closely with the Federal Government appointed Committee to assist selected states with the greatest burden, like Benue.

## **CONCLUSION**

In summary, our government policy emphasizes prevention linked with care and support for those who are HIV positive via Voluntary Counselling and Treatment (VCT).

- Priority activities/programmes include prevention among the youths, prevention of mother to child transmission, high risk among individuals (sexworkers, migrant workers, truckers, TB), STD awareness and treatment, VCT and care and support for the infected.
- Collaboration with all those working in this sector is to be encouraged. The past programme is under way and should be an example of a collaborative effort which is needed to control the HIV/AIDS epidemic in Benue and indeed the country.

### **Question and Answers on Review of Government Policy on HIV/AIDS in Benue State** **By Honourable Mike Iduma**

Mr. Febian Toro of BENPPLUS stated that although there were several government HIV/AIDS intervention programmes in existence, stigmatization to a large degree continues to pose a problem towards checking the spread of the disease. He wanted an explanation in this regard.

Another participant wanted to know if the reduction in the number of AIDS patients was as a result of death from the disease or as a result of effective cure or anything being done by government.

Mrs. Ritta Oparu stated that the effort of government in trying to reduce the hardship of PLWHA, results in this regard were not forthcoming. According to her the government should be encouraging BENPPLUS, which is more efficient in this regard.

Prof. Bimpe Aboyade wanted to know if Benue State had a poverty reduction programme as a strategy for reducing the scourge of AIDS. Another participant wanted to know what the State Government was doing to improve access of PLWHA to Anti-Retroviral Drugs (ARV's).

Honorable Iduma responded by saying the State Government organized public fora and workshops to change societal attitudes towards stigmatization associated with the disease. He emphasized that AIDS could not be eradicated in one day – its prevention, and mitigation is difficult because of national and international politics. The Federal Government supplied drug subsidies in this regard for 10,000 people and the State Government could not influence the former to increase it. Benue State is currently receiving drugs for 8,000 people. He added that pharmaceutical companies produced ARV drugs at prohibitive costs. Future arrangements between the Benue State Government and pharmaceutical companies will make more drugs available in the future. The State Government was in the process of industrializing the state to create employment, as a strategy for improving the lot of AIDS patients. As part of its 'Poverty Alleviation Strategy', the State Government purchased

motorcycles to distribute to unemployed people for the latter's use as taxis, in a bid to generating income for them.

Follow-up contributions to Honourable Iduma's presentation came from Reverend Uja and Dr. Utor of the Department of clinical services at the Benue State Ministry of Health. Reverend Uja stated that the strategies of government to aid support groups would be brought out more effectively during the syndicate group discussions. He added that BENSACA has been able to buy ARV's for other local governments in the state like Otukpo and Gboko. The latter was to serve as receiving centers for ARV's. According to Reverend Uja, Benue State is to administer 50 ARV's for every local government in the state. The State Government recently passed a law protecting the rights of PLWHA. More work needed to be done concerning societal awareness about the disease.

Dr. Utor stressed that the government must accept that treatment is the most important short term intervention AIDS programme. According to him, some progress has been made over the years concerning stigmatization, but more work needed to be done.

### **Plenary Session – Paper 2**

#### **CHALLENGES FACING PLWHA : A Paper Presented on the Occasion of The Makurdi City Consultation Forum organised by DPC , Ibadan**

By  
Stephen Yongo

Like any other person, the challenges facing PLWHA are similar. The peculiarity of these challenges is the stigma attached to HIV/AIDS - People viewing HIV/AIDS as a moral issue instead of a social or public issue. If this perception is reversed and HIV/AIDS normalized into one of the concerns of the public health sector, these challenges could be averted.

Ordinarily, bearing one another's burden is what Jesus Christ taught his apostles. The greatest commandment when he was asked to identify out of the ten by his apostles, he summarized it as love your neighbour as yourself. This if practiced by all, will ensure nobody suffers humiliation of any kind.

The following are the challenges facing PLWHA:

- **Emptiness:** Most PLWHA feel they are empty vessels immediately they have been diagnosed as being HIV positive. A feeling that they have nothing to offer to the society makes them empty and useless. They become challenged and develop an inferiority complex, which worsens their condition. They become helpless.
- **Absence of Counseling:** Most PLWHA who know their status were not given pre-test counseling. As a result, they were not prepared psychologically. This affects the psychological well being of the PLWHA, thereby leading to depression. Counseling is an important thing to the PLWHA. With counseling, which is supposed to be an on-going process, PLWHA gain and demonstrate courage. Lack of counseling services in our hospitals is greatly affecting PLWHA. Even those hospitals that have

trained counselors do not offer appropriate counseling services and are not committed to duty.

- **Lack of Family Support:** Experience has shown that some family members abandon and sometimes isolate PLWHA on the ground that they have tested positive to HIV. This is due largely to ignorance and lack of awareness in our families. Such utterance leads to suspicion and the PLWHA becomes an object of gossip. This eventually leads to the untimely death of most PLWHA. In some communities in Benue State, talking about HIV is taboo, there is more talk of one testing positive. Such persons tend to believe that it is better to die than to live. Little or no family support to give hope to PLWHA in most homes.
- **Poor Nutrition:** Benue State being an agrarian state, most PLWHA are farmers, in this condition, they are not strong enough to cultivate either food or cash crops. With this constraint of less energy to farm for even subsistence status makes them malnourished and subsequently leads to death. Good nutrition is very important for everybody, particularly PLWHA.
- **Stigma:** This is one of the most subtle and debilitating challenges and the hardest forces going against PLWHA. It inhibits open, honest communication between them and others. Stigma makes the disclosure of the disease by PLWHA within the family difficult. Without disclosure, prevention and care is almost impossible. Families and communities are deeply intertwined in the African context and should therefore be supported in preventing stigmatization, which will further enable their natural carrying role. This will also promote better self-esteem among PLWHA with respect to their careers. It will also eliminate the vicious cycle of self-stigmatization.
- **People living with HIV/AIDS face stigma** in the home, in the health care setting, in the religious sector and the mass media. The mass media can unintentionally promote stigma. But have potential to shape the attitude, values and perceptions of a large number of people.
- **Human Rights Violation:** Existing human rights instruments confirm that discrimination against PLWHA of those thought to be infected is a violation of their human rights. This is a great challenge facing PLWHA.
- **Discrimination:** The acts of stigma constitute discrimination based on presumed or actual HIV positive status and violate human rights. Because of the stigma associated with HIV/AIDS and their discrimination that may follow from this, the rights of PLWHA and their families are frequently violated. This violation of rights increases the negative impact of the epidemic. At the individual level, for example, it causes undue anxiety and distress-factors that are known in them to contribute to ill-health. At the level of the family and community, it causes people to feel ashamed to conceal their links with the epidemic and to withdraw from participation in more positive social responses. At the level of the society as a whole, discrimination against PLWHA reinforces the mistaken belief that such action is acceptable and that those infected with HIV/AIDS should be ostracized and blamed. This is a great challenge to PLWHA.

Around the world there have been numerous instances of such HIV/AIDS related cases of discrimination. People with HIV or believed to have HIV/AIDS have been:

- Segregated in schools and hospitals, including under cruel and degrading conditions. Cases of degrading treatment have often been reported in prisons where inmates are often mandatorily confined, often without basic needs being met, including access to medical care.
- Refused employment. An airline cabin attendant in South Africa was denied employment based on his HIV status. Fortunately, he was able to successfully challenge the discriminatory action in court.
- Denied the right to marry. For example, the Supreme Court in India ruled that a person living with HIV/AIDS has no right to marry and raise a family. Furthermore, some jurisdictions require mandatory HIV testing before granting marriage licenses.
- Required when returning to their home country to submit themselves to an HIV test. Individuals have been denied the right to return to their country on suspicion of being HIV-positive. Others have been denied visas or entry permission.
- Rejected by their communities. All over the world, PLWHA have been banished by their communities. Throughout Central and Southern Africa and in South Asia, a woman diagnosed with HIV/AIDS may be sent back to her family or village of origin once her serostatus becomes known.
- Killed because of their seropositive status. In December, 1999, a young community volunteer Ms Gugu Dlamini, was stoned and beaten to death by neighbours in her township near Durban, South Africa after she had spoken out openly on World AIDS Day about her HIV infection.

In conclusion therefore, continuing advocacy is needed for social change in response to PLWHA challenges. All hands must be on deck to tackle the challenges facing PLWHA. To win the war against HIV/AIDS, PLWHA must be used as agents of change in the society.

### **Questions and Answers on Challenges Facing PLWHA by Mr. Stephen Yongo**

Dr. Utor stated that it was interesting that most of the examples of challenges facing PLWHA came from South Africa, whose measures regarding AIDS intervention were being copied by other countries. He believed that BENSACA's World Bank assisted programme should be integrated with other initiatives to enhance the common goal of ARV access. The first challenge was the fact that there were over 200,000 PLWHA in the state, but government had drugs for 800 people. This point should have been included in the paper. He added that drugs were being abused and sustainability of its usage among PLWHA was a problem. Poverty was another problem weighing down on PLWHA. According to him, food subsidies could be provided to PLWHA by government through the networks because of the importance of PLWHA having a balanced diet. Other contributions from the participants expanded the problem of poverty and sustainability – improving the skill level of PLWHA and empowering them to make more money. Suspect secondary data from authorities like the university was a challenge

facing PLWHA. For example The Benue State University recently tested its students for HIV/AIDS, 75% of whom tested positive. Unfortunately the authorities did not inform the students about the results. Other participants wanted PLWHA to be more involved in policy formulation.

Mr. Yongo responded by saying all the contributions to his paper will be considered to make it more comprehensive. He confirmed the unfortunate incident at Benue State University that forced students to carry out tests at N600 without the latter being informed about the results.

### **Plenary Session – Paper 3**

#### **HIV/AIDS – ACHIEVING THE MILLENNIUM DEVELOPMENT GOALS (MDG'S) (A Paper presented on the occasion of the Makurdi City Consultation on HIV/AIDS)**

BY

DR. ANDREA A. JOGO, MBA, FMCOG, FWACS

One of the greatest health challenges of this age is that posed by infection with the Human Immune-deficiency Virus (HIV), which is the causative agent of the Acquired Immune-Deficiency Syndrome (AIDS). Since the first case of AIDS was described in the USA in 1981, the disease has spread so dramatically that it has now been diagnosed in virtually all countries of the world.

The transmission pattern of HIV has been documented to depend on a lot of viral and host factors which most often vary in different geographical regions. Success in reducing HIV transmission in some communities in the developed world is being overwhelmed by failure to prevent millions of new infections in Africa, Asia and other developing nations.

By the end of 2003, the total number of people living with HIV/AIDS globally was estimated at 40 million. Of these, 37 million were adults and 3 million were children below 15 years – more than 98 percent of them in developing countries. Available data clearly indicates that Sub-Saharan Africa bears the greatest brunt of the global HIV scourge. By the end of 2003, an estimated 26.6 million (66%) of the global 40 million people living with the virus are in sub-Saharan Africa. Twenty million adults and children have died of the epidemic worldwide. In 2003 alone, 5 million new infections and 3 million deaths were reported. Regrettably, 14 million orphans have emerged globally since the beginning of the epidemic. Sub-Saharan Africa accounts for three quarters of the total global deaths from HIV/AIDS, which has become the leading cause of death in Africa. It is responsible for one in five deaths in sub-Saharan Africa and the average prevalence of HIV in adults aged 15 to 49 is 8.8%.

Prevention programmes for HIV/AIDS reach fewer than one in five people who need them. Comprehensive prevention could avert 29 million of the 45 million new infections projected by 2010. Five to six million people need HIV treatment in low and middle-income countries, yet only 7 percent or 400,000 people had access by the end of 2003. The youth are the most affected – more than half of those newly infected today are between 15 and 24 years old. Women are particularly vulnerable.

In Nigeria, the first case of AIDS was diagnosed in 1986. Since then, the infection has been subtly but progressively transmitted within various communities and population. By the end of 1999, cases of HIV/AIDS infections had been diagnosed and reported in all the 774 local government areas (LGA's) of the country. Indeed every Nigerian is vulnerable to the disease. National HIV sentinel surveys show a rapid transition from near zero prevalence in 1990 to 5.8% prevalence rate among adult population aged 15 to 49 in 2001 and now down to 5.0% in 2003.

With the estimated 3.5 million cases, Nigeria ranked second in sub-Saharan Africa and fourth globally in the absolute number of adults living with the virus as at 2002. With



UNAIDS estimate of 1 million cases, Nigeria as at 2002 had the highest number of AIDS orphans in the world.

The adverse impact of the epidemic in Nigeria is already evident. It affects the urban elite as well as the rural poor, and generally in their most economically productive years. Health systems and social coping mechanisms in the country are over-burdened. The growing epidemic in the country is a challenge that will directly or indirectly affect its economic growth and democratic governance.

Hope was however rekindled in September, 2000 when the United Nations (UN) at her landmark Millennium Declaration unveiled an ambitious eight point blue print aimed at improving the lives of the one billion poor people in developing countries by 2015. Christened the Millennium Development Goals (MDG's), it proposes to eradicate extreme poverty and hunger, achieve universal primary education, promote gender equality and empower women, reduce child mortality, improve maternal health, combat HIV/AIDS, malaria and other diseases, ensure environmental sustainability and develop a global partnership for development. Millennium Development Goal 6 specifically targets, in part, to halt and effect a reverse in the spread of HIV/AIDS by the year 2015. Nowhere are the goals more urgent than in Africa, where progress towards achieving them have been slowest. Whereas over the past two decades, Asia made great strides-fuelled largely by decreasing poverty rates in China and India, the world's most populous countries. Africa lags far behind on every goal. According to a 3 year research carried out by 265 of the world's leading development experts under the aegis of the millennium project – an independent advisory group commissioned by Koffi Annan, the number of Africans living on less than one US-dollar a day rose from 227 million to 313 million between 1990 and 2001. Among the many obstacles hindering its advancement, the region suffers from the highest rates of undernourishment, lowest primary enrolment and the most devastating HIV/AIDS incidence.

In Nigeria, Africa's most populous country the official poverty rate is 57.8% with 70 million people living on less than one US-dollar a day. The country is also home to about 10 percent of the 40 million people worldwide living with HIV/AIDS. To date 46 percent of women and 31 percent of men have never attended school.

A glance at the Millennium Goals leaves no one in doubt as to the synergistic effect each goal has on the other. Attempting to achieve some of the goals in isolation may therefore not yield the desired results. However, considering the scope of this presentation, specific mention will now be made of combating HIV/AIDS.

### **HEALTH EDUCATION**

The 2003 National Demographic and Health Survey results indicate a need for more public education about HIV/AIDS transmission and prevention. Overall, the majority of Nigerians hold many misconceptions about HIV/AIDS transmission, believing for example that witchcraft can transmit the virus. Promoting abstinence and safe sex should be sustained.

### **CONTROL STI'S**

This can be done by promoting safe sexual habits, ensuring availability of inexpensive condoms, as well as early diagnosis and treatment of STI's.

## **ESTABLISHMENT AND MANAGEMENT OF SURVEILLANCE PROGRAMMES**

This would entail promoting voluntary counseling and testing of HIV/AIDS, where stand-alone centres are more acceptable than integrated services. The collating and analyzing of data from sentinel sites and groups to determine trends and identify high-risk groups will form part of the programmes.

## **PREVENT MOTHER TO CHILD TRANSMISSION**

Promoting voluntary counseling of pregnant women, preventing unwanted pregnancies in infected persons and use of antiretroviral therapy to protect the child and care for the mother. Prevent breast milk transmission via a policy on infant feeding on HIV infection.

## **PROVIDE AND MANAGE ANTIRETROVIRAL THERAPY PROGRAMMES**

High priority should be given to treatment of pregnant women and their children. Feasible chemotherapeutic programmes should be established in view of the complexity of the schedules, the need for close monitoring of patients including laboratory support as well as the high cost of drugs. There should be mandatory Post Exposure Prophylaxis (PEP) for occupational exposure and sexual assault. The HIV vaccine is still in the realm of research.

## **HUMAN RESOURCE DEVELOPMENT**

To achieve the goals in Africa, significant investments in human resource development are needed urgently since health services cannot function without a complement of properly trained staff. The Joint Learning Initiative (2004) estimates that Africa now faces a shortage of one million health workers. Pre-service and in-service training, adequate salaries and human resource management systems are other areas one could build Africa's capacity to deliver health services.

## **CONCERTED FINANCIAL AND TECHNICAL INPUT FROM DEVELOPED COUNTRIES AND NGO's**

The World Health Organization's (WHO) 3 by 5 initiative is a promising start, aiming to get 3 million of the world's AIDS patients on antiretroviral treatment by 2005. But such interventions need to be scaled up much more in the next decade to reach the 25 million Africans currently infected with HIV/AIDS (UNAIDS 2004).

## **GOVERNMENT INVOLVEMENT**

The various governments in developing countries must show commitment and a strong political will towards achieving these goals. To this end President Olusegun Obasanjo must be commended for launching the National Antiretroviral Programme in 2001. Under this programme, infected adults and children are treated with antiretroviral drugs at a subsidized cost of one thousand naira only per person, per month. The initiative to scale up the programme is equally commendable. Equally commendable are the drive for poverty reduction and the health insurance scheme.

Although the burdens of HIV/AIDS on developing countries are enormous, employing a multisectoral approach with a prophylactic bias towards its control may well place us on a sound footing as we strive to achieve the laudable ideals of the Millennium Development Goals.

**Questions and Answers on HIV/AIDS – Achieving The Millennium Development Goals by Dr. Andrea Jogo**

Participants wanted to know what packages the FMC had in line with Dr. Jogo's area of expertise in gynecology. They asked how discontinuities in the use of ARV's built the strength of the virus. In addition, they wanted to know why names of patients on the 'Drug Subsidy List' of the FMC were being arbitrarily removed and what factors determined the placement of PLWHA on this list. They also wanted to resolve the issue of compulsory testing for people at FMC whether they were HIV positive or not. Finally they wanted to know if there were other drugs available to assist PLWHA in AIDS treatment.

Dr. Jogo responded by saying the Federal Government and FMC had facilities and staff to address cases of 'Mother-Child' transmission of the disease. Efforts were being made to scale up these services. Group counseling was being given at antenatal clinics and people could point out of testing in this regard. Counseling was available for pregnant mothers and structures were being put in place to improve sustainability in ARV administration. Staff changes may be responsible for administrative inefficiencies but were being addressed.

## **Plenary Session – Paper 4**

### **CITY PROFILE OF HIV/AIDS IN MAKURDI**

**(Being Extracts from the DPC Research Report on HIV/AIDS in Makurdi)**

*By*  
**DR. A .O. OJOAWO**  
*Research Fellow*  
*Development Policy Centre*  
*Ibadan.*

#### **1.0 Background To The Study**

One of the most devastating scourges of our time is the problem of Human Immunodeficiency Virus Syndrome (AIDS). Undoubtedly HIV and AIDS present a major challenge to human development in Nigeria. Besides poverty, no problem has given Nigeria a daunting challenge as the present battle with HIV/AIDS. AIDS is indeed devastating Nigerian communities and poses a real threat to poverty reduction efforts and the achievement of the UN millennium Development Goals. Undoubtedly, HIV/AIDS present a serious challenge to human development in Nigeria because the exact cost and spread of the epidemic is still very difficult to calculate.

Upon noticing the scourge in 1986 with just one person affected, the infection rate has grown exponentially since then. By June 1999, the Federal Ministry of Health (FmoH) in Nigeria had recorded 26,276 AIDS cases. Because of the fear of social stigmatization, several cases are not reported through the hospitals, which means, the reported cases were gross underestimations of the rate of occurrence of the epidemic. The National AIDS/STDs Control Programme (NASCP) of the FmoH estimates that the total cumulative number of AIDS cases would have reached 590,000 by the end of 1999.

HIV prevalence amongst the sexually active age group of 15 – 49 years has been on the increase since the first survey in 1991 when the national average sero-prevalence rate was 1.8% to 3.4% in 1993, 4.5% in 1995 and 5.4% in 1999, 5.8% in 2001 and 5% in 2003 (Policy project 2003). Based on these prevalence rates, a total of 3.5 million of the estimated national population of 120 million were estimated to be living with HIV.

Currently, Nigerian has become the first largely populated country to cross the critical epidemiological threshold of 5%. It has since been projected that by the year 2009, in the absence of major changes in sexual behaviour and other control measures, the number of people living with HIV will soon reach 5 million.

Considering the global spread of the HIV/AIDS, of the 40 million people identified to be living with the disease globally, 3.5 million are estimated to be Nigerians. This accounts for

10% of the 40 million people infected worldwide (UNAIDS/WHO/UNICEF 2002). In a country like Nigeria with limited public capacity and resources to combat the problem, the prevalence is so high that the HIV virus is infecting more than 30 people a day, and the disease is growing faster health authorities than response to it. The prevalence reports in Nigeria revealed that there is no community in Nigeria with zero prevalence. (FmoH 1999).

Across the states, the table below also reveals that no state is an exception to the problem. Although some parts of the country have higher prevalence rates than others, all states record more than 1% prevalence. In 2003, prevalence rates ranged from 1.2% in Osun State to 12% State in Cross River State. Nationally, prevalence is higher in urban than in the rural areas. Persons between the ages of 20-29 are most affected, although in the South-south and Southwest zones, the prevalence is highest among the 15-19 age group (.USAID, Policy Project 2003).

The situation on the ground in Nigeria is very sobering indeed. Even with the recent drop in the National prevalence rate from 5.8 per cent to 5 per cent. According to official statistics, 3.5 million Nigerians already live with HIV and AIDS, which is more than the entire population of some countries. About 300,000 Nigerians die annually of AIDS-related diseases and 1.5 million Nigerian children have been made orphans as a result of these deaths. The fact that Nigeria's prevalence rate is in single digits can be misleading and can give the people a false sense of security. The real fact is that, Nigeria has the second highest number of infections in Africa, going by the actual figures, not the percentages.

In fact, the epidemic has acquired a "Generalised" status in Nigeria, meaning that HIV and AIDS is spreading across all geo-political zones of the country, spreading in both rural and urban areas equally and across all segments of the population, not just confined to high-risk groups such as commercials sex workers, homosexuals and drug users.

A more recent study by USAID in 2003 tagged "Policy Project" further reveals the terrible situation of the HIV/AIDS epidemic along geo-political zones, the states and the profile of the infections, and possible rate of spread in the nearest future. The table below reveals the details along the geopolitical zones, the North Central, South South Zones are in the lead with 7.0% and 5.8% prevalence rate accordingly from 7.0% and 5.2% in 1999. And at the state level, the spread reveals that Cross Rivers is in the lead with 12.0% followed by Benue State in the North Central Zone with 9.3% prevalence rate.

## Geopolitical Distribution of HIV Prevalence in Nigeria

		Population 2003	HIV Prevalen ce (%)	Number of people infected (2003)	Number of people likely to be infected by (2008)	Number of youth (15- 24yrs) infected (2003)	Number of youth (15- 24yrs) likely to be infected (2008)	Number of HIV+ pregnant women (2003)	Number of HIV+ pregnan t women (2008)	Number of people requiring Antiretroviral drugs (2003)
<b>North Central Zone</b>		13,894,924	7.0%	460,719	500,633	83,822	107,698	40,820	43,821	91,346
	Benue	3,902,638	9.3%	238,328	212,772	29,640	45,517	21,246	18,318	53,825
	FCT	526,977	8.4%	26,427	27,499	4,956	6,953	2,126	2,194	4,501
	Kogi	3,044,411	5.7%	90,974	106,093	20,111	23,419	8,556	9,395	15,296
	Kwara	2,194,976	2.7%	39,901	35,937	6,428	7,603	3,506	3,026	7,356
	Nassara wa	1,712,241	6.5%	67,897	68,570	7,887	16,092	5,897	5,917	15,862
	Niger	3,432,980	7.0%	129,660	149,327	31,699	35,336	11,415	12,896	20,676
	Plateau	2,983,339	6.3%	105,860	113,207	12,741	18,295	9,320	10,393	27,659
<b>North East Zone</b>		16,870,701	5.8%	498,589	550,631	102,828	127,399	44,439	47,668	84,788
	Adamaw a	2,979,806	7.6%	117,322	137,387	27,810	31,448	10,675	12,005	17,419
	Bauchi	4,056,992	4.8%	127,064	127,314	22,474	27,123	11,502	10,785	18,226
	Borno	3,595,100	3.2%	66,142	69,230	11,858	16,929	5,425	6,013	17,303
	Gombe	2,110,953	6.8%	79,597	91,323	14,180	21,828	7,153	7,880	12,792
	Taraba	2,143,617	6.0%	69,039	78,538	16,949	19,000	6,157	6,955	13,770
	Yobe	1,984,233	3.8%	39,425	46,839	9,557	11,071	3,527	4,030	5,273
<b>North West Zone</b>		32,481,910	2.7%	726,975	762,883	135,757	184,383	63,447	65,646	140,811
	Jigawa	4,076,353	2.0%	42,587	49,834	9,852	12,585	3,646	4,226	7,657
	Kaduna	5,579,401	6.0%	237,248	211,354	26,142	49,110	20,368	17,917	56,406
	Kano	8,237,029	4.1%	179,842	205,620	41,912	50,095	15,558	17,696	33,086
	Katsina	5,320,243	2.8%	84,861	95,984	15,639	23,231	7,596	8,413	14,398
	Kebbi	2,932,237	2.5%	51,768	46,092	9,723	10,724	4,540	3,971	10,227
	Sokoto	3,397,878	4.5%	80,761	96,072	20,538	24,160	7,332	8,393	10,782
	Zamfara	2,938,769	3.3%	49,908	57,927	11,951	14,478	4,407	5,030	8,255
<b>South East Zone</b>		15,272,983	4.2%	393,315	369,983	48,913	83,237	34,940	31,438	91,969
	Abia	2,712,984	3.7%	64,954	77,871	13,275	17,330	6,071	6,679	10,672
	Anambra	3,964,073	3.8%	107,853	92,485	15,130	20,136	9,066	7,315	23,007
	Ebonyi	2,060,679	4.5%	56,422	50,769	6,939	11,885	5,160	4,508	14,420
	Enugu	3,012,091	4.9%	76,860	81,998	4,629	19,095	6,719	7,258	21,494
	Imo	3,523,156	3.1%	87,226	66,860	8,940	14,791	7,924	5,678	22,376
<b>South South Zone</b>		18,985,583	5.8%	726,324	802,554	97,792	174,843	66,167	67,871	120,239
	Akwa Ibom	3,415,174	7.2%	168,862	157,240	1,742	31,415	15,401	13,434	33,042
	Bayelsa	1,590,201	4.0%	44,784	46,783	5,985	10,422	3,963	3,832	7,705
	Cross Rivers	2,709,823	12.0%	171,420	204,526	39,103	46,461	16,280	17,763	20,618
	Delta	3,672,077	5.0%	97,727	113,135	17,901	25,017	8,913	9,751	19,358
	Edo	3,078,963	4.3%	77,397	83,794	10,939	18,076	6,970	7,111	16,594
	Rivers	4,519,345	6.6%	166,134	197,076	22,122	43,452	14,640	15,980	22,922
<b>South West Zone</b>		24,744,106	2.3%	546,522	510,112	86,130	91,546	43,995	38,655	104,460
	Ekiti	2,177,048	2.0%	27,722	26,633	3,932	5,802	2,286	2,048	5,128
	Lagos	8,116,535	4.7%	216,826	236,820	36,597	53,894	16,252	18,099	53,441
	Ogun	3,308,128	1.5%	50,913	33,082	7,384	1,716	4,077	2,303	7,558
	Ondo	3,188,875	2.3%	91,770	58,309	13,189	2,045	7,747	4,242	12,794
	Osun	3,059,128	1.2%	55,094	30,598	7,409	1,000	5,097	2,435	9,683
	Oyo	4,894,392	3.9%	104,197	124,670	17,619	27,089	8,536	9,528	15,856
		126,250,207	5%	3,352,444	3,496,796	555,242	769,106	293,808	295,099	633,613

Source; USAID Policy Project 2003.

Based on the above-mentioned facts, all Nigerians are now at risk, where they live, no matter their situations in life, or their sexual orientations. It is evident that things could get worse very soon and if care is not taken, Nigeria may be one of the worst hit countries in the world.

### **Factors Responsible for the Spread of HIV/AIDS**

The cause of the disease all over the world relates to individuals' social behaviour such as casual sex and intravenous drug use (FmoH 2002). In Nigeria however, the leading driving force for the spread of the HIV infection include low level of education and a high level of ignorance, cultural practices such as polygamy and wife hospitality, crippling poverty and lack of access to appropriate reproductive health services and information particularly for young people. The practice and use of traditional surgery such as uvulectomy and blood-letting procedures with unsterilized instruments, sexual relations with traditional healers as part of treatment of infertile women, as non observance of infection control procedures by traditional birth attendants who are heavily patronized in Nigeria may all be implicated in the spread of HIV/AIDS in Nigeria.

Other factors blamed for the spread of the epidemic are cultural practices that encourage multiple sexual partners such as concubines, Levirate, wife exchange, polygamy and wife hospitality. This in addition to other cultural practices that expose people to unsterilised sharp objects such as body scarification and circumcision; the subordinate roles of women and its attendant vulnerability which prevents women from negotiating safe sex; ignorance; stigma and discrimination. Poverty, Illiteracy and the non-challant attitude of some individuals are to some extent also responsible for the spread of the disease.

In spite of various efforts at both domestic and international levels, Nigeria's situation seems not to translate to any reliable cheering news about HIV/AIDS epidemics. It is becoming more of a developmental problem than just a narrow view of health problem. The problem should be considered a major challenge to sustainable human development in Nigeria, which must be a concern for all. It is against this backdrop that the present research effort was undertaken with the hope of introducing a more pragmatic approach tagged 'City Consultation' that could translate into a more sustainable effort to step down the spread and the negative impacts of HIV/AIDS epidemic on the community of interest.

The study's focus is presently on one of the leading states in terms of prevalence, Benue State, the second leading State. The effort is focused on one of the Local government areas, Makurdi Local government.

### **Justification For The Study**

Concerns for the poor, especially people living with HIV/AIDS (PLWHAS) in terms of socio-psychological disturbances, discrimination, financial difficulties and other attendant problems as a result of HIV/AIDS infection prompted this study.

This study focuses on Benue state, located in north central Nigeria. The State has a total population of 2,780,398 (1991 census), which has been projected to 3,100,311 (1996), with an average population density of 99 persons per Sq. Km. This makes Benue the 14<sup>th</sup> most populous state in Nigeria. However, the distribution of the population according to LGA's shows marked duality. There are areas of low population density, such as Guma, Gwer, Ohimini, Katsina-Ala, Apa. Logo and Agatu, each with less than seventy persons per square kilometre. While Vandeik

Okpokwu, Ogbadibo, Obi and Gboko have densities ranging from 140 persons to 200 persons per square kilometer

The state's population shows a slight imbalance in favour of the females constituting 50.2 per cent. Benue State is one of the most under-developed states in Nigeria. This region was depleted of its human population during the trans-Saharan and trans-Atlantic slave trade. Benue State is largely rural, with scattered settlements mainly in tiny compounds or homesteads, whose population ranges from 6-30 people, most of whom are farmers. In the Idoma speaking part of the state, the settlements are larger (50-200 people). (NAPEP – Overview of Benue State)

### **Why Benue State and Makurdi in Particular**

In the 1999 and 2001 national antenatal HIV seroprevalence survey, Benue State recorded the highest state prevalence rates in both 1999 and 2001: 16.8% in 1999 and 13.5% in 2001. The higher prevalence rate in 1999 of 16.8% is thought to be either an overestimation due to mistakes in the methodology or due to the large variation around the mean in the relatively small samples. When comparing the confidence intervals of the Makurdi site for both years, they tend to overlap.

### **Makurdi City. (*The Study Area*)**

Makurdi has a projected 2005 population of 273, 724 people with 142,231 males and 129,483 females. The city has a projected Annual Population Growth Rate of 2.6% and is predominantly populated by the Tiv ethnic group. Other minority ethnic groups in the city include the Idoma, Jukun and Igalla. The dominant religion in the city is Christianity and the residents are mostly farmers, civil servants and traders. The city has a well laid out and planned road network, and maintains high environmental standards (little refuse was seen on the streets) because of the strict enforcement of environmental legislation in the state. In general, the people are accommodating, hospitable and friendly to visitors.

The city of Makurdi has a high incidence of the HIV/AIDS pandemic. It occupies the North Central Geopolitical Zone of Nigeria and is the socio-political capital of the region. While it suffers from all the disadvantages that encourage the spread of the disease, the city is located in an environment that engages in cultural habits that spread the disease such as traditional circumcision, tattooing etc. Unfortunately, the location of the city places it in geographical location where literacy rate is low and incidence of poverty very high.

Like other cities in Nigeria, the rest of the community usually ostracizes people identified as having HIV/AIDS. Consequently, nobody will own up to being infected with the disease. Unsuspecting sexual partners are thus easy victims. Because of the social stigma involved, people are not ready to carry out HIV tests. Lastly for the country, not much is being done to assist victims as well as check the spread of the epidemic. Consequently, the lives of the youths are perpetually under the threat of HIV/AIDS. There is thus the need to bring all segments of the people together to discuss the problem and find solutions rooted in their tradition to control the scourge.

### **Objectives of the Study**



The aim of the study is to depict a comprehensive picture of the situation of People Living With HIV and AIDS (PLWHA) in the city. The objectives are as follows:

1. Conduct desk reviews of HIV/AIDS studies.
2. Conduct a reconnaissance survey of Makurdi to familiarize the research team with the study area and plan the data gathering process for the study.
3. Conduct series of mini-consultations among stakeholders to encourage them to attend and discuss the problem of HIV/AIDS in an omnibus city consultation.
4. Gather data from targeted respondents (PLWHA) in the city of Makurdi.
5. Make policy, suggestions and recommendation to step down the epidemic in Makurdi city, and Nigeria in general.

## **Methodology**

The study commenced with desk reviews and a pilot survey of the city of Makurdi. This enabled the research team to identify stakeholders for City Consultation and brief them about the vision of The African Network of Urban Management Institutions (ANUMI) and the City Consultation on AIDS. It also afforded the research team the opportunity to plan the data gathering required for the city profile report. The research team found that although there were numerous AIDS intervention programmes in the city, the expected benefits to PLWHA were not commensurate with the heavy investments made in this regard. This finding necessitated the involvement of PLWHA throughout all stages of the City Consultation process.

Next, the research team began the data collection phase of the study, using primary data. The team administered questionnaires among PLWHA at the Federal Medical Centre and the Bishop Murray Catholic Mission in the city. Another set of questionnaires was administered among stakeholders involved in policy making with regards to AIDS. In Makurdi, this includes officials of the Benue State Ministry of Health and Human Services, the Federal Medical Centre, Bishop Murray Catholic Mission Health Centre, Makurdi, The Nigerian Television Authority, Makurdi, Associations of People Living with AIDS, non – governmental organizations and local action groups involved in AIDS management etc. The data from the questionnaires was complemented with focus group discussions with PLWHA to capture their perspectives about the disease and its impact on their lives.

Data from the questionnaires were analyzed on a computer software package called The Statistical Package for Social Scientists (SPSS). Descriptive analysis of the data, including case summaries of the questionnaire variables was carried out and the results were used to develop a comprehensive profile of AIDS in Makurdi.

## **FINDINGS FROM THE STUDY**

### **1) Sexual Practices**

Findings on sexual practices of PLWHA reveal the fact that 63% were sexually active. Out of this percentage, 8.5% had two sexual partners while the remaining 54.5% had one partner. Eighteen percent of the respondents had had sex with commercial sex workers and 48.5% had had casual sex. Most of the respondents had sex with their spouses or lovers (69.1%), but what is worrisome is the fact that 42.4% of the respondents indicated that their partners had other sexual partners. In addition 50.9% of the respondents used no form of protection during their last sexual

intercourse, while 38.8% used condoms – the most common form of protection. Consequently, the practice of multiple sexual partners and non-use of protection during sex must be examined because of the associated high risk of contracting and spreading the disease. This comes against the backdrop of the relatively high level of awareness that PLWHA had about modes of transmission of the disease.

As a likely consequence of the above-mentioned trends, a significant portion of the respondents indicated symptoms of other sexually transmitted diseases. For genital ulcers, 40.6% indicated having this symptom, 19.4% had experienced urethral discharge, 32.7% had dysuria and 46.7% had experienced vaginal discharge. The last figure being the highest percentage may be a pointer to the fact that female PLWHA were more vulnerable to contracting the disease before infection took place. Indeed, 57% of the respondents did indicate that they had contracted a sexually transmitted disease in the past.

## **2) Perception of Vulnerability to HIV/AIDS**

Interestingly, the respondents were aware of the relative potency of the HIV/AIDS epidemic. In this regard, 71.5% agreed that anyone is vulnerable to contracting the disease, 57% perceived AIDS as the deadliest known human disease and 87.3% perceived themselves as being vulnerable to the disease. In addition 60.6% of the respondents were aware about Voluntary Counseling and Testing and 50.9% were willing to be tested for the disease. Evidence that the disease is more rampant than is estimated by contemporary studies, is supported by the fact that 84.2% of the respondents knew other people who had the disease. Also, 49.1% of the respondents believed that HIV/AIDS is curable and 29.1% believed this could be achieved through orthodox doctors. Another 20% believed prayers could cure the disease as well. This confirms the respondents' beliefs in orthodox medicine and divine intervention as the likely sources for curing the disease.

## **3. Socio-Psychological Impact of the disease**

According to the respondents, a significant proportion experienced stigmatization in terms of discrimination at work, denial of unemployment, denial of social support like credit, loans, ostracism from relatives etc. Indeed, 42.4% of respondents experienced stigmatization. In addition, 44.3% mentioned denial of social support and ostracism from relatives and 32.9% mentioned discrimination at work as the principal types of stigmatization they experienced. The problem of stigmatization must be taken seriously because, based on the earlier definition, it deprives PLWHA the opportunity to make money to purchase the requisite drugs for treatment and other essential medical services they require. In spite of the stigmatization, the respondents mention the receipt of financial donations, as 40.4% received such help to cope with their predicament. Out of this, 26.1% of the respondents received financial aid from relatives and 16.4% from friends, the two principal sources. Interestingly these two sources of aid were the most likely to stigmatize PLWHA as 11.5% of respondents mentioned family members and friends as people who stigmatized them.

The financial assistance the respondents received is an indicator of the respondents' inability to cope with the costs of managing the disease. Up to 58.2% of the respondents mentioned a failure to meet their financial responsibilities, 15.5% mentioned loss of self-employment and 14.5% mentioned loss of savings. Other coping mechanisms of the respondents included their membership in 'Associations of PLWHA'. Up to 54% of respondents were members because of

the need to share their experiences with other PLWHA to reduce the negative health implications of stress, anger, frustration, rejection etc. Also 44.4% mentioned the need for moral support and counseling for proper education about the disease. Knowing the benefits of these associations, there is the need to sensitize PLWHA further, as 39.8% of the respondents indicated that they were not members of such associations because of ignorance. Interestingly, the disease did not significantly affect the social activities of the respondents, as 58.5% mentioned their attendance of village meetings, while 21.3% mentioned their participation in club activities.

Of course, the respondents listed several forms of 'Care and Support' they required to cope with the disease. Indeed, 27.9% mentioned employment – the need to have a job to make money, 21.8% wanted cheaper drugs required for their treatment and 18.2% mentioned availability of these drugs for treatment. This makes the issues of economic empowerment of PLWHA and the availability of cheaper drugs as key 'Care and Support' programmes to be deliberated upon at this City Consultation. In addition 39.8% of the respondents knew the HIV status of their spouses, again raising the issue of constraints working against PLWHA going for Voluntary Counseling and Testing, such as fear, ignorance etc.

#### **4. Impact of the disease on Personal Finances of PLWHA**

The AIDS epidemic has clearly worsened the financial situation of PLWHA, as 34.1% of respondents earned between N0 – N15000 per month making up about one-third of the respondents. Another 8.4% earned between N15,000 – N30,000 per month and 1.8% earned between N30,000 – N75,000 per month. This income includes money earned from their professions and financial assistance from relatives and friends. The respondents appear to be carrying heavy financial burdens as 74.5% had children in school and only 38.3% were able to afford their school fees.

Knowing the relatively high drug subsidy of N7,000 and other financial responsibilities of the respondents, such as children's educational needs, house rent, etc, it is extremely difficult for most of the patients to cope with the financial costs of managing the disease. This point is reinforced by the fact that 88.6% of the respondents spend between N0 – N10,000 per month attending HIV/AIDS clinic sessions for treatment and counseling. In addition, the respondents spend considerable time at these clinic sessions as 52.1% of the respondents spent between 5 – 7 hours per session. This tends to take considerable time from the PLWHA from other productive activities that could generate income in the long run.

According to the respondents, up to 33.9% were unemployed. Indeed 17% of the respondents indicated they were unemployed for reasons such as low level of education, were still looking for work, were dependents etc. Out of the employed respondents, 34.5% were self-employed in private businesses, commerce and trading activities and 32.7% were engaged in formal employment.

#### **Recommendations and Policy Issues**

Based on findings in this study, policy direction is urgently needed in the following areas to step down the impact and spread of HIV/AIDS in Benue State in particular and Nigeria in general.

- The political will is in existence to act decisively to prevent the further spread of HIV/AIDS and mitigate its impact, but efforts on the ground are too limited to make positive meaningful impacts on the lives of PLWHA. Political will need be strengthened to take care of these limitations. Stakeholders need to be sensitized about the impact of HIV/AIDS on lives and livelihoods, and advocacy needs to take place to mobilize resources and effort to address the spread of the epidemic.
- Policy actions are needed, not only on awareness programmes, but also more in the area of infection prevention, strengthening of care and support to PLWHA and caregivers. Efforts need be intensified on mitigating the impacts of HIV/AIDS.
- There is an urgent need to give much more attention to appropriate prevention measures in all cities and communities, with particular focus on high risk groups, that is, the youths and others affected by poverty and inequality which enhance susceptibility to infection.
- AIDS is still a highly stigmatized disease in Benue State, and as a result, HIV/AIDS is not addressed openly. This affects prevention, care and support interventions. Stigma also prevents the collection of accurate data on which to base policy and program decisions. Hence, policies to eradicate stigmatization must be put in place and intensify it across the federation.
- As regards care and support, the challenge here is how best to assist and strengthen local support networks so that they can become more effective without becoming overwhelmed. Support must build on local initiatives and existing safety nets, avoiding the development of external or parallel support systems which cannot be sustained. PLWHA needs be empowered, provided with employment and enough drugs to go round all the PLWHA identified in the country.
- Care and support efforts should focus directly on target groups and the most vulnerable groups such as: PLWHA, orphans, widows and elderly caregivers. PLWHA need better access to care, which improves their health, quality of life and survival. Caregivers and the bereaved need be economically engaged, financially empowered, given socio-psychological counseling and other types of support. Home-based care needs to be strengthened to prevent existing safety nets from collapsing and to improve quality of care. There is an urgent need to strengthen the involvement of civil society organizations in providing care and support.

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## **Questions and Answers of City Profile of HIV/AIDS in Makurdi by Dr. Abiodun Ojoawo**

Dr. Utor stated that the paper has revealed several issues geared around the AIDS situation in Makurdi. The State Ministry was concerned about ethical clearance for institutions looking to study HIV/AIDS in the State, so data could be cross-checked and checks and balances introduced. A health act was being considered in the state house to protect the rights of PLWHA. The sample size used in the study was worrisome because of the paper's use of percentages. In other words the sample size had implications for validity and Reliability Testing.

Other contributions from the participants wanted to know if percentages or figures were allocated to mitigation of data associated with the spread of the disease. Testing just for the sake of testing without giving drugs to patients was unethical. Although the government and BENSAA had taken some steps, not enough support was coming to justify all the data being collected. Availability of drugs should be the focus of the City Consultation – even an aggregate increase of 50% will make a big difference.

According to Reverend Tor Uja participants should have a copy of this profile for more fruitful deliberations during the Syndicate Group Discussions. He wanted to know why Makurdi was selected for the study. In addition, he believed that blood transfusion appeared not to be a factor responsible to the transmission of HIV – Oral sex was a more significant factor in this regard. We ran the risk of developing a unipolar approach and not a multipolar one, with the latter being the better policy option. He wanted to know how to stop new infections while taking care of old ones. The society needed awareness on a sustainable basis with a deliberate care approach. Lack of effective care and support programmes raised the risk of HIV positive people infecting others. Reverend Uja appreciated representatives of the Benue State Ministry and The Federal Medical Centre. He wanted to know if DPC could get government and PERFA to improve the treatment of patients.

### **Syndicate Group Discussions**

- GROUP A: Problems in the Care and Support Programmes
- GROUP B: Social Challenges of the PLWHA
- GROUP C: Improving Governance to arrest the spread of HIV/AIDS
- GROUP D: Fostering desirable attitudinal changes in a community living with HIV/AIDS
- GROUP E: Harmonizing HIV/AIDS Initiatives

## **REPORT OF SYNDICATE GROUP DISCUSSIONS**

### **GROUP A – PROBLEMS IN THE CARE AND SUPPORT PROGRAMMES**

#### **I. The following were identified as the components of the care and support programmes.**

- Financial assistance
- Counseling
- Educational
- Provision of ARV drugs
- Spiritual Support
- Skills Acquisition
- Support Groups
- Medicare

#### **II. General Problems Identified With HIV/AIDS**

1. Drugs
  - i) Inadequacy of drugs
  - ii) Inaccessibility of Care and Support to most PLWHAS
  - iii) Drug Shortages
  - iv) Drugs are expensive
2. Food – Inability to feed well
3. Lack of a source of income
4. Rejection of PLWHA by family and friends
5. Discrimination and Stigmatization of PLWHA

#### **III. Problems Encountered by Support Group & Agencies.**

1. Federal Medical Centre, Makurdi
  - Drug shortages
  - Irregularities in placement of PLWHA on Federal Government Drug List
  - Lack of privacy of AIDS patients
  - Irregularities in drug allocation and collection
  - Delays in Service Provision
  - High Cost of ARVS of the hospital initiative
  - ARV clinic is not shaded – too much sun exposure for AIDS patients
  - Improper counseling of patients
2. Others
  - High cost of ARVS by the other groups

#### **Support Groups**

- Rivalry among group members
- Continued high risk behaviour among members



#### **IV. List of Care and Support Programmes in Makurdi for PLWHA**

1. Federal Government ARV initiative at Federal Medical Centre, Makurdi
2. Hospital Initiatives on ARVS – at N7000 spent on one patient per month.
  - Federal Medical Centre, Makurdi
  - Bishop Murray Catholic Mission
3. PFD (Partners for Development) spends N5000 per patient per month on ARVS and Skill Acquisition
4. Society for Family Health – distributes free condoms to the public
5. PATHS – ARV programme at N5650 per patient
6. Health Information Centre (HIC) – for Skills Acquisition. Also gives:
  - Drugs for OI (Opportunistic Infections)
  - Foodstuffs
  - Financial Support
  - Counseling
  - VCT, Subsidized
7. OSA Foundation – for Microcredit Scheme
8. Benue Network of People Living With HIV/AIDS – provides
  - Income Generating Activities
  - Providing Home – based care free
  - Providing Foodstuff
9. Peace Support Group - gives
  - Home based Care free
  - Food Stuff
  - Counseling
10. DFID gives Financial support
11. Saint Joseph Catholic Mission Nigerian, gives
  - Spiritual support
  - Financial Support

#### **V. Strategies**

1. Drugs procured to be disbursed to PLWHA in Makurdi through BENPPLUS (Benue Network of People Living with HIV/AIDS) at a cost of N1000.
2. Skill Acquisition Training to be organized by BENPPLUS on a continuous basis (AFTER BENPPLUS has undergone a training by trainers)
3. Micro-credit schemes to mobilize those trained by the network.
4. Rejection by family and friends – Support group members to visit families rejecting PLWHA to counsel them.
5. Reducing high-risk behaviour – Support groups inviting health care givers to their meetings for talks, periodically.

## GROUP B: SOCIAL CHALLENGES FACING PLWHA

Serial Number	Problem	Solution
1	Stigmatization , Discrimination and Rejection of PLWHA and the people who work with them	<ul style="list-style-type: none"> <li>a) Makurdi Local Government should create awareness programmes in the community</li> <li>b) Outreach programmes through community based organizations, naming, burial ceremonies, public gatherings, and traditional authorities.</li> <li>c) Identify PLWHA and encourage them to form support groups.</li> <li>d) Educating the community about the rights of PLWHA</li> </ul>
2	Inadequate Counseling Services for PLWHA <ul style="list-style-type: none"> <li>- Pre Counseling</li> <li>- Post Counseling</li> <li>- Follow-up by Counselors</li> </ul>	<ul style="list-style-type: none"> <li>a) Retraining of Counselors in the Local Government in collaboration with the State Action Committee on AIDS to perform their duties effectively and to provide more counselors to serve the hinterland.</li> <li>b) Training of religious leaders for cost-effective financing of Local Government programmes</li> <li>c) Identify donor agencies and seek funding as a follow-up to day 3 of the consultation's funding</li> <li>d) NGO's and CBO'S with office space, equipment and trained personnel should collaborate with The Local Action Committee on AIDS</li> </ul>
3	Lack of Family Support for PLWHA – rejection, discrimination against PLWHA by relatives	<ul style="list-style-type: none"> <li>a) Encourage family members to obtain financial assistance from CBO's to care for their PLWHA.</li> <li>b) Sensitization of relatives of PLWHA about the modes of transmission of the disease</li> </ul>
4	Data Management Policy of HIV/AIDS Studies	a) LACA should enact a policy requiring any institution carrying out AIDS studies in its area of jurisdiction to make their research findings public.
5	Human Rights Violations of PLWHA	LACA should enforce recent State legislation protecting the rights of PLWHA to live, move freely, obtain employment, express their views freely, gender equality, against discrimination, stigma, to be treated like any other person.
6	Nutrition of PLWHA <ul style="list-style-type: none"> <li>- Inability of breadwinners to care for their family members because of discrimination, ill-health etc</li> </ul>	<ul style="list-style-type: none"> <li>a) LACA should provide jobs for these breadwinners, so they can afford food for their families.</li> <li>b) Encourage affected breadwinners to form cooperative groups and assist them in obtaining loans, credit from financial institutions.</li> <li>c) Educate PLWHA about local foodstuffs that can provide a balanced diet for them.</li> </ul>

Serial Number	Problem	Solution
7	Financial problems facing PLWHA	<ul style="list-style-type: none"> <li>a) Encourage relatives of PLWHA to help them and extend this initiative to the community.</li> <li>b) LACA can provide employment for PLWHA through its Poverty Alleviation Programmes.</li> <li>c) LACA can organize fund-raising activities, inviting community leaders to contribute.</li> </ul>
8	Mismanagement of drugs by health workers	<ul style="list-style-type: none"> <li>a) LACA should monitor the drug administration of health institutions in Makurdi to ensure PLWHA get requisite services.</li> <li>b) LACA should collaborate with The Benue Network of PLWHA to monitor the drug administration of health institutions in Makurdi.</li> </ul>

### **GROUP C – IMPROVING GOVERNANCE TO ARREST THE SPREAD OF HIV/AIDS**

Serial Number	Problem	Solution
1	Gross misuse of funds identified	Need for legislation to discourage misuse of funds
2	Monitoring mechanism observed to be weak	Legislation needed to enforce accountability, transparency. Local Governments to be more transparent and responsive to their responsibilities
3	Discrimination/Stigmatization of PLWHA at work, in the home, in the church, in business etc	Legislation is important to discourage this and corresponding enforcement of strict penalties against offenders needed.
4	Weak Political Will	Government to strengthen political will towards solving HIV/AIDS problems. In this regard, greater advocacy at the highest level of government is required.
5	Inadequate supply of ARVS and distribution outlets are few	Government to increase drug supply to reach all those that need to be regimented. More distribution outlets to be established.
6	Government does not involve PLWHAS in policy decision-making	Government to integrate PLWHA in formulating broad based statewide policies and decisions.
7	Many skilled and unskilled, strong and able PLWHAS are unemployed	Government to absorb these people in its public service departments, involving them in less strenuous tasks.
8	Care and Support not encouraged by government	Government to provide the needs like food, drugs, education of PLWHA.
9	Financial	Government to provide stipends for the unemployed PLWHA on a monthly basis to assist them.

## **GROUP D: FOSTERING DESIRABLE ATTITUDINAL CHANGES IN A COMMUNITY LIVING WITH HIV/AIDS**

The Group discussed at length the paper presented by Mr. Stephen Yongo, President of PLWHA and concluded that desirable attitudinal changes can be achieved but will be gradual. It can be encouraged through:

- Intensive effort at awareness creation
- Providing income-generating activities for people affected, such as Soap and Cake making.
- Empower PLWHA and PABA with skills to improve their self-image and promote positive attitudinal changes within the community.

## **GROUP E: HARMONIZING HIV/AIDS INITIATIVES**

The group affirms that it is very important to bring together different initiatives (ideas and actions) that are in tandem with the overall goal. To achieve this it is required that available services and gaps are identified, so as to channel correctly all resources. There should also be sharing of knowledge of best practices and information for effective monitoring and evaluation. There should also be networking among stakeholders.

### **Different kind of Initiatives were noted, such as:**

1. Prevention
  - Medical
  - Awareness Creation and Sensitization
  - Behavioural Changes
    - Abstinence
    - Faithfulness
    - Condom use
    - High level of identification with HIV/AIDS
    - VCT (Voluntary Counseling and Testing)
2. Care and Support
  - Care for orphans and vulnerable children
  - Fostering
  - Formation of different Support Groups
  - Care and support for PLWHA
    - Advocacy
    - Provision of ARV
    - Medical Care
3. Poverty Reduction
  - Skills Acquisition
  - Micro-Credit
4. Policy Development
  - NGO Networks
  - FBO Networks
  - Government Initiatives
  - PLWHA Networks
  - Youth Activities

### **How to Harmonize Strategies**

- Formation of Thematic networks
- Formation of umbrella Networks – Focal Groups
- Documentation
- Information Dissemination
- Periodic Meeting of Stakeholders on HIV/AIDS
- Advocacy
- Mapping and Profiling

### **The Challenges of Harmonization**

- Coordination
- Funding
- Reduction of the speed in the implementation of activities
- Capacity Building of Institutions managing HIV/AIDS
- Threat of Unwillingness of stakeholders to implement initiatives on AIDS
- Corporate Ownership of AIDS projects
- Resistance of stakeholders to change
- Monitoring and Evaluation of AIDS related programmes

### **Action Plan**

Organize another general meeting of stakeholders in Makurdi with a view to:

- Expose stakeholders to each other
- Share information on existing services
- Identify strengths and weaknesses of existing AIDS programmes
- Cause stakeholders to agree on the need for synergy in programme design

At the meeting there will be formation of networks and strengthening of existing ones along these lines:

- Thematic Focal Groups
- Professional Groups
- Community Grouping

There will also be Capacity Building for leaders and members of service providers.

The Harmonising Committee will be responsible for advocacy among Political and Religious Leaders, and Funding Agencies. Also for:

- Presentation of Services to the affected
- Sensitization of Stakeholders
- Publicity

The Harmonising Committee will also

- Undertake Training of Emerging Groups
- Monitoring and Evaluation.

**Action Plan and the Implementation Committee**  
**SUMMARY OF ACTION PLAN**

S/No	Activities	Objectives	Methodology	Resources	Who	When	Date
1	Reducing stigmatization and discrimination against PLWHA	Eradication of stigmatization by 40% in the year 2007	Consultation with community leaders Outreach to cbo's	Trained counselors, stationary, Information Education and Communication (IEC), Transportation	Local Government Council to sponsor 50% of needed funds, NGO's, Donor Agencies and Philanthropists to sponsor the other 50%	June, 2005, 4 <sup>th</sup> quarter, 2005	
2	Adequate Counseling	To improve the quality and increase the quantity of trained counselors	Training workshop for professional counselors Distribution of publications on HIV/AIDS	Health personnel in Makurdi in Health, Agriculture and Education Stationary Remuneration for professional staff	Local Governments, NGO's, University of Agriculture, Makurdi (UAM)	May 2005	
3	Family Support Programmes	To increase the cash flow into families of PLWHA for the benefit of PLWHA	Involvement of families of PLWHA in LACA programmes	Same as above	Local Government, NGO's, CBO's, UAM	Same as above	
4	Data Management Policy of HIV/AIDS studies	To ensure data on AIDS related studies is made available to PLWHA and Local Government Information Centre	Focus Group Discussions and semi-structured interviews of PLWHA	Funds for Transportation of professional staff and feeding	Personnel of the Makurdi Local Government, NGO's and donor agencies	July, 2005	
5	Human Rights Protection of PLWHA	To enforce Benue State Legislation protecting the rights of PLWHA	Train members of Benue Network of PLWHA to interact with PLWHA	Members of BENPPLUS Personnel from the Benue State Ministry of	BENPPLUS, LACA, Critical mass at Local Government Authority	August, 2005	



				Health			
S/No	Activities	Objectives	Methodology	Resources	Who	When	Date
6	Improving the nutrition of PLWHA	To ensure that PLWHA in Makurdi enjoy a balanced diet	Training workshop for PLWHA in agro-allied industrial activities	Stationary, Local Government Counselors, BENPPLUS Counselors, Feeding and transportation of participants	NGO's, Cob's, LACA, UAM	Oct 2005	
7	Improving the Financial Situation of PLWHA	To improve the quality of life of PLWHA through income generating activities	Organizing fund-raising activities through faith based organizations, community leaders, donor agencies	Personnel from NGO's, CBO's, Stationary, UAM	NGO's, CBO's, UAM	Nov 2005	
8	Improvement of drug administration by health workers	Ensuring proper administration of ARV's by health workers to PLWHA	LACA to establish collaborative mechanism with BENPPLUS	BENPPLUS, LACA, Transportation, Coordinators of Local Government Authority (LGA)	BENPPLUS and LACA	Nov 2005	

## Makurdi City Consultation

### Action plan for Makurdi City HIV/AIDS: Prevention and Impact Mitigation Initiative

The Makurdi City Board on HIV/AIDS was formed on the second day 7-4-05 of the City Consultation on HIV/AIDS in Makurdi. Its membership is listed as follows

S/No	Name	Institution	Position on Implementation Committee
1.	Mr. Stephen Yongo	Benue Network of People Living with HIV/AIDS	Chairman
2.	Mrs Becky Aernyi	Makurdi Local Government Action Committee on AIDS	Vice Chairman
3.	Miss Elizabeth Aluna	Makurdi Local Government Secretariat Personnel Department, Traditional Council Section	General Secretary
4.	Mr. Febian Tor	Benue Network of People Living with HIV/AIDS	Assistant Secretary
5.	Mr. Andrew Ogwuche	Cooperative Extension Centre, University of Agriculture, Makurdi	Financial Secretary
6.	Mr. David A. Orkar	Cooperative Extension Centre, University of Agriculture, Makurdi	Treasurer
7.	Miss Josephine Haba	Jireh Foundation Pauline Makka Centre, High Level, Makurdi	Member
8.	Mr Ona Ode	Benue State HIV/AIDS Programme Development Project. 18, Peter Achimugu Avenue. Behind Post Office Makurdi. C/O P.O. .Box 2062 Makurdi	Networking Officer
9.	Mr Richard Iorlaha	Ministry of Women Affairs and Youth Development Makurdi	Member
10.	Miss Janet Mbashar	Benue Network of People Living with HIV/AIDS, Makurdi	Member

## **Appendix**

1.	Goodwill Message from PATHS.....	43 – 44
2.	General Lists of Participants .....	45 – 49
3.	Lists of Participants in the Discussion Groups .....	50 – 52

**A GOODWILL MESSAGE FROM LIZZY AKOR – THE PROGRAMME OFFICER FOR PATHS ON THE CITY CONSULTATIVE FORUM ON HIV/AIDS AND LOCAL GOVERNANCE IN MAKURDI, 6 APRIL, 2005 AT THE PLAZA HOTEL**

I would like to salute you on behalf of my organization, Partnership for Transforming Health Systems (PATHS). PATHS is a Department for International Development programme on health related issues (DFID). This organization works in collaboration with Nigerian partners across all sectors to develop partnerships for transforming the health systems in Nigeria.

The objectives of DPC towards HIV/AIDS control here in Benue is a good idea. We have also discovered that so many parallel programmes in the state on these issues , with each one doing their own thing .This has not helped in the spread , rather it worsens the situation. Can we say here that what the situation needs now is Creating Awareness? I feel we need more than that now. We can actually come together, bring these different ideas together and come up with useful plans involving PLWAS.

DFID had earlier on sponsored another programme in Benue on HIV/AIDS through Liverpool Associates and Tropical Health (LATH). The organization did a lot of work on HIV/AIDS, mostly in Zone C, where the epidemic is said to be high. This time around, PATHS has come to partnership with organizations and work towards some priority health conditions that have been identified, like Safe motherhood, TB, Diarrhoea, other services provision like DRUGS and basic equipment.

Activities of PATHS Benue in managing this situation

- DRF system with the PLWAS on ARVs. PATHS provided an initial seeds stock by purchase. It also gave technical assistance to local health institutions in the running ARV/DRF systems.
- Drugs for the PMTCT has also been ordered as a drug to help positive mothers
- On the management aspect is an integrative plan of HIV/AIDS, Sexually Transmitted Diseases and Tuberculosis (HAST). A manual has been developed, and currently undergoing scrutinization before training of health workers can commence.
- As one of our major outputs, strengthening the stewardship role of Government which is also about Local Governance.

We are always looking forward to partnership with any organization that has these ideas to curb the menace. The city consultation on HIV/AIDS and Governance is a good step forward and after the stakeholders' consultative forum, it is hoped that good plans will come out. Consequently, we should have a common 'basket' which could be managed by the government whereby any NGOS coming to the state , both international and national would see these plans and put their money into the common basket. Then Strategic plans could follow.

It is hoped that the other DFID programme contracted by Family Health International (FHI) would come a long way to do so many things in this regard.

Once again I sincerely on behalf of my organization commend DPC for this brilliant idea and say here that our doors are open to whatever plans and ways we could work together to curb this problem from our state so it moves to the 5<sup>th</sup> position in the next survey.

Thank you and God bless.

Lizzy Akor.

**MAKURDI CITY CONSULTATION ON HIV/AIDS  
APRIL 6 – 8 2005**

**LIST OF PARTICIPANTS FOR DAY 1 – OPENING CEREMONY AND PLENARY  
SESSION**

SERIAL NUMBER	NAME	OCCUPATION / INSTITUTIONAL AFFILIATION	ADDRESS
1	Eunice Achakpa	Housewife	Gboko Road, Makurdi
2	Ibume O. Richard	Health Information Centre	HIC
3	Prof. B Aboyade	Chairman , DPC	Ibadan
4	Regina E. Ameli	Procurement Officer , Benue HIV/AIDS Project	Makurdi
5	Daniel Akpolo	Civil Servant	Makurdi
6	Nathaniel Ikape	Civil Servant	Makurdi
7	Ahuah Kulugh	Teaching	Makurdi
8	Febian Tor	HIV/AIDS Activist	Makurdi
9	Janet Mbashall	Benue Network of People Living with HIV/AIDS	Makurdi
10	Samuel Akase	Benue Network of People Living with HIV/AIDS	Makurdi
11	E.C Odiaka	Lecturing	University of Agriculture, Makurdi
12	D. K Adedzwa	Research / Extension	UAM
13	Mrs Justina Odumu	DP	Makurdi
14	Akighin A. Alfred	Civil Servant	Makurdi
15	Rita Abari	Nursing / Peace Health Care Organization	Makurdi
16	Yevvhi Iorlaha	Housewife	Makurdi
17	Numbeve B . Kenneth	Applicant	Makurdi
18	Stephen Yongo	Teaching (Benue Network of People Living with HIV/AIDS, BNPPLUS)	Makurdi
19	Koko Paul	Computer Operator (BNPPLUS)	Makurdi

SERIAL NUMBER	NAME	OCCUPATION INSTITUTIONAL AFFILIATION	ADDRESS
20	Tor Uja	Pastor	Makurdi
21	David A. Orkar	Agricultural Extension	University of Agriculture Makurdi
22	Paul Ogenyi	Teaching	Makurdi
23	Godwin Chukwu	Welder	Makurdi
24	Kuyisa Abu	Farming	Yam dev
25	Meg Chukwu	Social Worker	Makurdi
26	Ona Ode	Benue State Project Team	Makurdi
27	Myaagha Tsea Patrice	Business	Makurdi
28	Andrew Ogwuche	CEC , Civil Servant	Makurdi
29	Honourable Mike Iduma	Honourable Commissioner for Health	Makurdi
30	Dr (Mrs) Roselina H. Daudu	CEC , University of Agriculture	Makurdi
31	Nushukurc Jnding	Health Information Centre	Makurdi
32	Joshua Samuel	Health Information Centre	Makurdi
33	Pauline Ayo	Federal Ministry of Works	Makurdi
34	Veronica Ikyaagba	Saint Catherine's Primary School	Makurdi
35	Cecila Anoh	HIV/AIDS Coordinator , Makurdi Local Government	Makurdi
36	Mbakperan Cibor	Director Buwah Barracks Local Government Area	Makurdi
37	John T Ortese	Extension Agronomist CEC, University of Agriculture	Makurdi
38	Honourable Steve Asom	Makurdi Local Government	Makurdi

SERIAL NUMBER	NAME	OCCUPATION / INSTITUTIONAL AFFILIATION	ADDRESS
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39	Joseph Sokpo	Civil Servant	Makurdi
40	Simein Ihyo	Civil Servant	Makurdi
41	Member Peters	PASG	Makurdi
42	Mr Samuel A. Imo	PASG	Makurdi
43	Josephine Habba	CISNHM FP	Makurdi
44	Julian Demise	Business woman	Makurdi
45	Ephram Washima	Nurse	Zakibian
46	Evangelist Otsesunday	Civil Servant	Ohimini
47	Elizabeth Akor	Health Development Officer	PATHS
48	Tor Gondo	Civil Servant	NOHAHS
49	Achi Torsar	Student , Benue State University (BSU)	Logo II , Opposite BSU, Makurdi
50	Mermber Torsar	Housewife	Chito Ukum Local Government
51	Richard I. Iorlaha	Civil Servant, Ministry of Women Affairs and Youth Development	Makurdi
52	S.K Adetsan	Civil Servant	Makurdi
53	M.I Agber	Civil Servant	Makurdi
54	Victoria Onazi	Civil Servant	Makurdi
55	Becky Aernyi	PHCC/HODH Makurdi Local Government Council	Makurdi
56	Honourable Titus Akuta	Personnel Assistant, MLC. CHAM	Makurdi
57	Demvihin Vihishima	Unemployed	Makurdi

SERIAL NUMBER	NAME	OCCUPATION / INSTITUTIONAL AFFILIATION	ADDRESS
58	Veronica Vanger	Civil Servant	Kwande
59	Iveren P. Garba	Student	Makurdi
60	Roseline Odeh	Retired Arm Nigerian	Makurdi



		Custom Service	
61	Daphnie Dondo	Jlreh Foundation / SLIP	Pauline Makka Centre , Makurdi
62	Mercy Odu	Positive Vibes	Pauline Makka Centre , Makurdi
63	Mrs G.A Wende	Secretary State Action Committee on AIDS	Gwande
64	Nancy Vaatia	Radio Benue Health Correspondent	Makurdi
65	Awangeh Monica	Nursing Benue Med	Aweh , Makurdi
66	Dr Terrumun Z Swende	Federal Medical Centre	Makurdi
67	Dr Phillip Abata	Medical Director , Federal Medical Centre	Makurdi
68	Dr Adeniyi Alayoayo	Medical Director , Federal Medical Centre	Makurdi
69	Mr I. U. Mee	Civil Servant , JAF , MOH	Makurdi
70	Ubo James Shaapera	Civil Servant JAF , MOH	Makurdi
71	Dr . A.C. Ali	Federal Medical Centre	Makurdi
72	Grace Alashi	Teaching	Makurdi
73	Dr Kokara J.S	Medical Doctor , Federal Medical Centre	Makurdi
74	John Awnla		Makurdi
75	Hembadoon Dzege	Benue State University	Makurdi
76	Mr Simon U Iduh	S.A to Commissioner for Health	MOH
77	D.Z Guda	SMOH	Makurdi
78	Rev Sr Rose Udianefo	Nurse , Bishop Murray Medical Centre	Makurdi

79	Dr E. Akuto	SMOIA , Makurdi	Makurdi
80	Titus Ukyor	SA MKS Chairman	Makurdi
81	Mbumun Uche	Business	Makurdi
82	Dr Faogu E. N	Medical Doctor , Federal Medical Centre	Makurdi
83	Dr (Mrs) Dokunmu	Federal Medical Centre	Makurdi
84	Dr Andrea Jogo	Federal Medical Centre	Makurdi
85	Honourable Margaret Ugo	Makurdi Local Government Area Secretariat	Makurdi

## **GROUP A: PROBLEMS IN THE CARE AND SUPPORT PROGRAMMES**

**7 April 2005**

### **List of Participants**

Serial Number	NAME	OCCUPATION/INSTITUTIONAL AFFILIATION	ADDRESS
1	JANET MBASHALL	Benue Network of People Living with HIV/AIDS	Makurdi
2	PAUL KOKO	COMPUTER OPERATOR	Makurdi
3	SAMUEL AKASE	BUSINESS CONSULTANT	BNPPLUS MKD
4	TOR FRED	Cooperative Extension Centre , University of .Agriculture	Makurdi
5	YEVIHI IORLALA	TRADER	Makurdi
6	MEG CHUKWU	Coordinator EASJ	Makurdi
7	JOY MAKERI		Makurdi
8	YONGO STEPHEN	BENPPLUS	Makurdi
9	DR. VIVIAN SHAAHU	F.M.C	Makurdi
10	HUNDU TORDOO	STUDENT	Makurdi
11	UPAV TERHURA	STUDENT	Makurdi

## **GROUP B: SOCIAL CHALLENGES FACING PLWHA**

**7 April 2005**

### **List of Participants**

Serial Number	NAME	OCCUPATION/INSTITUTIONAL AFFILIATION	ADDRESS
1	YONGO STEPHEN	Teaching: Benue Network of People Living with HIV/AIDS	Makurdi
2	AHUAH KUHAH (Sec.	Peace Health Care Support Group	Makurdi
3	NUMBEVE KENNETH	Peace Health Care Support Group	Makurdi
4	DANIEL AKPOLO	Dooshining support group	Makurdi
5	MEMBER PETERS	Positive alliance support group	Makurdi
6	CECILIA ANOH	Makurdi Local Government (LGA)	Makurdi
7	MERCY ODU	Positive vibes	Makurdi
8	BEDY K. AERMY (Chairman)	PHC Dept (HODH) Makurdi LGC	Makurdi
9	OJETUNDE ABOYADE (Rappoteur)	Development Policy Centre	Ibadan

## **GROUP C: IMPROVING GOVERNANCE**

**7 April 2005**

### **List of Participants**

S/NO	NAME	OCCUPATION/INSTITUTIONAL AFFILIATION	ADDRESS
1	ONA ODE	BENUE SPT	Makurdi
2	DR. PINE ABATA	Medical Doctor, FMC Makurdi	Makurdi
3	DR. ADENIYI ALAYOAYO	Medical Doctor, FMC Makurdi	Makurdi
4	DR FAAGEE ERUKAH	F. M.C. Makurdi	Makurdi
5	EVANGELIST OTSE SUNDAY	Ohimuni	Makurdi
6	JOHN ANUKA	Wurukum	Makurdi
7	PAUL OGENYI	Wurukum	Makurdi
8	IKYAAGBA ISEA PATRICK	Benue State University	Makurdi
9	UBO JANICE SHAANA	Makurdi Culture & Tourism	Makurdi
10	HNNDY OGUCHE		

## **GROUP D: FOSTERING DESIRABLE ATTITUDINAL CHANGES**

**7 April 2005**

### **List of Participants**

S/NO	NAME	OCCUPATION/INSTITUTIONAL AFFILIATION	ADDRESS
1	IORHEN SAMUEL	Health Information Centre	Makurdi
2	EUNICE ACHAKPA	Self Employed	Gboko Road Mkd
3	JUDY NWACHUKWU	H.I.C Makurdi	Makurdi
4	IBUME RICHARD	Health Practitioner	HIC Makurdi
5	AKIGHIV A. AYREAL	Dooshina Support Group	Makurdi
6	VERONICA M. IKYAABA	Msuushina Support Group	Ucyaagbe Makurdi
7	IORHEMEN BETE	Civil Servant	Makurdi
8	NATHAIEL IKAPE	Civil Servant Dooshina Group	LOGO II
9	FEBIAN TOV	BNPPLUS Positive vibes Youths	
10	VICTORIA U		Makurdi
11	IMO SAMUEL A.	PLSG	Makurdi
12	ELIZABETH ALUNA	Civil Servant. Makurdi LGC	Makurdi

## **GROUP E: HARMONSING INITIATIVES**

**7 April 2005**

### **List of Participants**

<b>S/NO</b>	<b>NAME</b>	<b>OCCUPATION/INSTITUTIONAL AFFILIATION</b>	<b>ADDRESS</b>
1	RICHARD I. IORLAHA	Civil servant, Ministry of Women Affairs & Youth Dev.	Makurdi
2	JOSEPHINE HABBA	CISNHAN/ Jireh Foundation	Makurdi
3	JOHN T. ORTESE	Cooperative Extension Centre, University of Agriculture	Makurdi
4	REGINA S. AMEH	Procurement Officer- Benue HIV/AIDS Project	Makurdi
5	TOR UJA	Mission House, Makurdi	Makurdi

# **MAKURDI ACTION PLAN**

**Action Plan for Makurdi City HIV/AIDS  
Prevention and Impact Mitigation Initiative**

## 1.1 INTRODUCTION

In order to actualize practical, innovative and sustainable participatory governance vis-à-vis the AIDS epidemic, the Makurdi City Board on HIV/AIDS (MCBHA) was formed on the second day (7<sup>th</sup> April, 2005) of the City Consultation on HIV/AIDS in Makurdi. Its membership is listed as follows:

	NAME	INSTITUTION	POST ON IMPLEMENTATION COMMITTEE
1.	Mr. Stephen Yongo	Benue Network of people living with HIV/AIDS (BENPLUS)	Chairman
2.	Mrs Becky Aernyi	Makurdi Local Government Action Committee on AIDS	Vice Chairman
3.	Miss Elizabeth Aluna	Makurdi Local Government Secretariat Personnel Department, Traditional Council Section	General Secretary
4.	Mr. Fabian Tor	Benue Network of People Living with HIV/AIDS	Assistant Secretary
5.	Mr. Andrew Ogwuche	Cooperative Extension Centre, University of Agriculture Makurdi	Financial Secretary
6.	Mr. David A. Orkar	Cooperative Extension Centre, University of Agriculture Makurdi	Treasurer
7.	Miss Josephine Habba	JIRE Foundation Pauline Makka Centre High – Level Makurdi	Member
8.	Mr. Ona Ode	Benue State HIV Development Project 18, Peter Achimugu Avenue behind General Post Office, Makurdi C/o P.O.Box 2062 Makurdi	Networking officer
9.	Mr. Richard Iorlaha	Ministry of Women Affairs and Youth Development, Makurdi	Member
10.	Miss Janet Mbashal	Benue Network of People Living with HIV/AIDS Makurdi	Member

Indeed, the board depicts a robust and diverse group of stakeholders responsible for implementing the action plan agreed upon at the plenary session of the City Consultation. The diversity of the board membership is meant to solve the uncoordinated governance structures in the city that makes it difficult to cope with the rapid spread of the disease. Hitherto, the institutions represented in this new board have been involved in governance initiatives vis-à-vis the AIDS crisis. These are discussed as follows:

## **1.2 THE COOPERATIVE EXTENSION CENTRE (CEC), FEDERAL UNIVERSITY OF AGRICULTURE, MAKURDI**

The CEC has been involved in raising awareness about HIV/AIDS in the community over the past three to four years. It supports capacity building and extension support programmes in this regard. Recently, it carried out a survey of Benue State, focussing on the negative impact of the disease on the agricultural productivity of rural farmers in the state. Since agriculture is a major component of the community's economic base, the disease is having a negative impact on the farming population in the area. In this regard, the CEC trained all the enumerators who carried out the survey.

Within the university context, the agency was concerned about the impact of AIDS on university campuses in Nigeria, knowing that sexual promiscuity and casual sex among the student population makes them a high risk group, more likely to contract and spread the disease. The CEC was involved in capacity building programmes of students regarding peer education. In other words, senior students were trained in educating incoming freshmen about the disease, at the universities in Makurdi. In this regard, the agency purchased a computer and a projector to achieve its aims. The agency believes that projects like the 'City Consultation on HIV/AIDS in Makurdi' will compliment the existing AIDS intervention programmes in the city to cope with the spread of the disease.

## **1.3 THE BENUE NETWORK OF PEOPLE LIVING WITH HIV/AIDS (BENPLUSS)**

The Benue Network of People Living with AIDS sheds more light about the prevalence and spread of the disease. According to them, the association is aware of the problem in Makurdi, especially the way the infection rate has been affecting young people in Benue State. Statistics have shown that the problem has severely affected many young people in this state and this has caused a lot of concern to the activists in the association. In this regard, the association is working on this particular issue and involving the youth to change behaviour that tends to spread the disease, such as casual sex.

The mission of BENPLUSS is to educate PLWHAs in the state about reducing the negative impact of the disease on their lives and reduce its spread. The network has devised numerous strategies to reduce the viral load that PLWHAs carry. The group is affiliated with other support groups in the state, like the JIRE Foundation, creating awareness about the disease among the population.

The network has up to 30 sub-groups across the state and some local governments have more than 1 sub-group. Although this number appears to be high, there are no sub-groups in some local government areas of the state. This is an area in which philanthropists, donors, and government can support the network with funds in order to increase its capacity to create this awareness. The network believes that the era in which PLWHAs cannot do anything has passed. In addition, it believes it has the personnel and manpower to reach people at the grassroots, and create awareness about the disease. Its track record in this regard, is responsible for the increasing number of PLWHAs who join the network, publicly admitting their HIV status. The network started small, but has expanded considerably over the years.

In addition, the network requires funds to establish a practical training centre for PLWHAs in Benue State. Such a centre can disseminate information, in a friendly atmosphere,



encouraging fearful PLWHAs to come out publicly and admit their health status. The group believes care and support programmes are essential and constitute the desire of the PLWHAs, as lack of such services will cause them to adopt a non-challant attitude to their status and the disease, contributing to its spread.

The group is concerned about effective awareness programmes through radio and television programmes to benefit even the rural areas of the state, knowing that such areas lack access to such facilities. This causes unnecessary in-migration to cities like Makurdi. According to the group, the spread of AIDS is responsible for the depopulation of the state, the increasing prevalence of AIDS orphans, and increasing dependence of the population on the government for services. Government, according to the group, should support PLWHAs who have come out publicly to admit their health status, to make the fight to check the spread of the disease more effective.

#### **1.4 THE BENUE STATE HIV/AIDS DEVELOPMENT PROJECT**

This institution is an arm of the government of Benue State, involved in training and capacity building programmes for stakeholders involved in AIDS management in the state. The agency has twenty-three local action groups implementing HIV/AIDS intervention programmes with 2,000 registered patients. The agency believes the stigma associated with the disease has dropped considerably in the city because of the high level of awareness about the disease among the population.

#### **1.5 THE MAKURDI LOCAL GOVERNMENT**

The Makurdi Local Government has a Local Action Committee on AIDS (LACA), adopting an inward looking methodology to cover Makurdi metropolis. LACA is particularly interested in the socio-cultural factors spreading the disease in the metropolis. LACA Committee was put in place and inaugurated in 2002. Activities of LACA in Makurdi municipal Local Government Area (LGA) were started much later this year after the 3 line departments on HIV/AIDS namely Agriculture, Education and Health. These line departments on HIV/AIDS are part of the Local Government Council (LGCs) own multisectional initiative to combat the spread of the disease. The State Project Team on HIV/AIDS as well as the Local Government Council (LGC) funds the project. Each line department, otherwise known as a critical mass department on HIV/AIDS in the LACA is made up of the following personnel:

1. The LGA HIV/AIDS coordinator.
2. The Procurement Officer,
3. The HIV/AIDS Accountant and
4. The Monitoring and Evaluation (M&E) officer

The chairman of the LGC and the secretary of the LACA, together with the 3 departments make up the 14 members of the critical mass committee. The Health department coordinates the HIV/AIDS activities through the HIV/AIDS coordinator. Already, advocacy/awareness creation and sensitization workshops have been jointly carried out by the 3 departments to win over the policy makers, stakeholders, the PLWHAs and the entire staff of the LG Council.

## **MAKURDI CITY BACKGROUND INFORMATION**

Makurdi has a projected 2005 population of 273, 724 people with 142,231 males and 129,483 females. The city has a projected 'Annual Population Growth Rate' of 2.6% and is predominantly populated by the Tiv ethnic group. Other minority ethnic groups in the city include the Idoma, Jukun and the Igalla. The dominant religion in the city is Christianity and the residents are mostly farmers, civil servants and traders. The city has a well laid out and planned road network, and maintains high environmental standards (little refuse was seen on the streets) because of the strict enforcement of environmental legislation in the state. In general, the people are accommodating, hospitable and friendly to visitors.

The city of Makurdi occupies the North Central Geopolitical Zone of Nigeria and is the socio-political capital of the region. It has a high incidence of the HIV/AIDS pandemic. Based on the ratio of the number of infected people in the city and its total population, 1 out of 10 people in the city had the disease, according to derived findings from the 2003 sentinel survey of the Federal Ministry of Health, Abuja. While it suffers from all the disadvantages that encourage the spread of the disease, the city is located in an environment that engages in cultural habits that spread the disease such as traditional circumcision, tattooing etc. Unfortunately, the literacy rate is low and the incidence of poverty very high in the city.

Like other cities in Nigeria, people identified as having HIV/AIDS are usually ostracized by the rest of the community. Consequently, nobody will own up to being infected with the disease. Unsuspecting sexual partners are thus easy victims. Because of the social stigma involved, people are not ready to carry out HIV tests. Lastly for the country, not much is being done to assist victims as well as check the spread of the epidemic. Consequently, the lives of the youths are perpetually under the threat of HIV/AIDS. There is thus the need to bring all segments of the people together to discuss the problem and find solutions to control the scourge.

### **2.3 MAKURDI CITY CONSULTATION - ACTION PLAN FOR MAKURDI CITY HIV/AIDS PREVENTION AND IMPACT MITIGATION INITIATIVE**

**PROJECT NAME:** Makurdi City Board on HIV/AIDS

**PROJECT TITLE:** Makurdi City HIV/AIDS Prevention and Impact Mitigation Initiative

**PROJECT GOAL:** Reducing the Prevalence and Impact of HIV/AIDS on the Makurdi City Population

**OBJECTIVES: - Criteria for Impact Assessment Analysis of MCBHA**

1. To increase the programme implementation rate in Makurdi City by 15% in the year 2006 through improved condition mechanism and effective mobilization and utilization of resources.
2. To increase the percentage of youths who practice abstinence from sex, by 10% for both males and females by the year 2006.
3. To increase access to comprehensive gender sensitivity prevention care treatment and support services for people living with HIV/AIDS by 2006.
4. To strengthen the capacity of the board members and stakeholders in Programme design and implementation, proposal writing, resources, mobilization, monitoring and evaluation, advocacy etc.

**VARIABLES MODIFICATION: NUMBER OF STAKEHOLDERS INVOLVED IN IMPLEMENTATION**  
**OBJECTIVE I**

**TO INCREASE PROGRAMME IMPLEMENTATION RATE IN MAKURDI CITY BY 15% IN THE YEAR 2006 THROUGH IMPROVED  
CONDITION MECHANISM AND EFFECTIVE MOBILIZATION AND UTILIZATION OF RESOURCES**

<i>Activities</i>	<i>Total</i>	<i>Gender</i>	<i>Vulnerable Group</i>	<i>Level</i>	<i>Who is responsible</i>	<i>Objectively variables Indicators (OVI)</i>	<i>Means of Verification (MOV)</i>	<i>Time Frame</i>	<i>Budget (Naira, ₦)</i>	<i>Risk</i>
Conduct Monthly Board Meetings	12	Female/Male (F/M)	Not Applicable (N.A)	Local	MCBHA	Number of meetings held	Minutes of meeting produced	April 2005 to March 2006	144,000	May not record 100% attendance
Baseline Survey		General	N.A	Local	MCBHA	Number of variables of exposed	Report of survey presented	May to July 2005	400,000	There could be social upheaval
Mapping and Profiling of stakeholders (NGOs/CBOs)	1	General	N.A	Local	MCBHA	Number of stakeholders	The directory of stakeholders produced	April 2005 to March 2006	100,000	Some organizations may be ineffective
Monitor stakeholders' response to HIV/AIDS	4	General	N.A	Local	MCBHA	Numbering of monitoring activities	Report of monitoring activities produced	April 2005 to March 2006	270,200	
Encourage the formation of support groups & strengthen 5 umbrella and thematic networks	5	F/M	N.A	Local	MCBHA	Number of group networks	Number of umbrella organizations registered	April 2005 – March 2006	150,000	There may be structural and financial inhibitions
Development of HIV/AIDS Action Plan for 2006/2007	1	F/M	OVCS, Youths Women & Girls	Local	MCBHA	Number of activities proposed	Copy of Action Plan Presented	January 2006	30,000	The Board Meeting may be irregular
Operating Cost									810,600	

## OBJECTIVE II

### TO INCREASE THE PERCENT OF YOUTHS WHO PRACTICE ABSTINENCE FROM SEX BY 10% FOR BOTH MALE AND FEMALE BY THE YEAR 2006

	<i>TARGET BENEFICIARIES</i>									
<i>Activities</i>	<i>Total</i>	<i>Gender</i>	<i>Vulnerable Group</i>	<i>Level</i>	<i>Who is responsible</i>	<i>Objectively variables Indicators</i>	<i>Means of Verification</i>	<i>Time Frame</i>	<i>Budget in Naira</i>	<i>Risk</i>
Conduct Advocacy meetings with influential female and male stakeholders to mobilize their support for HIV/AIDS prevention and behavioral changes	4	F/M	Not Applicable	Local	MCBHA	Number of visits made	Report of visits made	April 2005 to March 2006	30,000	The stakeholders may be in accessible
Conduct sensitization meetings with media practitioners	1	F/M	N.A	Local	MCBHA	Number of sensitization meetings held	Report of meeting produced	October 2005	50,000	Might have low responses to invitations
Conduct outreaches on prevention of HIV/AIDS among youths at market places, motor parks and other public places within Makurdi metropolis	6	General	N.A	Local	MCBHA	Number of outreaches conducted	Report of outreaches conducted	April 2005 to March 2006	350,000	Disruption of meetings by hoodlums
Utilize youth related events (Youth week celebration) to promote HIV/AIDS prevention	2	F/M	Children and Youth	Local	MCBHA	Number of events/preventive activities	Report of preventive activities carried out	May to August 2005	200,000	Disruption of celebration by hoodlums

### OBJECTIVE III

#### TO INCREASE ACCESS TO COMPREHENSIVE GENDER SENSITIVITY, PREVENTION, CARE, TREATMENT AND SUPPORT SERVICES FOR PEOPLE LIVING WITH HIV/AIDS, ORPHANS AND VULNERABLE CHILDREN AND PEOPLE AFFECTED BY HIV/AIDS BY 2006

<i>Activities</i>	<i>Total</i>	<i>Gender</i>	<i>Vulnerable Group</i>	<i>Level</i>	<i>Who is responsible</i>	<i>Objectively variables Indicators</i>	<i>Means of Verification</i>	<i>Time Frame</i>	<i>Budget (Naira)</i>	<i>Risk</i>
Organize a number sensitization meetings with local communities on community driven initiatives on care and support	20	F/M	Not Applicable	Local	MCBHA	Number of communities attending	Attendance list of participants	October to November 2005	200,000	Initiative may not respond
Organize a one day sanitization seminar for PLWHAs on the use of available local foodstuffs to produce a balanced diet	37	F/M	PLWHA	Local	MCBHA	Number of participants at the seminar	Attendance list of participant and number of support groups represented	July 2005	250,000	There may be no funds
Train and support PLWHAs on IGA	30	F/M	PLWHA	Local	MCBHA	Number of PLWHA trained and supported	Types of IGAs established	June to November 2005	1.5m	Poor management
Subsidize the cost of ARV drugs and treatment services	100	F/M	PLWHA	Local	MCBHA	Number of PLWHA whose drugs are subsidized and percentage of the subsidy	List of persons accessing subsidized ARV therapy and treatment services	April 2005 to March 2006	1m	Disruption in supply chain

## OBJECTIVE IV

**TO STRENGTHEN THE CAPACITY OF THE BOARD MEMBERS AND STAKEHOLDERS IN PROGRAMME DESIGN AND IMPLEMENTATION, PROPOSAL WRITING, RESOURCE MOBILIZATION, MONITORING AND EVALUATION, ADVOCACY, ETC**

<i>Activities</i>	<i>Total</i>	<i>Gender</i>	<i>Vulnerable Group</i>	<i>Level of Implementation</i>	<i>Who is responsible</i>	<i>Objectively variables Indicators</i>	<i>Means of Verification</i>	<i>Time Frame</i>	<i>Budget (Naira, N)</i>	<i>Risk</i>
Organize training for board members in advocacy, Programme design and resource mobilization	10	F/M	Not Applicable	Local	MCBHA	Number of training programmes conducted	Report of training programmes	May 2005	1,000,000	Cost of training may be too high
<b>GRAND TOTAL</b>					N6,484,800.00					